EASY CHOICE HEALTH PLAN
Prior Authorization Requirements

Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

5HT3 ANTI-NAUSEA AGENT BVD DETERMINATION

DRUG NAME

GRANISETRON HCL | GRANISOL | ONDANSETRON HCL | ONDANSETRON ODT

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.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

ABATACEPT

DRUG NAME

ORENCIA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

INITIAL: FOR ALL DIAGNOSIS: NO TRIAL OF AT LEAST ONE OF THE FOLLOWING: ENBREL, HUMIRA, REMICADE, CIMZIA, OR SIMPONI. INITIAL: FOR RHEUMATOID ARTHRITIS OR JUVENILE ARTHRITIS: NO TRIAL/FAILURE OR EXPERIENCE WITH INTOLERABLE SIDE EFFECTS TO AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, OR AURANOFIN). RENEWAL: LESS THAN 20% IMPROVEMENT IN TENDER AND SWOLLEN JOINT COUNT.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST.

COVERAGE DURATION

INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

APPLIES TO NEW STARTS ONLY. RHEUMATOID ARTHRITIS/JUVENILE IDOPATHIC ARTHRITIS: TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, OR AURANOFIN).

PRIOR AUTHORIZATION GROUP DESCRIPTION

ABATACEPT SQ

DRUG NAME

ORENCIA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

INITIAL: FOR ALL DIAGNOSIS: NO TRIAL OF AT LEAST TWO OF THE FOLLOWING: ENBREL, HUMIRA, REMICADE, CIMZIA, OR SIMPONI. INITIAL: FOR RHEUMATOID ARTHRITIS NO TRIAL/FAILURE OR EXPERIENCE WITH INTOLERABLE SIDE EFFECTS TO AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, OR AURANOFIN). RENEWAL: LESS THAN 20% IMPROVEMENT IN TENDER AND SWOLLEN JOINT COUNT.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST.

COVERAGE DURATION

INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

CURRENTLY TAKING OR HAVE A CONTRAINDICATION TO METHOTREXATE.

PRIOR AUTHORIZATION GROUP DESCRIPTION

ABIRATERONE

DRUG NAME

ZYTIGA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

ADALIMUMAB

DRUG NAME

HUMIRA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

INITIAL: FOR ACTIVE RHEUMATOID ARTHRITIS/JUVENILE IDIOPATHIC ARTHRITIS: NO TRIAL/FAILURE/INTOLERABLE SIDE EFFECTS TO AT LEAST ONE DMARD THERAPY(METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, OR AURANOFIN), FOR MODERATE TO SEVERE PLAQUE PSORIASIS COVERING GREATER THAN OR EQUAL TO 10% BSA OR LESIONS COVERING HANDS, FEET, OR GENITAL AREA: NO TRIAL/FAILURE OF PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE. CROHN'S DISEASE: NO TRIAL/FAILURE OF CORTICOSTEROID, AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. RENEWAL: ACTIVE RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS/JUVENILE ARTHRITIS: LESS THAN 20%IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT. ANKYLOSING SPONDYLITIS: LESS THAN 50% IMPROVEMENT OR LESS THAN 2 UNIT INCREASE FROM BASELINE IN BASDAI. PLAQUE PSORIASIS: PATIENT HAS NOT ACHIEVED CLEAR OR MINIMAL DISEASE OR A DECREASE IN PASI OF AT LEAST 50%.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST, DERMATOLOGIST, GASTROENTEROLOGIST.

COVERAGE DURATION

INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.

OTHER CRITERIA

APPLIES TO NEW STARTS ONLY. RENEWAL: RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS/ANKYLOSING SPONDYLITIS: FOR HUMIRA 40 MG EVERY WEEK: TRY/FAIL AT LEAST A 3 MONTH TRIAL OF HUMIRA 40MG EVERY OTHER WEEK.

PRIOR AUTHORIZATION GROUP DESCRIPTION

ADHD ORAL STIMULANT AGENTS

DRUG NAME

AMPHETAMINE SALT COMBO | CONCERTA | DEXMETHYLPHENIDATE HCL | DEXTROAMPHETAMINE SULFATE | FOCALIN XR | METADATE CD | METHYLIN | METHYLIN ER | METHYLPHENIDATE ER | METHYLPHENIDATE HCL | METHYLPHENIDATE SR | RITALIN LA | VYVANSE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL OFF LABEL COVERAGE FOR NARCOLEPSY.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

65 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

ALEFACEPT

DRUG NAME

AMEVIVE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

INITIAL: FOR MODERATE TO SEVERE PLAQUE PSORIASIS COVERING 10% BSA: NO TRIAL/FAILURE/INTOLERABLE SIDE AFFECTS TO AT LEAST ONE PREFERRED THERAPY (PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE). RENEWAL: TWO PRIOR 3 MONTH COURSES OF ALEFACEPT.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR SUPERVISED BY A DERMATOLOGIST.

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

APPLIES TO NEW STARTS ONLY. INITIAL: PLAQUE PSORIASIS: TRIAL OF PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE. RENEWAL: 3 MONTH INTERVAL SINCE PREVIOUS COURSE OF TREATMENT AND A DECREASE IN PASI OF 50% OR MORE OR SIGNIFCANT IMPROVEMENT IN QUALITY OF LIFE OBSERVED BY PHYSICIAN AND PATIENT.

PRIOR AUTHORIZATION GROUP DESCRIPTION

ANAKINRA

DRUG NAME

KINERET

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

INTIAL: FOR ALL DIAGNOSIS: NO TRIAL OF HUMIRA OR SIMPONI. FOR RHEUMATOID ARTHRITIS: NO TRIAL/FAILURE OR EXPERIENCE WITH INTOLERABLE SIDE EFFECTS TO AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, OR AURANOFIN). RENEWAL: LESS THAN 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

18 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST.

COVERAGE DURATION

INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

APPLIES TO NEW STARTS ONLY.

EASY CHOICE HEALTH PLAN
Prior Authorization Requirements
Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

APREPITANT BVD DETERMINATION

DRUG NAME

EMEND

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.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

EASY CHOICE HEALTH PLAN
Prior Authorization Requirements

Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

BECAPLERMIN

DRUG NAME

REGRANEX

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

NON-DIABETIC. KNOWN NEOPLASM AT APPLICATION SITE. PRESSURE OR VENOUS STASIS ULCERS. ULCER DOES NOT EXTEND THROUGH DERMIS.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

VASCULAR SURGEON, PODIATRIST, ENDOCRINOLOGIST OR PHYSICIAN PRACTICING IN A SPECIALTY WOUND CLINIC ONLY

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

BELIMUMAB

DRUG NAME

BENLYSTA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

DIAGNOSIS OF SEVERE ACTIVE LUPUS NEPHRITIS OR SEVERE CENTRAL NERVOUS SYSTEM LUPUS. NO CURRENT USE OF CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. CONCURRENT USE OF BIOLOGIC AGENTS, OR INTRAVENOUS CYCLOPHOSAMIDE.

REQUIRED MEDICAL INFORMATION

AUTOANTIBODY POSITIVE LUPUS TEST.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

INITIAL: SELENA-SELDAI SCORE GREATER THAN OR EQUAL TO 6. RENEWAL: MAINTAIN AT LEAST A 4 POINT REDUCTION IN SELENA-SELDAI SCORE FROM BASELINE.

PRIOR AUTHORIZATION GROUP DESCRIPTION

BOCEPREVIR

DRUG NAME

VICTRELIS

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

PATIENT HAS FAILED SHORT TRIAL OR HAS CONTRAINDICATION TO TELAPREVIR (INCIVEK). FAILURE OF FULL COURSE OF TRIPLE THERAPY WITH TELAPREVIR (INCIVEK) OR BOCEPREVIR (VICTRELIS). CURRENTLY TAKING CARBAMAZEPINE, PHENOBARBITAL, PHENYTOIN, OR RIFAMPIN. CO-INFECTION WITH HIV OR HEPATITIS B, OR HISTORY OF PREVIOUS SOLID ORGAN TRANSPLANT. DETECTABLE HCV RNA LEVEL/VIRAL LOAD OR HCV RNA LEVEL/VIRAL LOAD GREATER THAN OR EQUAL TO 100 IU/ML AFTER TRIPLE THERAPY TREATMENT LEVEL WEEK 8, 12, AND 24.

REQUIRED MEDICAL INFORMATION

CHRONIC HEPATITIS C, GENOTYPE 1. NATIVE PATIENT: HCV RNA LEVEL/VIRAL LOAD AT TRIPLE THERAPY TREATMENT WEEK 4, 8, 12, AND 24 OF BOCEPREVIR THERAPY. PARTIAL RESPONDER, NULL RESPONDER, OR RELAPSER: HCV RNA LEVEL/VIRAL LOAD AT WEEK 8 AND 20 OF BOCEPREVIR THERAPY.

AGE RESTRICTIONS

PATIENT 18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTIONS

GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST) OR SPECIALLY TRAINED GROUP (E.G. EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES).

COVERAGE DURATION

INITIAL: UP TO 12 WKS. RENEWAL: W/ CIRRHOSIS UP TO 32 WKS, W/O CIRRHOSIS UP TO 20 WKS.

OTHER CRITERIA

CONCURRENT USE OF RIBAVIRIN AND PEGINTERFERON ALFA. APPROVAL CONSIDERATION GIVEN FOR PATIENTS WITH CIRRHOSIS, POOR INTERFERON RESPONSE AT TREATMENT WEEK 4, LESS THAN 2-LOG10 HCV RNA DECLINE BY TREATMENT WEEK 12 DURING PRIOR THERAPY WITH PEGINTERFERON/RIBAVIRIN, DECTECTABLE HCV RNA LEVEL AT TREATMENT WEEK 8 BUT UNDECTABLEABLE LEVEL AT WEEK 24, FAILURE (PARITAL RESPONDER, RELAPSER, OR NULL RESPONDER) OF PRIOR TRIAL OF RIBAVIRIN AND PEGINTERFERON THERAPY.

PRIOR AUTHORIZATION GROUP DESCRIPTION

BOTULINUM NEUROTOXIN

DRUG NAME

BOTOX | XEOMIN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

COSMETIC DIAGNOSIS: WRINKLES. MIGRAINE HEADACHE: NO TRIAL OF TWO OF THE FOLLOWING BETA BLOCKERS, TRICYCLIC ANTIDEPRESSANTS, OR VALPROIC ACID. BLEPHAROSPASM: NO TRIAL OF BOTOX.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

C1 ESTERASE INHIBITOR

DRUG NAME

CINRYZE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

NOT TRIED/FAILED OR INTOLERABLE SIDE EFFECTS TO DANAZOL

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST, IMMUNOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

CALCINEURIN INHIBITORS

DRUG NAME

ELIDEL | PROTOPIC

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

NOT TRIED/FAILED OR INTOLERABLE ADVERSE EFFECTS TO TOPICAL CORTICOSTEROIDS

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

ELIDEL 1% AND PROTOPIC 0.03%: 2 YEARS OR OLDER. PROTOPIC 0.1%: OVER 14 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

CERTOLIZUMAB PEGOL

DRUG NAME

CIMZIA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

FOR ALL DIAGNOSIS: TRIAL OF HUMIRA, OR SIMPONI. FOR MODERATE TO SEVERE CROHN'S DISEASE: NO TRIAL/FAILURE OF ONE OR MORE CONVENTIONAL THERAPIES FOR CROHN'S DISEASE SUCH AS CORTICOSTEROIDS, AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. FOR MODERATE TO SEVERE RHEUMATOID ARTHRITIS: NO TRIAL/FAILURE OF AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, OR AURANOFIN).

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR SUPERVISED BY A GASTROENTEROLOGIST OR RHEUMATOLOGIST.

COVERAGE DURATION

INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

APPLIES TO NEW STARTS ONLY.

EASY CHOICE HEALTH PLAN
Prior Authorization Requirements

Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

CHOLINESTERASE INHIBITORS

DRUG NAME

ARICEPT | EXELON

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

MINI MENTAL STATE EXAM (MMSE) SCORE GREATER THAN 26

REQUIRED MEDICAL INFORMATION

MINI MENTAL STATE EXAM (MMSE) SCORE OF 26 OR LESS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

CORTICOSTEROID BVD DETERMINATION

DRUG NAME

A-HYDROCORT | A-METHAPRED | CORTISONE ACETATE | DEPO-MEDROL | DEXAMETHASONE | DEXAMETHASONE SODIUM PHOSPHATE | HYDROCORTISONE | METHYLPREDNISOLONE | METHYLPREDNISOLONE ACETATE | METHYLPREDNISOLONE SOD SUCC | PREDNISOLONE SODIUM PHOSPHATE | PREDNISONE | PREDNISONE INTENSOL | SOLU-MEDROL | VERIPRED 20

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.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

CRIZOTINIB

DRUG NAME

XALKORI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

LOCALLY ADVANCED OR METASTATIC NON SMALL CELL LUNG CANCER IS ANAPLASTIC LYMPHOMA KINASE POSITIVE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

EASY CHOICE HEALTH PLAN
Prior Authorization Requirements

Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

CYCLOPHOSPHAMIDE BVD DETERMINATION

DRUG NAME

CYCLOPHOSPHAMIDE

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.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

CYCLOSPORINE OPHTHALMIC

DRUG NAME

RESTASIS

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

KERATOCONJUNCTIVITIS SICCA (KCS) OR DRY EYE DISEASE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR SUPERVISED BY A OPHTHALMOLOGIST, OPTOMETRIST, OR RHEUMATOLOGIST.

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

DABIGATRAN

DRUG NAME

PRADAXA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

DALFAMPRIDINE

DRUG NAME

AMPYRA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

PATIENT HAS NOT EXPERIENCED OR MAINTAINED AT LEAST 15% IMPROVEMENT IN WALKING ABILITY.

REQUIRED MEDICAL INFORMATION

WALKING DISABILITY SUCH AS MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS OR UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

NEUROLOGIST

COVERAGE DURATION

INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

DENOSUMAB

DRUG NAME

PROLIA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

A PATIENT WITH EITHER A HISTORY OF OSTEOPORTIC FRACTURE(S) OR GREATER THAN OR EQUAL TO TWO FACTORS FOR FRACTURE (E.G. HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS), OR FAILED AN ADEQUATE TRIAL OF BISPHOSPHONATES, IS INTOLERANT, OR HAS A CONTRAINDICATION TO BISPHOSPHONATES.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

DENOSUMAB-XGEVA

DRUG NAME

XGEVA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

DIAGNOSIS OF MULTIPLE MYELOMA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

ELTROMBOPAG

DRUG NAME

PROMACTA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

INITIAL: ADEQUATE RESPONSE TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR SUFFICIENT RESPONSE TO SPLENECTOMY, RENEWAL: NO CLINICAL RESPONSE AS DEFINED BY AN INCREASE IN PLATELET COUNT OF GREATER THAN OR EQUAL TO 50 X10^9/L AT THE MAX DOSE OF 75MG PER DAY FOR 4 WEEKS

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL:1 MONTH RENEWAL: NO RESPONSE AFTER INITIAL:1 MONTH AT MAX DOSE, IF RESPONSE: 12 MONTHS.

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

ENDOTHELIN RECEPTOR ANTAGONISTS

DRUG NAME

LETAIRIS | TRACLEER

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PULMONARY ARTIERAL HYPERTENTION GREATER OR EQUAL TO NYHA/WHO FUNCTIONAL CLASS II.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

CARDIOLOGIST OR PULMONOLOGIST.

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

EPIDERMAL GROWTH FACTOR RECEPTOR INHIBITORS

DRUG NAME

IRESSA | TARCEVA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

NON SMALL CELL LUNG CANCER: EPIDERMAL GROWTH FACTOR RECEPTOR ACTIVING MUTATIONS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR NON SMALL CELL LUNG CANCER: IF NO EPIDERMAL GROWTH FACTOR RECEPTOR ACTIVING MUTATIONS PATIENT WILL NEED TRIAL OF OR CONTRAINDICATION TO IV CHEMOTHERAPY. CURRENT OR PREVIOUS TREATMENT/BENEFIT FROM IRESSA CAN CONTINUE TREATMENT WITH DRUG. IF NOT WILL NEED TRIAL OF TARCEVA. FOR PANCREATIC CANCER: TARCEVA USED IN COMBINATION WITH GEMCITABINE.

PRIOR AUTHORIZATION GROUP DESCRIPTION

ERIBULIN

DRUG NAME

HALAVEN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PREVIOUS TREATMENT WITH AN ANTHRACYCLINE (DAUNORUBICIN, DOXORUBICIN, IDARUBICIN, EPIRUBICIN, OR MITOXANTRONE) AND A TAXANE (DOCETAXEL OR PACLITAXEL).

PRIOR AUTHORIZATION GROUP DESCRIPTION

ERYTHROPOIESIS STIMULATING AGENTS - ARANESP

DRUG NAME

ARANESP

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

CHRONIC RENAL FAILURE: HEMAGLOBIN LEVELS BETWEEN 9.5 AND 11.5 G/DL OR PRE-TREATMENT HEMOGLOBIN LESS THAN 10 G/DL. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CHEMOTHERAPY: HEMOGLOBIN LEVELS BETWEEN 10 AND 12 G/DL OR HEMOGLOBIN LEVEL LESS THAN 11 G/DL OR HEMOGLOBIN LEVEL DECREASED AT LEAST 2 G/DL BELOW THEIR BASELINE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

RENAL FAILURE/CANCER CHEMOTHERAPY THERAPY: 12 MONTHS.

OTHER CRITERIA

ALL INDICATIONS: TRIAL OF PROCRIT. PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.

PRIOR AUTHORIZATION GROUP DESCRIPTION

ERYTHROPOIESIS STIMULATING AGENTS - EPOETIN ALFA

DRUG NAME

EPOGEN | PROCRIT

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL OFF LABEL COVERAGE FOR ANEMIA IN HEPATITIS C BEING TREATED IN COMBINATION WITH RIBAVIRIN AND AN INTERFERON ALFA OR PEGINTERFERON ALFA.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

CHRONIC RENAL FAILURE HEMAGLOBIN LEVELS BETWEEN 9.5 AND 11.5 G/DL OR PRE-TREATMENT HEMOGLOBIN LESS THAN 10 G/DL. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CHEMOTHERAPY: HEMOGLOBIN LEVELS BETWEEN 10 AND 12 G/DL OR HEMOGLOBIN LEVEL LESS THAN 11 G/DL OR HEMOGLOBIN LEVEL DECREASED AT LEAST 2 G/DL BELOW THEIR BASELINE. ZIDOVUDINE THERAPY: HEMOGLOBIN LEVEL BETWEEN 10 AND 12 G/DL OR HEMOGLOBIN LESS THAN 10 G/DL. ELECTIVE, NONCARDIAC, NONVASCULAR SURGERY: HEMOGLOBIN LESS THAN 13 G/DL. CONCURRENT HEPATITS C TREATMENT: HEMOGLOBIN LESS BETWEEN 10 AND 12 G/DL OR CONTRAINDICATION TO RIBAVIRIN AND HEMOGLOBIN LESS THAN 10 G/DL.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

RENAL FAILURE/CANCER CHEMOTHERAPY/ZIDOVUDINE THERAPY: 12 MONTHS. SURGERY: 1 MONTH. HEP C: 6 MONTHS.

OTHER CRITERIA

ALL INDICATIONS: TRIAL OF PROCRIT. PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.

PRIOR AUTHORIZATION GROUP DESCRIPTION

ESRD BVD DETERMINATION

DRUG NAME

BONIVA | CALCITRIOL | CUBICIN | HECTOROL | HEPARIN SODIUM | LEVOCARNITINE | LIDOCAINE HCL | LIDOCAINE-PRILOCAINE | MIACALCIN | PAMIDRONATE DISODIUM | VANCOMYCIN HCL | ZEMPLAR

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.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

ETANERCEPT

DRUG NAME

ENBREL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

INITIAL: FOR RHEUMATOID ARTHRITIS OR JUVENILE ARTHRITIS: NO TRIAL/FAILURE TO AT LEAST ONE DMARD AGENT. FOR MODERATE TO SEVERE PLAQUE PSORIASIS COVERING 10% BSA OR LESIONS COVERING HANDS, FEET, OR GENITAL AREA: NO TRIAL/FAILURE/INTOLERABLE SIDE AFFECTS TO AT LEAST ONE PREFERRED THERAPY (PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE). RENEWAL: ACTIVE RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS/JUVENILE ARTHRITIS: NO LESS THAN 20% OR GREATER IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT. ANKYLOSING SPONDYLITIS: NO LESS THAN 50% IMPROVEMENT OR INCREASE IN 2 UNITS FROM BASELINE IN BASDAI. PLAQUE PSORIASIS: PATIENT HAS NOT ACHIEVED CLEAR OR MINIMIMAL DISEASE OR A DECREASE IN PASI OF 50% OR MORE.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST OR DERMATOLOGIST.

COVERAGE DURATION

INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

APPLIES TO NEW STARTS ONLY. INITIAL:FOR ALL DIAGNOSIS: TRIAL OF HUMIRA OR SIMPONI

PRIOR AUTHORIZATION GROUP DESCRIPTION

FENTANYL TRANSDERMAL PATCH

DRUG NAME

FENTANYL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

PATIENT ABLE TO TAKE OR HAS NOT FAILED A SUSTAINED-RELEASE MORPHINE PRODUCT. PRESCRIBED FOR AS NEEDED DOSAGE FREQEUNCY.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

EVERY 48 HOUR DOSING CONSIDERED FOR PATIENTS WHO FAIL EVERY 72 HOUR DOSING.

PRIOR AUTHORIZATION GROUP DESCRIPTION

FENTANYL TRANSMUCOSAL AGENTS

DRUG NAME

FENTANYL CITRATE

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

CANCER: ON A MAINTENANCE DOSE OF CONTROLLED- RELEASE PAIN MEDICATION, AND EITHER A TRIAL AND FAILURE OF 1 IMMEDIATE-RELEASE ORAL PAIN AGENT OR DIFFICULTY SWALLOWING TABLETS/CAPSULES

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

FINGOLIMOD

DRUG NAME

GILENYA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CONTRAINDICATION OR HAS NOT TRIED INTERFERON THERAPY (AVONEX, BETASERON, EXTAVIA, OR REBIF) AND COPAXONE.

PRIOR AUTHORIZATION GROUP DESCRIPTION

GLP-1 ANALOGS

DRUG NAME

BYETTA | VICTOZA 3-PAK

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

DIAGNOSIS: NON TYPE 2 DIABETES. NO FAILURE TO REACH TREATMENT GOAL WITH METFORMIN, SULFONYLUREA, OR THIAZOLIDINEDIONE.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS: TYPE 2 DIABETES

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

GOLIMUMAB

DRUG NAME

SIMPONI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

RENEWAL: ACTIVE RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS: GREATER THAN 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT. ANKYLOSING SPONDYLITIS: GREATER THAN 20% IMPROVEMENT IN ANKYLOSING SPONDYLITIS (ASAS20) CRITERIA.

AGE RESTRICTIONS

18 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST OR DERMATOLOGIST.

COVERAGE DURATION

INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

APPLIES TO NEW STARTS ONLY. ACUTE RHEUMATOID ARTHRITIS: CURRENTLY ON METHOTREXATE. PSORIATIC ARTHRITIS: TRIAL/FAILURE OR EXPERIENCE WITH INTOLERABLE SIDE EFFECTS TO AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, OR AURANOFIN).

PRIOR AUTHORIZATION GROUP DESCRIPTION

HEPATITIS A VACCINE (INACTIVATED) BVD DETERMINATION

DRUG NAME

HAVRIX | VAQTA

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.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

EASY CHOICE HEALTH PLAN
Prior Authorization Requirements

Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

HEPATITIS B VACCINE BVD DETERMINATION

DRUG NAME

ENGERIX-B | RECOMBIVAX HB

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.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

IMIQUIMOD - ALDARA

DRUG NAME

IMIQUIMOD

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL OFF LABEL COVERAGE FOR ACTINIC KERATOSIS NOT LIMITED TO THE FACE AND SCALP IN NON-IMMUNOCOMPETENT PATIENTS, MOLLUSCUM CONTAGIOSUM, AND LETIGO MALIGNA.

EXCLUSION CRITERIA

EXTERNAL GENITAL OR PERIANAL WARTS: NO TRIAL OR CONTRAINDICATION TO PODOFILOX. ACTINIC KERATOSIS: NO TRIAL OF OR NO CONTRAINDICATION TO TOPICAL 5-FLUOROURACIL.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

EXTERNAL GENITAL OR PERIANAL WARTS: GREATER THAN OR EQUAL TO 12 YEARS OF AGE. ACTINIC KERATOSIS: GREATER THAN OR EQUAL TO 18 YEARS OF AGE.

PRESCRIBER RESTRICTIONS

ACTINIC KERATOSIS: DERMATOLOGIST ONLY. SUPERFICIAL BASAL CELL CARCINOMA/LETIGO MALIGNA: DERMATOLOGIST OR ONCOLOGIST ONLY.

COVERAGE DURATION

4 MONTHS

OTHER CRITERIA

CRITERIA APPLIES TO NEW STARTS ONLY. SUPERFICIAL BASAL CELL CARCINOMA: LESS THAN 2CM IN SIZE AND NOT ON THE FACE. MOLLUSCUM CONTAGISOUM LIMITED TO THE FACE.

PRIOR AUTHORIZATION GROUP DESCRIPTION

IMIQUIMOD - ZYCLARA

DRUG NAME

ZYCLARA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

EXTERNAL GENITAL OR PERIANAL WARTS: NO TRIAL OR CONTRAINDICATION TO GENERIC IMIQUIMOID 5%. ACTINIC KERATOSIS: NO TRIAL OF OR NO CONTRAINDICATION TO TOPICAL 5-FLUOROURACIL AND GENERIC IMIQUIMOID 5%.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

EXTERNAL GENITAL OR PERIANAL WARTS: GREATER THAN OR EQUAL TO 12 YEARS OF AGE. ACTINIC KERATOSIS: GREATER THAN 18 YEARS OF AGE.

PRESCRIBER RESTRICTIONS

DERMATOLOGIST SUPERVISION.

COVERAGE DURATION

4 MONTHS

OTHER CRITERIA

CRITERIA APPLIES TO NEW STARTS ONLY.

PRIOR AUTHORIZATION GROUP DESCRIPTION

IMMUNE GLOBULIN BVD DETERMINATION

DRUG NAME

CARIMUNE NF NANOFILTERED | GAMASTAN S-D | GAMMAGARD S-D | GAMMAPLEX | GAMUNEX | HIZENTRA | PRIVIGEN | VIVAGLOBIN

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.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

IMMUNOSUPPRESSANT BVD DETERMINATION

DRUG NAME

AZATHIOPRINE | AZATHIOPRINE SODIUM | CELLCEPT | CYCLOSPORINE | CYCLOSPORINE MODIFIED | GENGRAF | MYCOPHENOLATE MOFETIL | MYFORTIC | NULOJIX | ORTHOCLONE OKT-3 | PROGRAF | RAPAMUNE | SIMULECT | TACROLIMUS | 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.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION
INFLIXIMAB

DRUG NAME

REMICADE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

RENEWAL: RHEUMATOID/PSORIATIC ARTHRITIS: GREATER THAN 20% IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT. FOR PLAQUE PSORIASIS: PASI OF GREATER THAN 50% OR SIGNIFCANT IMPROVEMENT IN QUALITY OF LIFE OBSERVED BY PHYSICIAN AND PATIENT. FOR ANKYLOSING SPONDYLITIS: IMPROVEMENT OF AT LEAST 50%, OR 2 UNITS (SCALE OF 1-10), IN THE BATH ANKYLOSING SPONDYLITIS DISEASE ACTIVITY INDEX (BASDAI) OR IMPROVEMENT OF AT LEAST 20% IN THE ASSESSMENT IN ANKYLOSING SPONDYLITIS (ASAS20) CRITERIA.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR SUPERVISED BY A GASTROENTEROLOGIST, RHEUMATOLOGIST OR DERMATOLOGIST.

COVERAGE DURATION

CROHN'S/UC/ACUTE ENTEROCUTANEOUS FISTULA: 12 MO. OTHER INDICATIONS INITIAL: 3 MO RENEWAL: 12 MO

OTHER CRITERIA

APPLIES TO NEW STARTS ONLY. INITIAL: FOR MODERATE TO SEVERE CROHN'S DISEASE/ULCERATIVE COLITIS/ACUTE ENTEROCUTANEOUS FISTULA: TRIAL/FAILURE OF ONE OR MORE CONVENTIONAL THERAPIES FOR CROHN'S DISEASE SUCH AS SULFASALAZINE, CORTICOSTEROIDS, AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OLSALAZINE, CYCLOSPORINE,OR MESALAMINE. FOR PSORIATIC ARTHRITIS/JUVENILE ARTHRITIS: TRIAL/FAILURE TO AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, OR AURANOFIN). FOR RHEUMATOID ARTHRITIS: ON METHOTREXATE. FOR SEVERE PLAQUE PSORIASIS COVERING 10% BSA: TRIAL/FAILURE/INTOLERABLE SIDE AFFECTS TO AT LEAST ONE PREFERRED THERAPY (PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE).

PRIOR AUTHORIZATION GROUP DESCRIPTION

INFUSIBLE DRUG BVD DETERMINATION

DRUG NAME

ABELCET | ACYCLOVIR SODIUM | ADRIAMYCIN | AMBISOME | AMPHOTEC | AMPHOTERICIN B | BLEOMYCIN SULFATE | CLADRIBINE | CYTARABINE | DOXIL | FLUOROURACIL | FOSCARNET SODIUM | GANCICLOVIR SODIUM | HERCEPTIN | IFOSFAMIDE | IFOSFAMIDE-MESNA | METHOTREXATE | MITOMYCIN | REMODULIN | TORISEL | VINBLASTINE SULFATE | VINCRISTINE SULFATE

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.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

INTERFERON AGENTS - INTERFERON ALFA-2B

DRUG NAME

INTRON A

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

DIAGNOSIS: HEPATITIS C: NOT IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED. PRETREATMENT HCV RNA LEVEL UNDER 50 IU/ML.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

HEP C: GENOTYPE 2 OR 3: 6-MONTHS. ALL OTHER INDICATIONS: 4-MONTHS. RENEWAL: 6 MONTHS.

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

INTERFERON AGENTS - PEG-INTERFERON ALFA-2A

DRUG NAME

PEGASYS | PEGASYS PROCLICK

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

DIAGNOSIS: HEPATITIS C: NO TRIAL OF PEGINTRON. NOT IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED. PRETREATMENT HCV RNA LEVEL UNDER 50 IU/ML. RENEWAL: HEPATITIS C: GENOTYPE 2 OR 3: NO RENEWAL. GENOTYPE 1, 4, 5, 6: UNABLE TO ACHIEVE A 2-LOG REDUCTION IN QUANTITATIVE HCV RNA LEVEL BY 12 WEEKS OR HAS A HCV RNA LEVEL GREATER THAN 50 IU/ML AT 24 WEEKS.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST).

COVERAGE DURATION

HEP B AND HEP C GENOTYPE 2, 3: 6 MONTHS. GENOTYPE 1, 4, 5, 6: 4-MONTHS.

OTHER CRITERIA

RENEWAL: HEP B: 6-MONTHS. HEP C: GENOTYPE 1, 4, 5, 6: HCV RNA LESS THAN 50 IU/ML AT 24 WKS: 12 MONTHS. HCV RNA ABOVE 50 IU/ML AT 12 WKS: 2 MONTHS THEN RE-TEST AT 24 WKS.

PRIOR AUTHORIZATION GROUP DESCRIPTION

INTERFERON AGENTS - PEG-INTERFERON ALFA-2B

DRUG NAME

PEGINTRON | PEGINTRON REDIPEN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

DIAGNOSIS: HEPATITIS C: NOT IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED. PRETREATMENT HCV RNA LEVEL UNDER 50 IU/ML. RENEWAL: HEPATITIS C: GENOTYPE 2 OR 3: NO RENEWAL. GENOTYPE 1, 4, 5, 6: UNABLE TO ACHIEVE A 2-LOG REDUCTION IN QUANTITATIVE HCV RNA LEVEL BY 12 WEEKS OR HAS A HCV RNA LEVEL GREATER THAN 50 IU/ML AT 24 WEEKS.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

OVER 2 YEARS.

PRESCRIBER RESTRICTIONS

GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST).

COVERAGE DURATION

HEP C: GENOTYPE 2 OR 3: 6-MONTHS. GENOTYPE 1, 4, 5, 6: 4-MONTHS.

OTHER CRITERIA

RENEWAL: HEP C: GENOTYPE 1, 4, 5, 6: HCV RNA LESS THAN 50 IU/ML AT 24 WKS: 12 MONTHS. HCV RNA ABOVE 50 IU/ML AT 12 WKS: 2 MONTHS THEN RE-TEST AT 24 WKS.

PRIOR AUTHORIZATION GROUP DESCRIPTION

IPILIMUMAB

DRUG NAME

YERVOY

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

EASY CHOICE HEALTH PLAN
Prior Authorization Requirements
Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

LOW MOLECULAR WEIGHT HEPARIN AGENTS

DRUG NAME

FRAGMIN

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

CURRENTLY ON WARFARIN AND SCHEDULED FOR MINOR SURGERY OR MAJOR SURGERY AND HAS A THERAPEUTIC INR (GREATER THAN 2 FOR AT LEAST 2 DAYS).

REQUIRED MEDICAL INFORMATION

PREGNANCY TEST, INR.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

CANCER: LIFETIME. HIP REPLACEMENT/FRACTURE SURGERY UP TO 30 DAYS. OTHER INDICATIONS UP TO 17 DAYS.

OTHER CRITERIA

EASY CHOICE HEALTH PLAN
Prior Authorization Requirements
Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

MEMANTINE

DRUG NAME

NAMENDA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

MINI MENTAL STATE EXAM (MMSE) SCORE GREATER THAN 19

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

EASY CHOICE HEALTH PLAN
Prior Authorization Requirements
Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

METHOTREXATE BVD DETERMINATION

DRUG NAME

METHOTREXATE | TREXALL

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.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

METHYLNALTREXONE

DRUG NAME

RELISTOR

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

NOT ON PALLIATIVE CARE.

REQUIRED MEDICAL INFORMATION

CONSTIPATION DUE TO OPIOIDS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

UP TO 6 MONTHS

OTHER CRITERIA

EASY CHOICE HEALTH PLAN
Prior Authorization Requirements
Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

MODAFINIL AND ARMODAFINIL

DRUG NAME

NUVIGIL | PROVIGIL

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

NARCOLEPSY: TRIAL/FAILURE OR CONTRAINDICATION TO AMPHETAMINE, DEXTROAMPHETAMINE AND/OR METHYLPHENIDATE.

PRIOR AUTHORIZATION GROUP DESCRIPTION

NATALIZUMAB

DRUG NAME

TYSABRI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

MULTIPLE SCLEROSIS: NO TRIAL OF AN INTERFERON OR COPAXONE. CROHN'S DISEASE: NO TRIAL OF A TNF-ALPHA INHIBITOR. RENEWAL: CROHN'S: CONTINUED CONCOMITANT CORTICOSTEROID TREATMENT AFTER 6 MONTHS ON NATALIZUMAB, OR REQUIRED MORE THAN 3 MONTHS OF CORTICOSTEROID

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

MULTIPLE SCLEROSIS:12 MONTHS. CROHN'S DISEASE: 6 MONTHS. RENEWAL: CROHN'S: 12 MONTHS.

OTHER CRITERIA

EASY CHOICE HEALTH PLAN
Prior Authorization Requirements

Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

NEBULIZER BVD DETERMINATION

DRUG NAME

ALBUTEROL SULFATE | CROMOLYN SODIUM | PULMOZYME | TOBI

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.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

EASY CHOICE HEALTH PLAN
Prior Authorization Requirements
Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

OFATUMUMAB

DRUG NAME

ARZERRA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

CHRONIC LYMPHOCYTIC LEUKEMIA: NO FAILED TREATMENT WITH FLUDARABINE AND ALEMTUZUMAB

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

OMALIZUMAB

DRUG NAME

XOLAIR

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

INITIAL: PATIENT MEETS THE CRITERIA OF MODERATE TO SEVERE ASTHMA, POSITIVE SKIN PRICK OR RAST TEST, FEV1 LESS THAN 80%, DEMONSTRATED INADEQUATELY CONTROLLED SYMPTOMS ON INHALED CORTICOSTEROIDS AND SECOND ASTHMA CONTROLLER, BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30 IU/ML. RENEWAL: PATIENT REDUCED EXACERBATIONS BY AT LEAST 25% FROM BASELINE, REDUCTION IN ORAL OR INHALED CORTICOSTEROID USE FROM BASELINE.

AGE RESTRICTIONS

PATIENT 12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

SPECIALIST IN ALLERGY OR PULMONARY MEDICINE ONLY

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

DRUG NAME

ADCIRCA | REVATIO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PULMONARY ARTERIAL HYPERTENSION: WHO CLASS I-IV SYMPTOMS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

CARDIOLOGIST OR PULMONOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

EASY CHOICE HEALTH PLAN
Prior Authorization Requirements
Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

PEG-INTERFERON ALFA-2B-SYLATRON

DRUG NAME

SYLATRON 4-PACK

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CRITERIA APPLIES TO NEW STARTS ONLY. DURATION LIMITATION OF 5 YEARS OF THERAPY.

PRIOR AUTHORIZATION GROUP DESCRIPTION

PLERIXAFOR

DRUG NAME

MOZOBIL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

USE IN COMBINATION WITH GRANULOCYTE-COLONY STIMULATING FACTOR (G-CSF) TO MOBILIZE HEMATOPOIETIC STEM CELLS TO THE PERIPHERAL BLOOD FOR COLLECTION AND SUBSEQUENT AUTOLOGOUS TRANSPLANTATION IN PATIENTS WITH NON-HODGKIN'S LYMPHOMA AND MULTIPLE MYELOMA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

4 DOSES (UP TO 8 VIALS) FOR ONE FILL PER DAY.

OTHER CRITERIA

EASY CHOICE HEALTH PLAN
Prior Authorization Requirements
Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

QUININE SULFATE

DRUG NAME

QUALAQUIN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

RABIES VACCINE BVD DETERMINATION

DRUG NAME

IMOVAX RABIES VACCINE | RABAVERT

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.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

EASY CHOICE HEALTH PLAN
Prior Authorization Requirements

Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

RIFAXIMIN

DRUG NAME

XIFAXAN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL OFF LABEL COVERAGE FOR SMALL INTESTINAL BACTERIAL OVERGROWTH (SIBO).

EXCLUSION CRITERIA

TRAVELERS' DIARRHEA: NO PREVIOUS TRIAL OF CIPROFLOXACIN OR AZITHROMYCIN. HEPATIC ENCEPHALOPATHY: NO TRIAL OF LACTULOSE MONOTHERAPY. SMALL INTESTIONAL BACTERIAL OVERGROWTH: NO TRIAL OF AT LEAST 2 OF THE FOLLOWING: AMOXICILLIN-CLAVULANIC ACID, CIPROFLOXACIN, DOXYCYCLINE, METRONIDAZOLE, NEOMYCIN, TETRACYCLINE, OR TRIMETHOPRIM-SULFAMETHOXAZOLE.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

TRAVELERS' DIARRHEA: 12 YEARS OR OLDER. HEPATIC ENCEPHALOPATHY: 18 YEARS OR OLDER.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

TRAVELERS' DIARRHEA: 1 FILL IN 1 MONTH. HEPATIC ENCEPHALOPATHY: 12 MONTHS. SIBO: 10 DAYS.

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

RITUXIMAB

DRUG NAME

RITUXAN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

INITIAL: FOR RHEUMATOID ARTHRITIS: NOT ON METHOTREXATE AND NO TRAIL OF ENBREL, HUMIRA, REMICADE, SIMPONI OR CIMZIA. RENEWAL: FOR RHEUMATOID ARTHRITIS: LESS THAN 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT.

REQUIRED MEDICAL INFORMATION

FOR NON-HODGKIN'S LYMPHOMA OR CHRONIC LYMPHOCYTIC LEUKEMIA: USED IN COMBINATION WITH CHEMOTHERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR SUPERVISED BY: FOR RHEUMATOID ARTHRITIS A RHEUMATOLOGIST. FOR NHL OR CLL AN ONCOLOGIST.

COVERAGE DURATION

RA: INITIAL 3 MO, RENEW 6 MO. HNL: 1 YEAR. CLL: 6 MO. WG, MPA: 1 MO.

OTHER CRITERIA

APPLIES TO NEW STARTS ONLY.

EASY CHOICE HEALTH PLAN
Prior Authorization Requirements
Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

RIVAROXABAN

DRUG NAME

XARELTO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

HIP REPLACEMENT UP TO 35 DAYS. KNEE REPLACEMENT UP TO 12 DAYS. ATRIAL FIB: 12 MONTHS.

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

ROMIDEPSIN

DRUG NAME

ISTODAX

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ABLE TO TOLERATE ORAL MEDICATIONS AND NOT TRIED VORINOSTAT, OR NOT ABLE TO TOLERATE ORAL MEDICATIONS AND NOT TRIED AT LEAST ONE SYSTEMIC THERAPY (RETINOID, INTERFERON, EXTRACORPOREAL PHOTOPHERESIS, DENILEUKIN DIFTITOX, METHOTREXATE, LIPOSOMAL DOXORUBICIN, GEMCITABINE, CHLORAMBUCIL, PENTOSTATIN, ETOPOSIDE, CYCLOPHOSPHAMIDE, TEMOZOLOMIDE, BORTEZOMIB).

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

RUXOLITINIB

DRUG NAME

JAKAFI

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

RENEWAL: IMPROVEMENT OR MAINTENANCE OF SYMPTOM IMPROVEMENT SUCH AS A 50% OR GREATER REDUCTION IN TOTAL SYMPTOM SCORE ON THE MODIFIED MYELOFIBROSIS SYMPTOM ASSESSMENT FORM (MFSAF) V2.0 OR 50% OR GREATER REDUCTION IN PALPABLE SPLEEN LENGTH, OR REDUCTION OF 35% OR GREATER FROM BASELINE SPLEEN VOLUME AFTER 6 MONTHS OF THERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

SOMATROPIN

DRUG NAME

GENOTROPIN | HUMATROPE | NORDITROPIN NORDIFLEX | NUTROPIN | NUTROPIN AQ | NUTROPIN AQ NUSPIN | OMNITROPE | SAIZEN | SEROSTIM | TEV-TROPIN | ZORBTIVE

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ATHLETIC ENHANCEMENT OR ANTI-AGING PURPOSE. GROWTH FAILURE DUE TO CHRONIC RENAL INSUFFICIENCY(CRI) IF PATIENT HAS HAD A RENAL TRANSPLANT

REQUIRED MEDICAL INFORMATION

FOR GROWTH FAILURE DUE TO (CRI): PATIENT HAS NOT UNDERGONE A RENAL TRANSPLANT, PATIENT'S HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER, LACK OF RESPONSE FROM PREVIOUS YEAR, PATIENT HAS REACHED 50TH PERCENTILE FOR TARGET HEIGHT FOLLOWING GROWTH HORMONE THERAPY. FOR HIV/WASTING: THE PATIENT ON ANTIRETROVIRAL THERAPY, MEETS CRITERA OF WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, 7.5% OVER 6 MONTHS, 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN) OR 23% (WOMEN) OF TOTAL BODY WT. AND A BODY MASS INDEX (BMI) LESS THAN 27KG/M2, OR BMI LESS THAN 20KG/M2. IF CURRENTLY ON GROWTH HORMONE, PATIENT HAS SHOWN CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT OR IF NOT ON GROWTH HORMONE, PATIENT HAS HAD INADEQUATE RESPONSE TO PREVIOUS THERAPY. (I.E. EXERCISE TRAINING, NUTRITIONAL SUPPLEMENTS, APPETITE STIMULANTS OR ANABOLIC STEROIDS). FOR SHORT-BOWEL SYNDROME: CURRENTLY ON SPECIALIZED NUTRITIONAL SUPPORT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

HIV/AIDS: 3 MONTHS. SHORT BOWEL: 4 WEEK ONCE. ALL OTHER DIAGNOSES: 12 MONTHS.

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

TELAPREVIR

DRUG NAME

INCIVEK

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

PATIENT HAS FAILED THERAPY WITH TELAPREVIR (INCIVEK) OR BOCEPREVIR (VICTRELIS). CURRENTLY TAKING RIFAMPIN OR ST JOHN'S WORT. CO-INFECTION WITH HIV OR HEPATITIS B, OR HISTORY OF PREVIOUS SOLID ORGAN TRANSPLANT.

REQUIRED MEDICAL INFORMATION

CHRONIC HEPATITIS C, GENOTYPE 1. HCV RNA LEVEL/VIRAL LOAD OF LESS THAN 1,000 IU/ML AT 4 WEEKS OF TELAPREVIR THERAPY.

AGE RESTRICTIONS

PATIENT 18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTIONS

GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST) OR SPECIALLY TRAINED GROUP (E.G. EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES).

COVERAGE DURATION

INITIAL: 8 WEEKS RENEWAL: 4 WEEKS

OTHER CRITERIA

CONCURRENT USE OF RIBAVIRIN AND PEGINTERFERON ALFA.

PRIOR AUTHORIZATION GROUP DESCRIPTION

TESTOSTERONE

DRUG NAME

TESTIM | TESTOSTERONE CYPIONATE | TESTOSTERONE ENANTHATE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

CURRENTLY RECIEVING TESTOSTERONE REPLACMENT. MALE HYPOGONADISM CONFIRMED BY EITHER: 1) LABORATORY CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL OF LESS THAN 250NG/DL (8.7NMOL/L) OR A LOW TOTAL SERUM TESTOSTERONE LEVEL AS INDICATED BY A LAB RESULT WITH A REFERENCE RANGE OBTAINED WITHIN 90 DAYS, OR 2) LABORATORY CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL BETWEEN 250NG/DL AND 350NG/DL (12NMOL/L) TOGETHER WITH A FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 50NG/L (174 PMOL/L) OR A LOW, LOW/NORMAL TOTAL SERUM TESTOSTERONE LEVEL WITH A CONFIRMED LOW FREE SERUM TESTOSTERONE LEVEL AS INDICATED BY A LAB REFERENCE RANGE OR 3) MALE DELAYED PUBERTY NOT SECONDARY TO PATHOLOGY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

TETANUS TOXOID VACCINE BVD DETERMINATION

DRUG NAME

TETANUS TOXOID ADSORBED

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.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

TETRABENAZINE

DRUG NAME

XENAZINE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

NEUROLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

TOCILIZUMAB

DRUG NAME

ACTEMRA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

NO FAILURE OF AT LEAST ONE OF THE FOLLOWING: ENBREL, HUMIRA, REMICADE, SIMPONI OR CIMZIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS: ACTIVE RHEUMATOID ARTHRITIS. RENEWAL: AT LEAST 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

RHEUMATOLOGIST

COVERAGE DURATION

INITIAL: 6 MONTHS. RENEWAL: 6 MONTHS

OTHER CRITERIA

EASY CHOICE HEALTH PLAN
Prior Authorization Requirements
Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

TOPICAL TRETINOIN

DRUG NAME

AVITA | RETIN-A MICRO | TRETINOIN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

WRINKLES, PHOTOAGING, MELASMA.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

BRAND TRETINON WILL REQUIRE TRIAL OF GENERIC TOPICAL TRETINOIN.

EASY CHOICE HEALTH PLAN
Prior Authorization Requirements

Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

TOTAL PARENTARAL NUTRITION AGENT BVD DETERMINATION

DRUG NAME

AMINOSYN | AMINOSYN II | AMINOSYN II 3.5% M-DEXTROSE 5% | AMINOSYN II 3.5%-DEXTROSE 25% | AMINOSYN II 3.5%-DEXTROSE 5% | AMINOSYN II 4.25% M-DEXT 10% | AMINOSYN II 4.25%-DEXTROSE 25% | AMINOSYN II 5% IN 25% DEXTROSE | AMINOSYN II IN DEXTROSE | AMINOSYN II WITH LYTES-CA-DW | AMINOSYN M | AMINOSYN-HBC | AMINOSYN-HF | AMINOSYN-PF | CLINIMIX | CLINIMIX E | CLINISOL | DEXTROSE IN WATER | FREAMINE III | FREAMINE III WITH ELECTROLYTES | HEPATAMINE | HEPATASOL | INTRALIPID | LIPOSYN II | LIPOSYN III | NEPHRAMINE | PREMASOL | PROCALAMINE | PROSOL | TRAVASOL | TROPHAMINE

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.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

USTEKINUMAB

DRUG NAME

STELARA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

INITIAL: PLAQUE PSORIASIS: LESS THAN 10% BODY SURFACE AREA OR PASI SCORE LESS THAN 12. NO TRIAL/FAILURE OF AT LEAST ONE OF THE FOLLOWING: PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORIN. RENEWAL: PHYSICIAN'S GLOBAL ASSESMENT GREATER THAN 1 OR LESS THAN 50% DECREASE IN PASI SCORE.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

DERMATOLOGIST OR RHEUMATOLOGIST

COVERAGE DURATION

INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA

PRIOR AUTHORIZATION GROUP DESCRIPTION

VANDETANIB

DRUG NAME

CAPRELSA | VANDETANIB

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CRITERIA APPLIES TO NEW STARTS ONLY.

EASY CHOICE HEALTH PLAN
Prior Authorization Requirements
Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

VARENICLINE

DRUG NAME

CHANTIX

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

INITIAL: NOT ENROLLED IN A SMOKING CESSATION PROGRAM. RENEWAL: NOT ABSTAINING FROM CIGARETTE USE DURING THE INITIAL 12 WEEKS OF TREATMENT

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL: 12 WEEKS. RENEWAL:12 WEEKS.

OTHER CRITERIA

EASY CHOICE HEALTH PLAN
Prior Authorization Requirements

Effective Date: 05/01/2012

PRIOR AUTHORIZATION GROUP DESCRIPTION

VEMURAFENIB

DRUG NAME

ZELBORAF

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

BRAFV600E MUTATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA