

## Prior Authorization Criteria

### PA\_GroupNm:

#### Covered Uses for this Drug

#### Coverage Excluded Reasons

#### Information Required

#### Age Restrictions

#### Prescriber Restrictions

#### Duration of Approval

#### Other Information we may

#### Require:

### Abilify

All FDA-approved indications

No Exclusion Criteria

Diagnosis and Chart Documentation

No Age Restrictions

No Prescriber Restrictions

365 days

Members must have a diagnosis of Bipolar Disorder, Schizophrenia, Major Depression with Psychosis or irritability associated with Autistic disorder or a diagnosis of treatment resistant Major Depressive Disorder and failure of both mono and combination antidepressant therapy which includes: An adequate trial and failure, duration of at least 4 weeks, or intolerance to monotherapy with 2 different Antidepressant therapies AND trial and failure, duration of at least 4 weeks, or intolerance to a single trial of combination Antidepressant therapy (such as a SSRI and bupropion or SNRI and bupropion) OR trial and failure, duration of at least 4 weeks, or intolerance to a single trial of an Antidepressant with augmentation therapy (such as Lithium).

### PA\_GroupNm:

#### Covered Uses for this Drug

#### Coverage Excluded Reasons

#### Information Required

#### Age Restrictions

#### Prescriber Restrictions

#### Duration of Approval

#### Other Information we may

#### Require:

### Acne Products

All FDA approved indications

Diagnoses not covered: solar elastosis, sun damage, wrinkles, actinic damage, melasma, lentigines / freckles (hyperpigmented macules, liver spots), heliodermatitis, Dermatoheliosis

Diagnosis required for initial coverage. Reauthorization will require response to therapy.

Prior authorization applies to members 35 years of age and older.

No Prescriber Restrictions

365 days

Will be covered for members 35 years of age and older with the following diagnoses: Acne, Acne vulgaris, Cystic acne, Comedones, Papules, Pustules, Precancerous or cancerous lesions, Psoriasis, Keratosis follicularis (Darier's Disease, Darier-White disease), Folliculitis, Molluscum contagiosum, Facial warts, Milia, Malignant neoplasm, Rosacea, Grover's disease, Verruca plana, or Favre-Racouchot Syndrome (Nodular Elastosis with Cysts and Comedones).

## Prior Authorization Criteria

<b>PA_GroupNm:</b>	<b>Actemra</b>
<b>Covered Uses for this Drug</b>	All FDA-approved indications
<b>Coverage Excluded Reasons</b>	No Exclusion Criteria
<b>Information Required</b>	Diagnosis
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Rheumatologist
<b>Duration of Approval</b>	365 Days
<b>Other Information we may Require:</b>	Member must have a negative Tuberculin PPD (purified protein derivative) test or QuantiFERON blood test, and have a diagnosis of moderate to severely active rheumatoid arthritis, and member must have an adequate trial of at least 3 months of at least 2 TNF-blocking agents with an inadequate response, significant side effects/toxicity, or a have a contraindication to these therapies, and Member must currently not be using a TNF-blocking agent or other biologic agents in combination with Actemra, and Member must have no evidence of infection. Member must have the following laboratory values – AST and ALT laboratory values less than or equal to 1.5x upper limit of normal, and absolute neutrophil count greater than or equal to 2000cells/mm <sup>3</sup> , and Platelet count greater than or equal to 100,000cells/mm <sup>3</sup> . All prior authorization renewals will be reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. Member must have the following laboratory values for reauthorization of treatment - AST and ALT laboratory values less than or equal to 5x upper limit of normal, Absolute neutrophil count greater than or equal to 500cells/mm <sup>3</sup> , Platelet count greater than or equal to 50,000cells/mm <sup>3</sup> . Authorization may be extended at one-year intervals based upon documentation from the prescriber that the member's disease has improved based upon the prescriber's assessment while on therapy and no evidence of infection.
<b>PA_GroupNm:</b>	<b>Acute Hereditary Angioedema Products: Berinert and Kalbitor</b>
<b>Covered Uses for this Drug</b>	All FDA approved indications
<b>Coverage Excluded Reasons</b>	No Exclusion Criteria
<b>Information Required</b>	Diagnosis
<b>Age Restrictions</b>	No Age Restrictions
<b>Prescriber Restrictions</b>	Must be prescribed by or under the direction of a HAE specialist
<b>Duration of Approval</b>	365 Days
<b>Other Information we may Require:</b>	Diagnosis of HAE confirmed by the following laboratory values on two separate instances (copy of laboratory reports required, must include reference ranges): Low C4 complement level (mg/dL), AND Normal C1q complement component level (mg/dL), AND C1q complement component level is not required for patients under the age of 18 OR patients whose symptoms began before age 18. Low C1 esterase inhibitor antigenic level (mg/dL), OR Low C1 esterase inhibitor functional level (percent). Patient has received at least one dose of requested product as treatment for acute HAE attack in the past. Chart documentation indicating patient response and ability to tolerate medication is required.
<b>PA_GroupNm:</b>	<b>Adagen</b>
<b>Covered Uses for this Drug</b>	All FDA approved indications
<b>Coverage Excluded Reasons</b>	No Exclusion Criteria
<b>Information Required</b>	Diagnosis
<b>Age Restrictions</b>	18 years of age or less.
<b>Prescriber Restrictions</b>	Specialist in treatment of inherited metabolic disorders
<b>Duration of Approval</b>	365 days
<b>Other Information we may Require:</b>	Must have a confirmed diagnosis of adenosine deaminase deficiency (ADA) with severe combined immunodeficiency disease (SCID) who have failed or are not candidates for bone marrow transplantation

## Prior Authorization Criteria

### **PA\_GroupNm:**

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### **Adcirca**

All FDA-approved indications  
 No Exclusion Criteria.  
 Diagnosis and confirmed diagnosis by right heart catheterization. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.  
 No Age Restrictions  
 Cardiologist or pulmonologist  
 90 days initially.  
 Member has a confirmed diagnosis of PAH with WHO functional class II-IV symptoms AND member is NOT currently taking a nitrate product. Additional yearly authorizations may be granted upon review of chart documentation from the prescriber indicating that the member's condition has improved as a result of therapy.

**Age Restrictions**

**Prescriber Restrictions**

**Duration of Approval**

**Other Information we may Require:**

### **PA\_GroupNm:**

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### **Afinitor**

All FDA-approved indications  
 No Exclusion Criteria.  
 Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.  
 No Age Restrictions  
 No Prescriber Restrictions  
 180 days  
 Patients with advanced renal cell carcinoma after failure of treatment with sunitinib or sorafenib.

**Age Restrictions**

**Prescriber Restrictions**

**Duration of Approval**

**Other Information we may Require:**

### **PA\_GroupNm:**

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### **Aldurazyme**

All FDA approved indications  
 No Exclusion Criteria  
 Diagnosis  
 Must 5 years of age or older.  
 Specialist in treatment of inherited metabolic disorders  
 365 days  
 Must have a confirmed diagnosis of Mucopolysaccharidosis, Type I (Hurler and Hurler-Scheie forms) and Scheie form with moderate to severe symptoms.

**Age Restrictions**

**Prescriber Restrictions**

**Duration of Approval**

**Other Information we may Require:**

### **PA\_GroupNm:**

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### **Alpha1-Proteinase Inhibitors**

All FDA-approved indications  
 No Exclusion Criteria  
 Diagnosis  
 18 or older  
 By or in consultation with a pulmonologist  
 365 Days  
 Member must have a confirmed diagnosis of congenital alpha1-antitrypsin deficiency with clinically evident emphysema or airflow obstruction, must have an alpha1-antitrypsin phenotype of PI\*ZZ, PI\*ZNull or PI\*NullNull, must have a baseline (pretreatment) serum alpha1-antitrypsin concentration of less than 11 µmol/L as documented by either of the following: less than 50mg/dL as determined by nephelometry OR less than 80mg/dL as determined by radial immunodiffusion. Must be a non-smoker and must not have selective IgA deficiencies with known antibodies against IgA (anti-IgA antibodies). All prior authorization renewals will be reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. Authorization may be extended at one-year intervals based upon documentation from the provider that the member's disease has improved based upon the prescriber's assessment while on therapy.

**Age Restrictions**

**Prescriber Restrictions**

**Duration of Approval**

**Other Information we may Require:**

## Prior Authorization Criteria

### PA\_GroupNm:

#### Covered Uses for this Drug

#### Coverage Excluded Reasons

#### Information Required

#### Age Restrictions

#### Prescriber Restrictions

#### Duration of Approval

#### Other Information we may

#### Require:

### Amevive

All FDA approved indications

No Exclusion Criteria

Diagnosis and CD4 count.

Member is age 18 or older.

Dermatologist

Initially for 12 weeks. 12 weeks off of therapy after initial 12 weeks on therapy.

Member must have a diagnosis of chronic moderate to severe plaque psoriasis, have a minimum body surface area involvement of greater than or equal to 10%, (members with plaque psoriasis of the palms, soles, head and neck, or genitalia are not required to have a minimum body surface area involvement), have an adequate trial of a conventional systemic therapy (e.g. methotrexate, cyclosporine, acitretin) with an inadequate response, significant side effects or toxicity, or have a contraindication to these therapies, have an adequate trial of a TNF-blocking agent (e.g. Enbrel, Humira, Remicade) with an inadequate response, significant side effects or toxicity, or have a contraindication to these therapies, have a normal CD4 lymphocyte count (250 cells/ $\mu$ L or greater), member cannot have HIV, as this is a contraindication for treatment with Amevive, currently not using the following in combination with Amevive such as TNF-blocking agents, other biologic agents, immunosuppressant agents or phototherapy, and have no evidence of infection. Reauthorization may be granted for an additional 12 weeks of therapy if the member has had at least 12 weeks off of therapy after the initial 12 weeks on therapy and chart documentation from the provider must indicate that that the member's disease has improved based upon the provider's assessment while on therapy and has a CD4 lymphocyte count of 250 cells/ $\mu$ L or greater and no evidence of infection. If the reauthorization criteria is met, the medication will be approved for an additional 12 weeks of therapy. Therapy will be limited to 2 treatment courses per year.

### PA\_GroupNm:

#### Covered Uses for this Drug

#### Coverage Excluded Reasons

#### Information Required

#### Age Restrictions

#### Prescriber Restrictions

#### Duration of Approval

#### Other Information we may

#### Require:

### Ampyra

All FDA-approved indications

No Exclusion Criteria

Diagnosis

18 or older

Neurologist or Physical Medicine and Rehabilitation physician in consultation with the member's treating Neurologist

60 days initially then annually

Member must have a diagnosis of multiple sclerosis, have documented motor dysfunction (chart documentation of member's baseline motor disability must be included), member must not be on concomitant therapy with any other forms of 4-aminopyridine, member must not have a history of seizure, and member must not have moderate or severe renal impairment (CrCl less than or equal to 50 mL/min). Authorization may be extended at 1 year intervals based upon chart documentation from the provider that the member's motor function has improved based upon the prescriber's assessment.

## Prior Authorization Criteria

### PA\_GroupNm:

#### Covered Uses for this Drug

#### Coverage Excluded Reasons

#### Information Required

#### Age Restrictions

#### Prescriber Restrictions

#### Duration of Approval

#### Other Information we may

#### Require:

### Androgens

All FDA approved indications

No Exclusion Criteria

Diagnosis and morning serum testosterone level less than 300ng/Dl

No Age Restrictions

No Prescriber Restrictions

365 days

Androgenic agents will be covered for Primary hypogonadism (congenital or acquired) – testicular failure due to cryptorchidism, bilateral torsions, orchitis, vanishing testis syndrome, or orchidectomy, or, Hypogonadotropic hypogonadism (congenital or acquired) – idiopathic gonadotropin or LHRH deficiency, or pituitary-hypothalamic injury from tumors, trauma or radiation.

### PA\_GroupNm:

#### Covered Uses for this Drug

#### Coverage Excluded Reasons

#### Information Required

#### Age Restrictions

#### Prescriber Restrictions

#### Duration of Approval

#### Other Information we may

#### Require:

### Antipsychotics in Children (Abilify, Clozaril, Zyprexa, Seroquel, Risperdal, Geodon)

All FDA approved indications

No Exclusion Criteria

Diagnosis and Chart Documentation

Children under the age of 12

Must be prescribed by or in consultation with a child and adolescent psychiatrist, pediatric neurologist, or child development pediatrician.

365 Days

The member must have severe behavioral problems related to one of the following diagnoses: Bipolar Mania: Member must be 10 years of age or older; Autism: Member must be 5 years of age or older AND Chart documented evidence of a comprehensive evaluation and non-pharmacologic therapies such as, but not limited to, evidence based behavioral, cognitive, and family based therapies must be provided.

### PA\_GroupNm:

#### Covered Uses for this Drug

#### Coverage Excluded Reasons

#### Information Required

#### Age Restrictions

#### Prescriber Restrictions

#### Duration of Approval

#### Other Information we may

#### Require:

### Aranesp

All FDA approved indications

No Exclusion Criteria

Hemoglobin level, iron studies, and diagnosis for initial authorization.

No Age Restrictions

No Prescriber Restrictions

2 months initially then every 6 months all pts except for those on ribavirin which is app every 2 months.

Member must have a ONE of the following: Anemia of chronic renal failure and on renal dialysis when Hgb < 10 g/dL or Anemia of chronic renal failure, not requiring dialysis when Hgb < 10 g/dL or Anemia in members with non-myeloid malignancies where anemia is due to the effect of concomitantly administered chemotherapy (Hgb < 10 g/dL) or Anemia associated with the use of ribavirin when Hgb < 10 g/dL or a 2 g/dL decrease from baseline Hgb or Anemia associated with myelodysplastic syndrome when Hgb < 10 g/dL. Iron status must be evaluated by the provider for all members before and during treatment. Supplemental iron therapy is required for all members whose serum ferritin is below 100 mcg/L (<300 mcg/L in members with chronic kidney disease) or whose serum transferrin saturation is below 20%. Member must not have uncontrolled hypertension. Not have a known hypersensitivity to the active substance or any of the excipients of the product. Prescribed dose must be within the recommended dosing guidelines.

## Prior Authorization Criteria

<b>PA_GroupNm:</b>	<b>Angiotensin II Receptor Blockers (ARB's) – (Diovan, Diovan HCT, Micardis, Micardis HCT, Exforge, Exforge HCT, Twynsta)</b>
<b>Covered Uses for this Drug</b>	All FDA approved indications
<b>Coverage Excluded Reasons</b>	No Exclusion Criteria
<b>Information Required</b>	Diagnosis
<b>Age Restrictions</b>	No Age Restrictions
<b>Prescriber Restrictions</b>	No Prescriber Restrictions
<b>Duration of Approval</b>	365 Days
<b>Other Information we may Require:</b>	The member must have a documented pharmacy claim history of prior therapy with the following: An angiotensin converting enzyme inhibitor (ACE inhibitor) For members without a prior claim history of an ACE inhibitor, a medical necessity review will be completed, and the following criteria must be met: Documentation indicating that the member has failed one (1) ACE inhibitor for at least one month at the maximum tolerated dose or has a contraindication or intolerance to an ACE inhibitor.
<b>PA_GroupNm:</b>	<b>Banzel</b>
<b>Covered Uses for this Drug</b>	All FDA approved indications
<b>Coverage Excluded Reasons</b>	No Exclusion Criteria
<b>Information Required</b>	Diagnosis
<b>Age Restrictions</b>	No Age Restrictions
<b>Prescriber Restrictions</b>	Neurologist
<b>Duration of Approval</b>	365 days
<b>Other Information we may Require:</b>	Member must have a diagnosis of Lennox-Gastaut syndrome. Authorizations may be extended at one-year intervals based upon chart documentation from the prescriber that the member's disease has improved based upon the prescriber's assessment while on therapy.
<b>PA_GroupNm:</b>	<b>Botox</b>
<b>Covered Uses for this Drug</b>	All FDA-approved indications
<b>Coverage Excluded Reasons</b>	No Exclusion Criteria.
<b>Information Required</b>	Diagnosis
<b>Age Restrictions</b>	12 or older for blepharospasm associated with dystonia including benign essential blepharospasm or VII nerve disorders
<b>Prescriber Restrictions</b>	Dermatologist for severe primary axillary hyperhidrosis.
<b>Duration of Approval</b>	90 days initially then 365 days per reauthorization criteria.
<b>Other Information we may Require:</b>	Approved for members with strabismus, blepharospasm associated with dystonia including benign essential blepharospasm or VII nerve disorders in patients greater than 12 years old, cervical dystonia (spasmodic torticollis), spasticity in the flexor muscles of the elbow, wrist or fingers in adults, severe primary axillary hyperhidrosis that is inadequately managed by topical agents. It is also covered for neurogenic detrusor overactivity in adults after trial and failure of at least one previous agent, detrusor sphincter dyssynergia after spinal cord injury, drooling in Parkinson's Disease, spasticity in adults due to stroke, trauma, multiple sclerosis, and neoplasm involving the CNS, spasticity due to cerebral palsy in children, blepharospasm, cervical dystonia, Focal upper extremity dystonia, adductor laryngeal dystonia, and essential hand tremor in patients after trial and failure of at least one previous agent.
<b>PA_GroupNm:</b>	<b>Buphenyl</b>
<b>Covered Uses for this Drug</b>	All FDA approved indications
<b>Coverage Excluded Reasons</b>	No Exclusion Criteria
<b>Information Required</b>	Diagnosis
<b>Age Restrictions</b>	No Age Restrictions
<b>Prescriber Restrictions</b>	Specialist in treatment of inherited metabolic disorders
<b>Duration of Approval</b>	365 days
<b>Other Information we may Require:</b>	Member must have a diagnosis of urea cycle disorder

## Prior Authorization Criteria

### PA\_GroupNm:

**Covered Uses for this Drug**

**Coverage Excluded Reasons**

**Information Required**

**Age Restrictions**

**Prescriber Restrictions**

**Duration of Approval**

**Other Information we may Require:**

### Cerezyme

All FDA approved indications

No Exclusion Criteria

Diagnosis

No Age Restrictions

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

365 days

Member must have a diagnosis of Gaucher's disease with Anemia, Thrombocytopenia, Bone Disease, Hepatomegaly, or Splenomegaly

### PA\_GroupNm:

**Covered Uses for this Drug**

**Coverage Excluded Reasons**

**Information Required**

**Age Restrictions**

**Prescriber Restrictions**

**Duration of Approval**

**Other Information we may Require:**

### C1 Inhibitor [human] (Cinryze)

All FDA approved indications

No Exclusion Criteria

Diagnosis, Lab Values

9 years of age or older.

Must be prescribed by or under the direction of a HAE specialist

Initial treatment 4 Months, Continuation 1 year

Must be used as prophylactic therapy for the prevention of HAE attacks. Diagnosis of HAE confirmed by the following laboratory values on two separate instances (copy of laboratory reports required, must include reference ranges): Low C4 complement level (mg/dL), AND Normal C1q complement component level (mg/dL), AND C1q complement component level is not required for patients under the age of 18 OR patients whose symptoms began before age 18. Low C1 esterase inhibitor antigenic level (mg/dL), OR Low C1 esterase inhibitor functional level (percent). Patient is a candidate for HAE prophylaxis therapy, demonstrating at least one of the following (chart documentation of each attack is required): History of frequent HAE attacks defined as two or more HAE attacks per month; OR History of severe HAE attacks defined as one or more abdominal attack in the past 12 months; OR any attack of the respiratory tract which compromised the airway. Patient has had a trial and failure, intolerance, or contraindication to an attenuated androgen (e.g., danazol, stanozolol, oxandrolone).

### PA\_GroupNm:

**Covered Uses for this Drug**

**Coverage Excluded Reasons**

**Information Required**

**Age Restrictions**

**Prescriber Restrictions**

**Duration of Approval**

**Other Information we may Require:**

### Effexor XR

All FDA approved indications

No Exclusion Criteria

Documented pharmacy claim history of prior therapy with a Selective Serotonin Reuptake Inhibitor (SSRI).

No Age Restrictions

No Prescriber Restrictions.

365 Days

For diagnosis other than psychiatric, clinical information is required for review.

### PA\_GroupNm:

**Covered Uses for this Drug**

**Coverage Excluded Reasons**

**Information Required**

**Age Restrictions**

**Prescriber Restrictions**

**Duration of Approval**

**Other Information we may Require:**

### Elaprase

All FDA approved indications

No Exclusion Criteria

Diagnosis

5 years of age and older

Specialist in treatment of inherited metabolic disorders

365 days

Confirmed diagnosis of Hunter Syndrome

## Prior Authorization Criteria

### PA\_GroupNm:

### Elidel and Protopic

<b>Covered Uses for this Drug</b>	All FDA approved indications
<b>Coverage Excluded Reasons</b>	Weakened or compromised immune system
<b>Information Required</b>	Diagnosis
<b>Age Restrictions</b>	2 years of age or older.
<b>Prescriber Restrictions</b>	No Prescriber Restrictions.
<b>Duration of Approval</b>	365 days
<b>Other Information we may Require:</b>	Member must have a diagnosis of atopic dermatitis (eczema), be over the age of 2, be without a weakened or compromised immune system, and had a trial and failure of a moderate to high potency topical corticosteroid unless a contraindication or intolerance to topical corticosteroid therapy, such as dermatitis on the face.

### PA\_GroupNm:

### Enbrel

<b>Covered Uses for this Drug</b>	All FDA approved indications
<b>Coverage Excluded Reasons</b>	No Exclusion Criteria
<b>Information Required</b>	Diagnosis, negative Tuberculin PPD test or QuantiFERON blood test and no evidence of infection for initial authorization. Authorization may be extended at one-year intervals based upon documentation from provider that the member's disease has improved based upon the prescriber's assessment while on therapy and no evidence of infection.
<b>Age Restrictions</b>	2 and older for juvenile idiopathic arthritis and 18 and older for other conditions.
<b>Prescriber Restrictions</b>	Rheumatologist or dermatologist
<b>Duration of Approval</b>	90 days initially for psoriasis then 365 days. 365 days for other conditions.
<b>Other Information we may Require:</b>	<p><b>For a diagnosis of Rheumatoid Arthritis and Juvenile Idiopathic Arthritis:</b> Member must have a diagnosis of moderately to severely active rheumatoid arthritis, an adequate trial of at least 3 months, of methotrexate with an inadequate response. Members with significant side effects/toxicity or have a contraindication to methotrexate, must have an adequate trial of at least 3 months of leflunomide, hydroxychloroquine, minocycline, or sulfasalazine with an inadequate response, significant side effect/toxicity, or have a contraindication to these therapies. Member must currently not be using a TNF-blocking agent or other biologic agents in combination with Enbrel.</p> <p><b>For a diagnosis of Psoriatic Arthritis:</b> Member must have a diagnosis of moderate to severely active psoriatic arthritis. For members with dominant peripheral disease: Must have an adequate trial of at least 3 months with at least 2 NSAIDs at anti-inflammatory target dose, with an inadequate response, significant side effects/toxicity, or have a contraindication to these therapies AND have an adequate trial of at least 3 months, of a conventional systemic therapy (methotrexate, cyclosporine, sulfasalazine, or leflunomide) with an inadequate response, significant side effects/toxicity, or have a contraindication to these therapies. For members with dominant axial disease: Must have an adequate trial of at least 3 months with at least 2 NSAIDs at anti-inflammatory target dose, with an inadequate response, significant side effects/ toxicity, or have a contraindication to these therapies. Member must currently not be using a TNF-blocking agent or other biologic agents in combination with Enbrel.</p> <p><b>For a diagnosis of Ankylosing Spondylitis:</b> Member must have a diagnosis of active ankylosing spondylitis. For members with dominant axial disease: Member must have an adequate trial of at least 3 months with at least 2 NSAIDs at anti-inflammatory target dose, with an inadequate response, significant side effects/toxicity, or have a contraindication to these therapies. For members with dominant peripheral disease: Must have an adequate trial of at least 3 months with at least 2 NSAIDs at anti-inflammatory target dose, with an inadequate response, significant side effects/toxicity, or have a contraindication to these therapies AND Member must have an adequate trial of a conventional systemic therapy (sulfasalazine or methotrexate) with an inadequate response, significant side effects /toxicity, or have a contraindication to this therapy. Member must currently not be using a TNF-blocking agent or other biologic agents in combination with Enbrel.</p> <p><b>For a diagnosis of Plaque Psoriasis:</b> The following criteria must be met: Member must have a diagnosis of chronic severe plaque psoriasis, have a minimum body surface area involvement of <math>\geq 10\%</math> (members with plaque</p>

## Prior Authorization Criteria

psoriasis of palms, soles, head and neck, or genitalia are not required to have a minimum body surface area involvement), have an adequate trial of topical treatments, phototherapy, or photochemotherapy with an inadequate response, significant side effects /toxicity, or have a contraindication to these therapies. Member must have an adequate trial of at least 3 months of a conventional systemic therapy (methotrexate, cyclosporine, or acitretin) with an inadequate response, significant side effects /toxicity, or have a contraindication to these therapies. Member must currently not be using a TNF-blocking agent or other biologic agents in combination with Enbrel, no evidence of infection

### **PA\_GroupNm:**

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Duration of Approval**  
**Other Information we may Require:**

### **Epogen and Procrit**

All FDA-approved indications  
 No Exclusion Criteria  
 Hemoglobin level, iron studies, and diagnosis for initial authorization.  
 No Age Restrictions  
 No Prescriber Restrictions  
 2 months initially then every 6 months. Every 2 months for ribavirin use.  
 Member must have a ONE of the following: Anemia of chronic renal failure and on renal dialysis when Hgb < 10 g/dL or Anemia of chronic renal failure, not requiring dialysis when Hgb < 10 g/dL or Anemia in members with non-myeloid malignancies where anemia is due to the effect of concomitantly administered chemotherapy (Hgb < 10 g/dL) or Anemia associated with the use of ribavirin when Hgb < 10 g/dL or a 2 g/dL decrease from baseline Hgb or Anemia associated with myelodysplastic syndrome when Hgb < 10 g/dL. Iron status must be evaluated by the provider for all members before and during treatment. Supplemental iron therapy is required for all members whose serum ferritin is below 100 mcg/L (<300 mcg/L in members with chronic kidney disease) or whose serum transferrin saturation is below 20%. Member must not have uncontrolled hypertension. Not have a known hypersensitivity to the active substance or any of the excipients of the product. Prescribed dose must be within the recommended dosing guidelines.

### **PA\_GroupNm:**

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Duration of Approval**  
**Other Information we may Require:**

### **Fabrazyme**

All FDA approved indications  
 No Exclusion Criteria  
 Diagnosis  
 No Age Restrictions  
 Specialist in treatment of inherited metabolic disorders  
 365 days  
 Men with a diagnosis of Fabry disease based on clinical symptoms or by genetic testing.  
 Women with presumed symptoms of Fabry disease (heterozygous carriers) based on family history and/or genetic testing.

### **PA\_GroupNm:**

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Duration of Approval**  
**Other Information we may Require:**

### **Fanapt**

All FDA approved indications  
 No Exclusion Criteria  
 Diagnosis  
 No Age Restrictions  
 Prescribed by or in consultation with a psychiatrist.  
 365 days  
 Member must have a diagnosis of schizophrenia and member must have an adequate trial and failure or inadequate response, duration of at least 4 weeks, or intolerance to risperidone and 2 other atypical antipsychotics. For continuation, documentation required from the provider that the member's disease has improved based upon the prescriber's assessment while on therapy.

## Prior Authorization Criteria

### PA\_GroupNm:

### Gleevec

#### Covered Uses for this Drug

All FDA-approved indications

#### Coverage Excluded Reasons

No Exclusion Criteria

#### Information Required

Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy

#### Age Restrictions

No Age Restrictions

#### Prescriber Restrictions

No Prescriber Restrictions

#### Duration of Approval

180 days.

#### Other Information we may

Adult and pediatric Philadelphia positive (Ph+) chronic myeloid leukemia (CML) in chronic phase, patients in Ph+ CML in blast crisis, accelerated phase or interferon-refractory chronic phase, pediatric Ph+ CML recurrence after stem cell transplant or interferon-alpha resistant, adult relapsed or refractory Ph+ acute lymphoblastic leukemia (ALL), adult myelodysplastic disease/myeloproliferative disease (MDS/MPD) associated with PDGFR gene rearrangements, adult aggressive systemic mastocytosis (ASM) without D816V c-Kit mutation or c-Kit mutation unknown, adult hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL) with platelet derived growth factor receptor (FIP1L1-PDGFRa) fusion kinase positive, negative, or unknown, adult unresectable, recurrent and/or metastatic dermatofibrosarcoma protuberans (DFSP), or patients with Kit cancer protein (CD117) unresectable and/or metastatic malignant GI stromal tumors.

#### Require:

### PA\_GroupNm:

### Growth Hormone

#### Covered Uses for this Drug

All FDA approved indications

#### Coverage Excluded Reasons

Children with constitutionally delayed growth and development (i.e., delayed skeletal maturation with normal growth velocities and rates of bone age advancement, members who are at the lowest 5% of the growth curve at age 3), steroid-induced growth failure, kidney transplant recipients, Down syndrome, Fanconi's syndrome, Bloom syndrome, chromosomal and genetic disorders. Adults with chronic fatigue syndrome, fibromyalgia, obesity, athletic performance enhancer, anti-aging treatment, sepsis, burns, trauma, surgery, ESRD, wasting associated with cancer or organ failure. No evidence of malignancy in adults.

#### Information Required

Diagnosis, growth charts, growth hormone levels from stimulation tests, IGF-1 level, x-rays of left hand and wrist, and pituitary hormone levels. For continued authorization, one of the following cannot be true: growth velocity while on therapy is less than 2.5 expected final adult height has been reached, growth plates have fused, bone age in females reaches age 14, in males age 16, or renal transplantation for CRI.

#### Age Restrictions

No Age Restrictions

#### Prescriber Restrictions

Endocrinologist, pediatric endocrinologist, or pediatric nephrologist dependent upon diagnosis.

#### Duration of Approval

180 days for children with extreme short stature and 365 days for other indications.

#### Other Information we may

#### **Diagnosis of Children and Adolescents with Classic Growth Hormone Deficiency (GHD):**

Documented failure to respond to 2 Growth Hormone (GH) provocative tests, defined as a serum GH level (peak level) <10ng/mL. Unless contraindicated, one of the tests must be the insulin tolerance test; others include levodopa, arginine, clonidine, propranolol, and glucagon. One abnormal GH test is sufficient in children with a history of irradiation or multiple pituitary hormone deficiency; and Insulin-like growth factor-I (IGF-I) levels below normal for bone age and sex; and at least two of the following: Present height is <5<sup>th</sup> percentile for age/sex; Pretreatment growth velocity is <10<sup>th</sup> percentile for bone age and gender or <4.5cm/yr

#### **Diagnosis of Children with growth retardation due to chronic renal insufficiency (CRI):**

documented diagnosis of CRI up to the time of renal transplant; and At least *one* of the following: Present height is <5<sup>th</sup> percentile for age/sex; Growth velocity is <10<sup>th</sup> percentile for bone age and gender or <4.5cm/yr

#### **Diagnosis of Turner syndrome/Noonan Syndrome:**

Documented diagnosis of Turner's syndrome or Noonan Syndrome; and At least *one* of the

## Prior Authorization Criteria

following: Present height is <5<sup>th</sup> percentile for age/sex; Growth velocity is <10<sup>th</sup> percentile for bone age and gender or <4.5cm/yr

**Diagnosis of Children with Prader-Willi Syndrome:** Documented diagnosis of Prader-Willi Syndrome; and At least *one* of the following: Present height is <5<sup>th</sup> percentile for age/sex; Growth velocity is <10<sup>th</sup> percentile for bone age and gender or <4.5cm/yr

**Diagnosis of Children with extreme short stature:** Documentation that includes specific examples of how basic activities of daily life (ADL) are affected; and Height Standard Deviation Score must be <-2.25 cm/yr; and Documentation that associated growth rates are unlikely to permit attainment of adult height within the target height range calculated based on parental heights; and Documentation that children with short stature born small for gestational age (SGA) have not shown catch-up growth by age two (2) years; and GH therapy in children must be prescribed by a pediatric endocrinologist and must be used with appropriate physician follow-up; and GH request must include a treatment plan outlining the dose, monitoring parameters such as when the member will be seen for follow-up, methods for determining treatment response and anticipated duration of use.

**Diagnosis of Adult Growth Hormone Deficiency – Childhood Onset** Members who were diagnosed with GHD during childhood who have GH deficiency reconfirmed as an adult; GH treatment should be stopped for 2-3 months after completion of linear growth, and then GH levels should be reassessed by stimulation test; and Member has a biochemical diagnosis of GH deficiency determined by a negative response to a standard GH stimulation test defined as a peak GH level of <3ng/ml. The insulin tolerance test (ITT) is required unless contraindicated. Growth Hormone Releasing Hormone (GHRH)-arginine stimulation test results may be submitted for those members with a documented contraindication to ITT; and Member has NOT reached adult peak bone mass (between 25 and 30 years of age). After adult peak bone mass has been reached, then the Adult GHD – Adult Onset criteria should be followed.

**Diagnosis of Adult Growth Hormone Deficiency – Adult Onset** Members who were diagnosed with GHD during childhood who have GH deficiency reconfirmed as an adult; GH treatment should be stopped for 2-3 months after completion of linear growth, and then GH levels should be reassessed by stimulation test; and Member has a biochemical diagnosis of GH deficiency determined by a negative response to a standard GH stimulation test defined as a peak GH level of <3ng/ml. The ITT is required unless contraindicated. GHRH-arginine stimulation test results may be submitted for those members with a documented contraindication to ITT; and Member has NOT reached adult peak bone mass (between 25 and 30 years of age). After adult peak bone mass has been reached, then the Adult GHD – Adult Onset criteria should be followed; and GH therapy in adults must be prescribed by an endocrinologist; and GH request must include a treatment plan outlining the dose, monitoring parameters such as when the member will be seen for follow-up, methods for determining treatment response and anticipated duration of use; and Member has a biochemical diagnosis of GH deficiency determined by a negative response to a standard growth hormone stimulation test defined as a peak GH level of <3ng/ml. The ITT is required unless contraindicated. GHRH-arginine stimulation test results may be submitted for those members with a documented contraindication to ITT. If GHRH-arginine test results are not available, then the results of two other stimulation tests, including clonidine, L-Dopa, or arginine stimulation, should be submitted; OR If the cause of pituitary disease is known AND if *three* or more pituitary hormones are deficient (Adrenocorticotrophic hormone (ACTH), Thyroid Stimulating Hormone (TSH) and gonadotropins), an Insulin-like Growth Factor (IGF)-1 level of < 84 ng/mL is sufficient to diagnose GH deficiency. Additional GH stimulation tests are not required in these members; OR If the cause of GH deficiency is unknown, evidence of hypothalamic-pituitary disease, defined as documented deficiencies in at least *two* of the following: TSH, ACTH or gonadotropins, must be provided in addition to the GH levels from the stimulation test; and If the member has a pituitary adenoma, documentation must be submitted that the tumor size has remained stable for a period of one (1) year prior to initiating GH therapy; and No evidence of active malignancy; and The member does not have poorly controlled diabetes or diabetes with unstable proliferative retinopathy, as GH therapy is contraindicated in these members

## Prior Authorization Criteria

### PA\_GroupNm:

### Humira

### Covered Uses for this Drug

All FDA-approved indications

### Coverage Excluded Reasons

No Exclusion Criteria

### Information Required

Diagnosis, negative Tuberculin PPD or QuantiFERON blood test, and no evidence of infection. Authorization may be extended at one-year intervals based upon doc from prescriber that the member's disease has improved based upon the prescriber's assessment while on therapy and no evidence of infection.

### Age Restrictions

4 or older for Juvenile Idiopathic Arthritis and 18 or older for other conditions

### Prescriber Restrictions

Rheumatologist, dermatologist, or gastroenterologist based on diagnosis

### Duration of Approval

365 Days

### Other Information we may Require:

**For a diagnosis of Rheumatoid Arthritis and Juvenile Idiopathic Arthritis:** Member must have a diagnosis of moderately to severely active rheumatoid arthritis, an adequate trial of at least 3 months, of methotrexate with an inadequate response. Members with significant side effects/toxicity or have a contraindication to methotrexate, must have an adequate trial of at least 3 months of leflunomide, hydroxychloroquine, minocycline, or sulfasalazine with an inadequate response, significant side effect/toxicity, or have a contraindication to these therapies. Member must currently not be using a TNF-blocking agent or other biologic agents in combination with Humira. **For a diagnosis of Psoriatic Arthritis:** Member must have a diagnosis of moderate to severely active psoriatic arthritis. For members with dominant peripheral disease: Must have an adequate trial of at least 3 months with at least 2 NSAIDs at anti-inflammatory target dose, with an inadequate response, significant side effects/toxicity, or have a contraindication to these therapies AND have an adequate trial of at least 3 months, of a conventional systemic therapy (methotrexate, cyclosporine, sulfasalazine, or leflunomide) with an inadequate response, significant side effects/toxicity, or have a contraindication to these therapies. For members with dominant axial disease: Must have an adequate trial of at least 3 months with at least 2 NSAIDs at anti-inflammatory target dose, with an inadequate response, significant side effects/ toxicity, or have a contraindication to these therapies. Member must currently not be using a TNF-blocking agent or other biologic agents in combination with Humira. **For a diagnosis of Ankylosing Spondylitis:** Member must have a diagnosis of active ankylosing spondylitis. For members with dominant axial disease: Member must have an adequate trial of at least 3 months with at least 2 NSAIDs at anti-inflammatory target dose, with an inadequate response, significant side effects/toxicity, or have a contraindication to these therapies. For members with dominant peripheral disease: Must have an adequate trial of at least 3 months with at least 2 NSAIDs at anti-inflammatory target dose, with an inadequate\_response, significant side effects/toxicity, or have a contraindication to these therapies AND Member must have an adequate trial of a conventional systemic therapy (sulfasalazine or methotrexate) with an inadequate response, significant side effects /toxicity, or have a contraindication to this therapy. Member must currently not be using a TNF-blocking agent or other biologic agents in combination with Humira. **For a diagnosis of Plaque Psoriasis:** The following criteria must be met: Member must have a diagnosis of chronic severe plaque psoriasis, have a minimum body surface area involvement of  $\geq 10\%$  (members with plaque psoriasis of palms, soles, head and neck, or genitalia are not required to have a minimum body surface area involvement), have an adequate trial of topical treatments, phototherapy, or photochemotherapy with an inadequate response, significant side effects /toxicity, or have a contraindication to these therapies. Member must have an adequate trial of at least 3 months of a conventional systemic therapy (methotrexate, cyclosporine, or acitretin) with an inadequate response, significant side effects /toxicity, or have a contraindication to these therapies. Member must currently not be using a TNF-blocking agent or other biologic agents in combination with Humira, no evidence of infection **For a diagnosis of Crohn's disease:** The following criteria must be met: Member must have a diagnosis of moderate to severely active Crohn's disease or fistulizing Crohn's disease, have an adequate trial of conventional therapy including corticosteroids or at least 3 months of immunosuppressants (e.g., azathioprine, 6-mercaptopurine) with an inadequate response, significant side effects/toxicity, or have a contraindication to these therapies. Member

## Prior Authorization Criteria

must currently not be using a TNF-blocking agent or other biologic agents in combination with Humira. **Reauthorization Criteria:** All prior authorization renewals will be reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. Authorization may be extended at one-year intervals based upon documentation from the provider that the member's disease has improved based upon the prescriber's assessment while on therapy and no evidence of infection.

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Duration of Approval**  
**Other Information we may Require:**

### Hyaluronic Acid Products (Synvisc, Supartz)

All FDA approved indications  
 No Exclusion Criteria  
 Diagnosis  
 No Age restrictions  
 No Prescriber Restrictions  
 365 Days  
 Diagnosis of osteoarthritis of the knee. Documentation of trial and failure of physician directed exercise or physical therapy program. Trial and failure of or contraindication to the following conservative treatments for at least 3 months: Acetaminophen OR NSAIDs AND Intra-articular corticosteroid injection. No contraindications to hyaluronic injections such as: Active joint infection or Bleeding disorder.

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
**Age Restrictions**  
**Prescriber Restrictions**  
  
**Duration of Approval**  
**Other Information we may Require:**

### Immune Globulins

All FDA approved indications  
 No Exclusion Criteria  
 Diagnosis, IgG level, platelet counts.  
 No Age Restrictions  
 Prescribed by immunologist or hematologist or in consultation with an immunologist, hematologist or transplant specialist dependent upon diagnoses.  
 30 to 365 days dependent upon diagnosis.  
**For the diagnosis Primary Immunodeficiency** one of the following if prescribed by a specialist: Common Variable Immunodeficiency (hypogammaglobulinemia); Congenital Agammaglobulinemia; Bruton's or X-linked Agammaglobulinemia; Severe Combined Immunodeficiency (SCID); X-linked Hyper-IgM Syndrome; Wiskott-Aldrich Syndrome.  
**Diagnosis of Idiopathic or Immune Thrombocytopenic Purpura (ITP) Children with ITP approved for one of the following:** If platelet count < 20,000 and significant mucous membrane bleeding or if platelet count < 10,000 and minor purpura or If splenectomy planned and platelet count < 30,000 or If platelet count < 20,000 and inaccessibility or noncompliance is a concern or If surgery, dental extractions, or other procedures likely to cause blood loss are needed **Adults with ITP approved for one of the following:** Member has tried a corticosteroid and the platelet count < 30,000 and there is acute bleeding or To increase platelet counts before major surgical procedures (e.g. splenectomy) or If platelet count is < 20,000 and the patient is considered to be at risk for intracerebral bleeding or If there will be predictable bleeding such as from surgery, dental procedures, or pregnancy/labor, then approve IVIG if the platelet counts are as follows: Dentistry ≤ 10,000, teeth extractions ≤ 30,000, regional dental block ≤ 30,000, minor surgery ≤ 50,000, major surgery ≤ 80,000 or To defer or avoid splenectomy  
**Pregnant Women with ITP approved for one of the following:** Platelet count is < 100,000 or Past history of splenectomy or Have previously delivered infants with autoimmune thrombocytopenia. **Diagnosis of Kawasaki Disease:** Approve for 1 dose in the acute phase; May approve second dose in patients who fail to respond to initial therapy or Patients should receive a single dose of IVIG together with aspirin within the first 10 days of illness, and if possible, within 7 days of illness or Children presenting after the 10th day of illness with persistent fever without other explanation or aneurysms and ongoing systemic inflammation.  
**Diagnosis of Chronic B-cell Lymphocytic Leukemia:** Members with hypogammaglobulinemia (IgG < 640mg/dl) and/or with previous history of serious bacterial infection (requiring antibiotics). **Diagnosis of HIV in pediatric patients (< 13 years old) with**

## Prior Authorization Criteria

**CD4 count > or equal to 200/mm<sup>3</sup> approved for one of the following:** Infants and children with recurrent (2 or more) serious bacterial infections such as bacteremia, meningitis, or pneumonia during a 1-year period despite administration of highly active antiretroviral therapy (HAART) and prophylactic sulfamethoxazole/ trimethoprim (TMP-SMZ) or other antimicrobials (HIV-infected infants and children with hypogammaglobulinemia (IgG < 400mg/dl)) or Failure to form antibodies to common antigens, e.g., measles, pneumococcal, and/or haemophilus influenzae Type B; Absence of detectable antibody to measles in children who have received two measles immunizations and who live in regions with a high prevalence of measles. Chronic parvovirus B19 infection; Adjunctive therapy for bronchiectasis not optimally responsive to antibiotics and pulmonary therapy; Passive immunization for measles if Intramuscular Immune Globulin (IMIG) is contraindicated. IM injection contraindicated with severe thrombocytopenia or any coagulation disorder. **Diagnosis of Chronic Inflammatory Demyelinating Polyneuropathy (CIDP):** Member has unequivocal CIDP AND Member has impaired function by objective assessment AND Trial and failure of or contraindications to steroid therapy for at least 2 months and/or plasma exchange. **Diagnosis of Guillain-Barre Syndrome:** Approve if IVIG initiated within 2 weeks and no longer than 4 weeks of onset of neuropathic symptoms in nonambulant adult patients. Approve for 1 month initially. Treatment after 4 weeks will be considered on a case by case basis since some patients may relapse. **Diagnosis of Dermatomyositis including juvenile and polymyositis:** Member has unequivocal Dermatomyositis or Polymyositis AND tried and failed or has contraindications to prednisone for 4 months AND adjuvant therapy. Azathioprine, methotrexate, cyclosporine, or hydroxychloroquine. Approve for 6 months initially. **Diagnosis of Systemic Lupus Erythematosus (SLE):** Member with severe active SLE, AND has tried and failed or has contraindications to first-line therapies (NSAIDs, steroids, antimalarials (e.g., hydroxychloroquine) AND has tried and failed or has contraindications to second-line therapies (immunosuppressants, azathioprine, cyclophosphamide, methotrexate, cyclosporine, or mycophenolate). Approve for 1 year initially. **Diagnosis of Multiple Sclerosis (MS):** Approve for 1 year for relapsing, remitting MS after trial and failure for at least 3 months or contraindication to an interferon (e.g., Betaseron®, Avonex®, Rebif®) or glatiramer (Copaxone®). Treatment of acute exacerbation of MS, primary-progressive MS, secondary-progressive MS, MS during pregnancy, and MS-related syndromes, such as muscle group weakness and optic neuritis, will NOT be covered due to lack of current scientific literature to support improvement in health outcomes. **Diagnosis of Autoimmune mucocutaneous blistering disease:** pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphoid (a.k.a., cictrical pemphigoid), and epidermolysis bullosa acquisita AND meets one of the following criteria: has tried and failed or has contraindications to conventional therapies (corticosteroids or immunosuppressive agents) or in rapidly progressive, extensive, or debilitating cases given with conventional therapy. Approve for 4 months. **Diagnosis of Myasthenia Gravis Syndrome:** has unequivocal Myasthenia Gravis Syndrome AND has severely impaired function AND has tried and failed for at least 3 months or has contraindications to other agents, cholinesterase inhibitors-pyridostigmine or neostigmine AND immunosuppressants or steroids. Approve for 1 month. **Diagnosis of Parvovirus B19 Infection:** Parvovirus B19 infection AND severe anemia associated with bone marrow suppression. Approve for 1 month. **Diagnosis of Renal and/or Pancreatic Transplant Desensitization in Combination with Rituxan:** Must be prescribed by a transplant specialist, age 18 or older, awaiting kidney and/or pancreas transplant requiring desensitization as defined by the following criteria: For deceased donor transplants: Panel reactive antibody (PRA) level >30% OR PRA <30% with previous kidney and/or pancreas transplant, for living donor transplants: Positive crossmatch OR Positive donor-specific antibody using Luminex® assay. IVIG will be approved based on the above regimen for 1 course of treatment (2 doses). Additional authorization for another course of treatment will be considered in 6 months if the member has not yet received a renal and/or pancreatic transplant. Authorization will not be granted until 6 months have passed since the initial treatment. **Diagnosis of IVIG Monotherapy for Renal Desensitization:**

## Prior Authorization Criteria

prescribed by a transplant specialist, awaiting kidney transplant (either from a living or deceased donor) requiring desensitization. Approve for 4 months. Additional authorization for another course of treatment will be considered in 12 months if the member has not received a renal transplant. Authorization for ongoing use past 4 months will not be granted until 12 months have passed since the initial treatment. **Diagnosis of Renal Transplant Rejection:** must have received a renal transplant from a living donor with post-transplant rejection. Approve for 1 month. **Diagnosis of Allogenic Bone Marrow Transplantation or Hematopoietic Stem Cell Transplantation (HSCT):** Severe hypogammaglobulinemia (IgG < 400 mg/dL); does not have to be **severe** due to transplantation for multiple myeloma or malignant macroglobulinemia ORHSCT recipients with unrelated marrow grafts (allogeneic) with severe hypogammaglobulinemia within first 100 days after transplant. Approve for 6 months.

### PA\_GroupNm:

### Covered Uses for this Drug

### Coverage Excluded Reasons

### Information Required

### Age Restrictions

### Prescriber Restrictions

### Duration of Approval

### Other Information we may Require:

### Increlex

All FDA approved indications

Member with closed epiphyses, presence of active or suspected neoplasia, or allergy to mecasecmin.

Diagnosis, growth hormone levels from stimulation tests, IGF-1 level.

Must be at least 2 years of age.

Must be prescribed by a pediatric endocrinologist and must be used with appropriate physician (pediatric endocrinologist) follow-up.

365 days

Two of the following must be present: present height less than 5th percentile for age/sex, pretreatment growth velocity is less than 10th percentile for age and gender or less than 4.5 cm/yr until age 10, and lower growth rates thereafter, comparison of skeletal (bone) age by x-ray of the left hand and wrist is greater than 2 standard deviations below the chronological age. Must have basal serum IGF-1 level which is low for age (greater than 3 standard deviations below the normal level for age and gender, as measured in clinical labs where appropriate normative data are available) and normal or elevated growth hormone (GH) shown by growth stimulation tests, except for members with GH gene deletion and cannot have secondary forms of IGF-1 deficiency, such as growth hormone deficiency, malnutrition, hypothyroidism, or chronic treatment with pharmacologic doses of anti-inflammatory steroids. If thyroid or nutritional deficiencies exist, this should be corrected beforehand. For continued authorization, the member must have positive response to therapy as demonstrated through growth velocity increase, member has not reached expected final adult height and growth plates have not fused as proven through x-ray of left hand and wrist.

## Prior Authorization Criteria

<p><b>PA_GroupNm:</b>  <b>Covered Uses for this Drug</b>  <b>Coverage Excluded Reasons</b>  <b>Information Required</b></p>	<p><b>Iressa</b>  All FDA-approved indications  No Exclusion Criteria.  Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.  No Age Restrictions  No Prescriber Restrictions  Renewable every 180 days.  Monotherapy for locally advanced or metastatic non-small cell lung cancer after failure of both platinum-based AND docetaxel-based chemotherapies who are benefiting or have benefited from Iressa.</p>
<p><b>Age Restrictions</b>  <b>Prescriber Restrictions</b>  <b>Duration of Approval</b>  <b>Other Information we may Require:</b></p>	<p><b>Kineret</b>  All FDA approved indications  No Exclusion Criteria  Diagnosis  18 or older  Rheumatologist  365 days  Member must have a diagnosis of moderate to severely active rheumatoid arthritis, have an adequate trial of at least 3 months, of methotrexate with an inadequate response. (Members with significant side effects/toxicity or have a contraindication to methotrexate, must have an adequate trial of at least 3 months of leflunomide, hydroxychloroquine, minocycline, or sulfasalazine with an inadequate response, significant side effect/toxicity, or have a contraindication to these therapies).  Member must have an adequate trial of at least 3 months, of TNF-blocking agent with an inadequate response, significant side effects/toxicity, or a have a contraindication to these therapies, currently not be a TNF-blocking agent or other biologic agents in combination with Kineret, no evidence of infection.</p>
<p><b>PA_GroupNm:</b>  <b>Covered Uses for this Drug</b>  <b>Coverage Excluded Reasons</b>  <b>Information Required</b>  <b>Age Restrictions</b>  <b>Prescriber Restrictions</b>  <b>Duration of Approval</b>  <b>Other Information we may Require:</b></p>	<p><b>Kuvan</b>  All FDA-approved indications  No Exclusion Criteria  Diagnosis, baseline serum phenylalanine level, and follow-up serum phenylalanine levels.  No Age Restrictions  No Prescriber Restrictions  1 month initially then annually.  The member must have a diagnosis of phenylketonuria (PKU) and a documented baseline serum phenylalanine level. Continuation/Discontinuation criteria: lab reassessment will be conducted after an initial one month trial to determine if authorization may be extended. Patients on the 10mg/kg/day dose whose blood phenylalanine levels have not decreased from baseline after 1 month of treatment should increase to 20mg/kg/day. These patients will be approved for another one month trial at the higher dose. Patients on the 20mg/kg/day dose whose blood phenylalanine levels have not decreased from baseline after 1 month are considered non-responders, and treatment with Kuvan should be discontinued in these patients.</p>

## Prior Authorization Criteria

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**

**Information Required**

**Age Restrictions**

**Prescriber Restrictions**

**Duration of Approval**

**Other Information we may Require:**

### Letairis

All FDA-approved indications

No Exclusion Criteria.

Diagnosis and confirmed diagnosis by right heart catheterization.

No Age Restrictions

Cardiologist or pulmonologist

90 days initially.

Member has a confirmed diagnosis of PAH with WHO functional class II or III symptoms AND member has had baseline liver function tests (ALT, AST) prior to initiation of therapy AND if a member is a woman of childbearing potential, she has had a baseline negative pregnancy test prior to initiation of therapy. Additional yearly authorizations may be granted upon review of chart documentation from the prescriber indicating that the member's condition has improved as a result of therapy.

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**

**Information Required**

**Age Restrictions**

**Prescriber Restrictions**

**Duration of Approval**

**Other Information we may Require:**

### Lucentis

All FDA approved indications

No Exclusion Criteria

Diagnosis

Member must be at least 18 years of age.

Prescriber must be a retinal specialist.

365 Days

Member must have a diagnosis of neovascular (wet) age-related macular degeneration or macular edema following retinal vein occlusion.

AND must not have an active ocular or periocular infection.

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

**Age Restrictions**

**Prescriber Restrictions**

**Duration of Approval**

**Other Information we may Require:**

### Leuprolide and derivatives (*Lupron Depot-Ped, Eligard, Supprelin LA, Vantas, Viadur, Trelstar, Zoladex, Degarelix, Synarel*)

All FDA approved indications

No Exclusion Criteria

Diagnosis. For continued authorization, chart documentation is required from the prescriber that the member's disease has improved based upon the prescriber's assessment while on therapy.

No Age Restrictions

No Prescriber Restrictions

365 days for prostate cancer, breast cancer, and central precocious puberty, 180 days for endometriosis, 90 days for uterine leiomyomata, 60 days for endometrial thinning.

Covered for the following: diagnosis of prostate cancer or diagnosis of breast cancer. Diagnosis of endometriosis confirmed by laparoscopy OR if the diagnosis is not confirmed by surgery, then chart documentation of an adequate work-up and the clinical rationale for the diagnosis must be provided, for mild endometriosis, the member must have tried oral contraceptives and/or progestins. For the diagnosis of uterine leiomyomata (fibroids), member must have a diagnosis of uterine leiomyomata (fibroids), and the use of GnRh (gonadotropin-releasing hormone) agonist can be used in the treatment for fibroid in the following contexts it may be used preoperatively to maximize preoperative hemoglobin in patients with documented preexisting anemia (Hemoglobin less than 11) or it may be used preoperatively to decrease the size of the fibroid uterus so a less invasive route of hysterectomy can be attempted. (i.e. from an abdominal hysterectomy to a vaginal hysterectomy or a laparoscopic hysterectomy) and clinical rationale for other use of GnRh agonist outside of the context of preoperative adjuvant in the surgical management of leiomyoma must be provided. For the diagnosis of central precocious puberty, the member must have a diagnosis of central precocious puberty with onset of secondary sexual characteristics earlier than 8 years in females and 9 years in males. For endometrial thinning, the member must have a diagnosis of dysfunctional uterine bleeding and the member must be undergoing endometrial ablation.

### PA\_GroupNm:

**Covered Uses for this Drug**

### Lexapro

All FDA approved indications

## Prior Authorization Criteria

<b>Coverage Excluded Reasons</b>	None
<b>Information Required</b>	Evidence of prior use of 2 generic selective serotonin reuptake inhibitors
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Duration of Approval</b>	365 Days
<b>Other Information we may Require:</b>	None

<b>PA_GroupNm:</b>	<b>Lidoderm Patch</b>
<b>Covered Uses for this Drug</b>	All FDA-approved indications
<b>Coverage Excluded Reasons</b>	No Exclusion Criteria
<b>Information Required</b>	Diagnosis
<b>Age Restrictions</b>	No Age Restrictions
<b>Prescriber Restrictions</b>	No Prescriber Restrictions
<b>Duration of Approval</b>	365 days
<b>Other Information we may Require:</b>	Diagnosis of post-herpetic neuralgia.

<b>PA_GroupNm:</b>	<b>Lyrica</b>
<b>Covered Uses for this Drug</b>	All FDA approved indications
<b>Coverage Excluded Reasons</b>	No Exclusion Criteria
<b>Information Required</b>	Diagnosis
<b>Age Restrictions</b>	No Age Restrictions
<b>Prescriber Restrictions</b>	No Prescriber Restrictions
<b>Duration of Approval</b>	365 days
<b>Other Information we may Require:</b>	For fibromyalgia: chart documentation showing the diagnosis of fibromyalgia with a history of widespread pain involving the extremities for three months and localized area of tenderness and trial and failure of two agents unless documented intolerance or contraindication to the agents: gabapentin at a dose of at least 1200 mg daily which is documented in pharmacy claims or through physician chart documentation and tricyclic antidepressants (i.e., amitriptyline) OR muscle relaxants (i.e., cyclobenzaprine) and physician chart documentation showing trial of exercise or physical therapy. For Postherpetic Neuralgia: trial and failure of one of the following agents: tricyclic antidepressants (i.e., amitriptyline) or gabapentin. For Diabetic Peripheral Neuropathy: documented pharmacy claim history of prior therapy with a diabetic medication or medical claim/lab claim for the diagnosis of diabetes or physician chart documentation of diagnosis of diabetes and trial and failure of gabapentin. For seizure disorder: diagnosis.

<b>PA_GroupNm:</b>	<b>Lysteda</b>
<b>Covered Uses for this Drug</b>	All FDA-approved indications
<b>Coverage Excluded Reasons</b>	No Exclusion Criteria.
<b>Information Required</b>	Diagnosis
<b>Age Restrictions</b>	18 years or older
<b>Prescriber Restrictions</b>	Must be prescribed by a gynecologist
<b>Duration of Approval</b>	365 Days
<b>Other Information we may Require:</b>	Must have a documented diagnosis of cyclic heavy menstrual bleeding. Member has tried and failed or has documented contraindication to NSAIDs and combined hormonal contraceptives. Must not be on concomitant therapy with a hormonal contraceptive. Must not have active thromboembolic disease or a history or intrinsic risk of thrombosis or thromboembolism, including retinal vein or artery occlusion. Must not have a hypersensitivity to tranexamic acid

## Prior Authorization Criteria

### PA\_GroupNm:

#### Covered Uses for this Drug

#### Coverage Excluded Reasons

#### Information Required

#### Age Restrictions

#### Prescriber Restrictions

#### Duration of Approval

#### Other Information we may

#### Require:

### Mozobil

All FDA-approved indications

No Exclusion Criteria.

Diagnosis

18 years or older

Must be prescribed by a bone marrow transplant specialist or oncologist

4 days

Member must have non-Hodgkin's lymphoma or multiple myeloma (MM) and require hematopoietic stem cell mobilization for collection and subsequent autologous transplantation, plerixafor must be used in combination with G-CSF and initiated after the member has received G-CSF once daily for four days, plerixafor will be administered approximately 11 hours prior to the initiation of apheresis for up to 4 consecutive days, plerixafor dose should not exceed maximum daily dose of 40 mg SC, and quantity limits will be for 8 vials (1.2ml single-use vial, 20mg/ml) which allows for a 4-day course at a maximum dose of 40mg SC. If all criteria are met, plerixafor will be authorized for a one time use of up to 4 days for mobilization of hematopoietic stem cells. All plerixafor therapy attempts must meet initial authorization.

### PA\_GroupNm:

#### Covered Uses for this Drug

#### Coverage Excluded Reasons

#### Information Required

#### Age Restrictions

#### Prescriber Restrictions

#### Duration of Approval

#### Other Information we may

#### Require:

### Myobloc

All FDA-approved indications

No Exclusion Criteria

Diagnosis.

No Age Restrictions

Dermatologist for severe primary axillary hyperhidrosis.

90 days initially then 365 days.

Myobloc is covered for the medical treatment of the following FDA approved indication: Cervical dystonia (spasmodic torticollis) It is also covered for neurogenic detrusor overactivity in adults after trial and failure of at least one previous agent, detrusor sphincter dyssynergia after spinal cord injury, drooling in Parkinson's Disease ,spasticity in adults due to stroke, trauma, multiple sclerosis, and neoplasm involving the CNS, spasticity due to cerebral palsy in children, blepharospasm, cervical dystonia, Focal upper extremity dystonia, adductor laryngeal dystonia, and essential hand tremor in patients after trial and failure of at least one previous agent. If the above criteria are met, initial authorization will be granted for 1 course of treatment in a 3-month period for each different diagnosis. Additional authorization at 1-year intervals may be granted upon review of chart documentation from the prescriber indicating that the member's condition has improved as a result of therapy.

### PA\_GroupNm:

#### Covered Uses for this Drug

#### Coverage Excluded Reasons

#### Information Required

#### Age Restrictions

#### Prescriber Restrictions

#### Duration of Approval

#### Other Information we may

#### Require:

### Myozyme

All FDA-approved indications

No Exclusion Criteria

Diagnosis

No Age Restrictions

Physician that specializes in the treatment of inherited metabolic disorders or in consultation with these specialties.

365 Days

Member must have a confirmed diagnosis of Pompe disease. Authorization will be extended at one-year intervals based upon chart documentation from the prescriber that the member's disease has improved based upon the prescriber's assessment while on therapy.

## Prior Authorization Criteria

### PA\_GroupNm:

#### Covered Uses for this Drug

#### Coverage Excluded Reasons

#### Information Required

#### Age Restrictions

#### Prescriber Restrictions

#### Duration of Approval

#### Other Information we may Require:

### Naglazyme

All FDA approved indications

No Exclusion Criteria

Diagnosis

Must be 5 years of age and older.

Specialist in treatment of inherited metabolic disorders

365 days

Members must have a confirmed diagnosis of Mucopolysaccharidosis VI (Maroteaux-Lamy syndrome)

### PA\_GroupNm:

#### Covered Uses for this Drug

#### Coverage Excluded Reasons

#### Information Required

#### Age Restrictions

#### Prescriber Restrictions

#### Duration of Approval

#### Other Information we may Require:

### Neulasta

All FDA approved indications

No Exclusion Criteria

Diagnosis

No Age Restrictions

No Prescriber Restrictions

90 days.

Neulasta will be covered for members who meet the following criteria: primary prophylaxis of febrile neutropenia in members must be receiving a chemotherapy regimen with a dosing frequency of once every 2 weeks or greater AND are receiving myelosuppressive chemotherapy which has a greater than 20% risk of febrile neutropenia (FN) (as calculated in current ASCO and NCCN guidelines for myeloid growth factors) OR are receiving non-myelosuppressive chemotherapy (less than or equal to 20% risk of FN), who are considered to be at high risk for chemotherapy-induced FN or infection due to at least one of the following: age greater than 65 years, poor performance status, previous episode of FN, extensive prior treatment including large radiation ports, administration of combined chemoradiotherapy, cytopenias due to bone marrow involvement by tumor, poor nutritional status, presence of open wounds or active infections, advanced cancer, poor renal function, liver dysfunction, most notably elevated bilirubin, or, other serious comorbidities. Neulasta will be for members for secondary prophylaxis of febrile neutropenia who are receiving a chemotherapy regimen with a dosing frequency of once every 2 weeks or greater AND experienced a neutropenic complication from a prior cycle of chemotherapy for which primary prophylaxis was not received, in which a reduced dose may compromised disease-free or overall survival or treatment outcome.

## Prior Authorization Criteria

<b>PA_GroupNm:</b>	<b>Neupogen</b>
<b>Covered Uses for this Drug</b>	All FDA approved indications
<b>Coverage Excluded Reasons</b>	No Exclusion Criteria
<b>Information Required</b>	Diagnosis
<b>Age Restrictions</b>	No Age Restrictions
<b>Prescriber Restrictions</b>	No Prescriber Restrictions
<b>Duration of Approval</b>	90 days
<b>Other Information we may Require:</b>	<p>Neupogen will be covered for the following criteria: <b>Primary prophylaxis of febrile neutropenia:</b> Members with nonmyeloid malignancies who are receiving myelosuppressive chemotherapy which has a greater than 20% risk of febrile neutropenia (FN) (as calculated in current ASCO and NCCN guidelines for myeloid growth factors) OR are receiving non-myelosuppressive chemotherapy (<math>\leq 20\%</math> risk of FN), who are considered to be at high risk for chemotherapy-induced FN or infection due to at least one of the following: Age greater than 65 years; Poor performance status; Previous episode of FN; Extensive prior treatment including large radiation ports; Administration of combined chemoradiotherapy; Cytopenias due to bone marrow involvement by tumor; Poor nutritional status; Presence of open wounds or active infections; Advanced cancer; Poor renal function; Liver dysfunction, most notably elevated bilirubin; Other serious comorbidities OR Are receiving a dose-dense chemotherapy regimen for the treatment of node-positive breast cancer, small-cell lung cancer, or diffuse aggressive non-Hodgkin's Lymphoma. <b>Secondary prophylaxis of febrile neutropenia:</b> Experienced a neutropenic complication from a prior cycle of chemotherapy for which primary prophylaxis was not received, in which a reduced dose may compromised disease-free or overall survival or treatment outcome. <b>Treatment of febrile patients with neutropenia:</b> Members with fever and neutropenia who are at high-risk for infection-related complications, or who have prognostic factors that is predictive of poor clinical outcomes. Must have <i>at least one</i> of the following high-risk features: Sepsis syndrome; Expected prolonged (<math>&gt; 10</math> days) and profound (<math>&lt; 0.1 \times 10^9/L</math>) neutropenia; Age greater than 65 years; Uncontrolled primary disease; Pneumonia; Hypotension and multi-organ dysfunction (sepsis syndrome); Invasive fungal infection; Being hospitalized at time of fever AND Have NOT received Neulasta during current chemotherapy cycle. <b>Use in bone marrow transplant:</b> Require administration after <i>autologous</i> (not allogeneic) peripheral blood progenitor cell (PBPC) transplant OR Require mobilization of progenitor cells into peripheral blood, often in conjunction with chemotherapy, for collection by leukaphoresis. <b>Use in Acute Myeloid Leukemia (AML):</b> Adults with a diagnosis of AML receiving induction or consolidation therapy. <b>Use in Acute Lymphocytic Leukemia (ALL):</b> Diagnosis of ALL after completion of the initial first few days of chemotherapy of the initial induction or first post-remission course. <b>Use in Myelodysplastic Syndromes (MDS):</b> Diagnosis of MDS, severe neutropenia and recurrent infection. <b>Use in Patients Receiving Radiation:</b> Members receiving radiation therapy, without concomitant chemotherapy, if prolonged delays secondary to neutropenia are expected. <b>Use in Older Lymphoma Patients:</b> Age 65 years and older, with a diagnosis of acute aggressive lymphoma treated with curative chemotherapy (CHOP or more aggressive regimens). <b>Use in congenital, cyclic, or idiopathic neutropenia:</b> Diagnosis of congenital, cyclic, or idiopathic neutropenia with symptomatic neutropenia. <b>Use in drug-induced agranulocytosis:</b> Members with severe neutropenia associated with fever or evidence of serious infection as a result myelosuppressive medication</p>

## Prior Authorization Criteria

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### Nexavar

All FDA-approved indications  
 No Exclusion Criteria.  
 Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.

**Age Restrictions**

No Age Restrictions

**Prescriber Restrictions**

No Prescriber Restrictions

**Duration of Approval**

365 days

**Other Information we may Require:**

Advanced renal cell carcinoma or unresectable hepatocellular cancer (hepatoma).

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### Nuvigil

All FDA approved indications

**Age Restrictions**

No Age Restrictions

**Prescriber Restrictions**

No Prescriber Restrictions

**Duration of Approval**

6 months for the diagnosis of Shift-work sleep disorder. 365 days for other approvable indications

**Other Information we may Require:**

For all indications, prior use of Provigil is required. For narcolepsy: documentation of diagnosis through sleep study and trial/failure of a CNS stimulant (i.e., methylphenidate, Dexedrine, generic Adderall) documented in pharmacy claims or through physician chart documentation. For Obstructive sleep apnea: documentation of diagnosis through sleep study and documentation/compliance report from physician that the member is using a CPAP machine on a regular basis, defined by at least 4 hours a night on at least 70% of the nights and symptoms still persist. For Shift-work sleep disorder (SWSD): must meet the International Classification of Sleep Disorders (ICSD)-10 criteria for chronic SWSD (which are consistent with the American Psychiatric Association DSM-IV criteria for Circadian Rhythm Sleep Disorder: Shift Work Type). The criteria includes either a primary complaint of excessive sleepiness or insomnia which is temporarily associated with a work period (a minimum of 5 night shifts per month) that occurs during the habitual sleep phase, OR polysomnography and the Multiple Sleep Latency Test (MSLT) demonstrate loss of a normal sleep-wake pattern and no other medical or mental disorder accounts for the symptoms and the symptoms do not meet criteria for any other sleep disorder producing insomnia or excessive sleepiness (e.g., time zone change [jet lag] syndrome).

## Prior Authorization Criteria

<b>PA_GroupNm:</b>	<b>Orencia</b>
<b>Covered Uses for this Drug</b>	All FDA approved indications
<b>Coverage Excluded Reasons</b>	No Exclusion Criteria
<b>Information Required</b>	Diagnosis
<b>Age Restrictions</b>	6 older for Juvenile Idiopathic Arthritis and 18 or older for rheumatoid arthritis.
<b>Prescriber Restrictions</b>	Rheumatologist
<b>Duration of Approval</b>	365 days
<b>Other Information we may Require:</b>	For the diagnosis of Rheumatoid Arthritis, member must have a diagnosis of moderate to severely active rheumatoid arthritis, must have an adequate trial of at least 3 months, of methotrexate with an inadequate response, members with significant side effects/toxicity or have a contraindication to methotrexate, must have an adequate trial of at least 3 months of leflunomide, hydroxychloroquine, minocycline, or sulfasalazine with an inadequate response, significant side effect/toxicity, or have a contraindication to these therapies. Member must have an adequate trial of at least 3 months, of a TNF-blocking agent with an inadequate response, significant side effects/toxicity, or a have a contraindication to these therapies. For the diagnosis of Juvenile Idiopathic Arthritis, must have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis, must have an adequate trial of at least 3 months, of methotrexate with an inadequate response, members with significant side effects/toxicity or have a contraindication to methotrexate, must have an adequate trial of at least 3 months of leflunomide or sulfasalazine with an inadequate response, significant side effect/toxicity, or have a contraindication to these therapies. Member must have an adequate trial of at least 3 months, of a TNF-blocking agent with an inadequate response, significant side effects/toxicity, or a have a contraindication to these therapies. Member must currently not be using a TNF-blocking agent or other biologic agents in combination with Orencia and have no evidence of infection. All prior authorization renewals will be reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. Authorization may be extended at one-year intervals based upon documentation from the prescriber that the member's disease has improved based upon the prescriber's assessment while on therapy and no evidence of infection.

<b>PA_GroupNm:</b>	<b>Peg Interferons</b>
<b>Covered Uses for this Drug</b>	All FDA approved indications
<b>Coverage Excluded Reasons</b>	Extended or Maintenance therapy for Hepatitis C. Autoimmune hepatitis or other conditions known to be exacerbated by interferon. Known hypersensitivity to drugs used to treat hepatitis C. Patients with decompensated liver disease
<b>Information Required</b>	Diagnosis, Hepatitis C genotype and baseline quantitative hepatitis C virus titer. For retreatment, liver biopsy needed.
<b>Age Restrictions</b>	18 years of age and older for peg alpha-2a and at least 3 years of age for peg alpha-2b.
<b>Prescriber Restrictions</b>	Must be prescribed by an infectious disease physician, gastroenterologist, hepatologist, or a transplant physician or in consultation with these physicians.
<b>Duration of Approval</b>	48 wks for genotype 1 and 4, genotype 2 and 3 is 24 weeks
<b>Other Information we may Require:</b>	<b>For Initial Treatment of Chronic Hepatitis C Genotype 1 and 4:</b> Treatment with peginterferon alfa is authorized for up to 16 weeks (the initial authorization is for 12 weeks with an additional 4 weeks granted for the prescriber to obtain the quantitative HCV RNA). After 12 weeks of therapy, a quantitative HCV RNA is required to continue therapy. If the member has attained an early virological response as defined above, continued treatment for a maximum of 48 weeks total is authorized. If the member has not attained an early virological response as defined above, further treatment with peginterferon is considered not medically necessary and should not be authorized. Consideration for continuation will be individualized based on severity of disease, demonstration of some virologic response, and tolerability of treatment. <b>Extended Treatment for Genotype 1 Patients</b> – Patients who achieve an early virological response (defined above) to initial therapy, but also have a delayed virological response (defined above) may be authorized for up to 72 weeks therapy. Additional chart documentation will be required showing clearance of the HCV RNA at 24 weeks of therapy. <b>For Initial Treatment of Chronic Hepatitis C Genotypes 2 and 3:</b> For members with chronic hepatitis C genotypes 2

## Prior Authorization Criteria

and 3 who have not been previously treated with interferon, treatment with peginterferon alfa is authorized for 24 weeks. **For Treatment of Chronic Hepatitis C in HIV-Infected Members:** For all genotypes, treatment with peginterferon will be authorized for up to 48 weeks. **For Treatment of Chronic Hepatitis C in Members with Renal Disease:** Members with slight to mild kidney disease can be treated with the same regimen routinely administered to patients without kidney disease. Members with moderate to severe kidney disease can be treated with reduced doses of both peginterferon alfa-2a (at a dose of 135mcg/week) or peginterferon alfa-2b (at a dose of 1mcg/kg/week). For peginterferon alfa-2b, a 25% reduction is recommended for creatinine clearance of 30-50ml/min and a 50% reduction for creatinine clearance of 10-29ml/min. Members on dialysis may be treated with either standard interferon (3MU 3 times per week) or reduced dose pegylated interferons (135mcg/week for peginterferon alfa-2a or 1mcg/kg/week for peginterferon alfa-2b). For peginterferon alfa-2b, a 50% reduction is recommended. **For Liver Transplant Members with Recurrent Hepatitis C:** For members with recurrent hepatitis C after liver transplantation, authorization will be evaluated on a case-by-case basis using the initial treatment criteria (including genotype and viral load) for up to 48 weeks. **For Treatment of Chronic Hepatitis C in Children:** For all genotypes, treatment with peginterferon alpha-2b will be authorized for up to 48 weeks. **Retreatment:** Retreatment with peginterferon plus ribavirin in patients who did not achieve a sustained viral response after a prior full course treatment of peginterferon plus ribavirin is not recommended. Retreatment with peginterferon plus ribavirin can be authorized for patients who failed standard interferon therapy (with or without ribavirin), peginterferon monotherapy, or patients who did not complete a full course of peginterferon/ribavirin. Consensus interferon, up to once daily dosing, will be approved for nonresponders to pegylated interferon/ribavirin therapy based on certain prognostic factors, among which must include the following: adequate previous response defined as a greater than 2 log<sub>10</sub> decrease in HCV RNA during initial course of pegylated interferon/ribavirin therapy; current fibrosis score defined as a Metavir fibrosis score of between grades 2 and 4. In addition to the above criteria, all retreatments will be based on the progression of the disease. Moderate to severe fibrosis scores will be considered, defined as a Metavir fibrosis score  $\geq 2$ . A liver biopsy will be required to determine the extent of disease progression for the patient. **Extended or Maintenance Therapy:** Upon medical review, extended treatment with peginterferon alfa beyond the treatment course of 24-48 weeks may be considered medically necessary for persons with cryoglobulinemia. Based on results of the HALT-C trial, maintenance therapy of low dose peginterferon alfa-2a is not indicated in patients who have bridging fibrosis or cirrhosis and who have not responded to a standard course of peginterferon/ribavirin and will not be authorized. The risks and benefits of prescribing maintenance therapy with peginterferons are under investigation, and currently being evaluated in ongoing clinical trials. **For Indications Other Than Hepatitis C:** Authorization for treatment will be given for the following conditions: chronic hepatitis B - adult (as monotherapy for 48 weeks), hairy cell leukemia, malignant melanoma, follicular lymphoma, condylomata acuminata, AIDS-Related Kaposi's Sarcoma

## Prior Authorization Criteria

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Duration of Approval**  
**Other Information we may Require:**

### Promacta

All FDA approved indications  
 No Exclusion Criteria  
 Platelet counts and diagnosis  
 18 years of age or older  
 Hematologist or oncologist  
 3 months initially and then every 6 months thereafter  
 For initial approval, diagnosis of ITP and platelet count less than  $30 \times 10^9/L$ .  
 Discontinue if the platelet count does not increase to a level sufficient to avoid clinically important bleeding after 4 weeks of therapy at the maximum daily dose of 75 mg. Discontinue if ALT levels increase to greater than or equal to 3 times upper limit of normal and progressive, or persistent for greater than or equal to 4 weeks or accompanied by increased direct bilirubin or accompanied by clinical symptoms of liver injury or evidence for hepatic decompensation. Utilization of the lowest dose of eltrombopag to achieve and maintain platelet count =  $50 \times 10^9/L$ . Dosing adjustments to follow the prescribing information. Authorization may be extended at 6 month intervals based upon chart documentation from the provider that the member's disease has improved based upon the prescriber's assessment and documented improvement in platelet count from baseline.

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Duration of Approval**  
**Other Information we may Require:**

### Provigil

All FDA approved indications including diagnosis of chronic fatigue due to Multiple Sclerosis AND the member has had a previous trial of amantadine  
 No Exclusion Criteria  
 Diagnosis  
 No Age Restrictions  
 No Prescriber Restrictions  
 6 months for the diagnosis of Shift-work sleep disorder. 365 days for other approvable indications.  
 For narcolepsy: documentation of diagnosis through sleep study and trial/failure of a CNS stimulant (i.e., methylphenidate, Dexedrine, generic Adderall) documented in pharmacy claims or through physician chart documentation. For Obstructive sleep apnea: documentation of diagnosis through sleep study and documentation/compliance report from physician that the member is using a CPAP machine on a regular basis, defined by at least 4 hours a night on at least 70% of the nights and symptoms still persist. For Shift-work sleep disorder (SWSD): must meet the International Classification of Sleep Disorders (ICSD)-10 criteria for chronic SWSD (which are consistent with the American Psychiatric Association DSM-IV criteria for Circadian Rhythm Sleep Disorder: Shift Work Type). The criteria includes either a primary complaint of excessive sleepiness or insomnia which is temporarily associated with a work period (a minimum of 5 night shifts per month) that occurs during the habitual sleep phase, OR polysomnography and the Multiple Sleep Latency Test (MSLT) demonstrate loss of a normal sleep-wake pattern and no other medical or mental disorder accounts for the symptoms and the symptoms do not meet criteria for any other sleep disorder producing insomnia or excessive sleepiness (e.g., time zone change [jet lag] syndrome). For chronic fatigue due to Multiple Sclerosis: the member has had a previous trial of an amantadine.

## Prior Authorization Criteria

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Duration of Approval**  
**Other Information we may Require:**

### Relistor

All FDA approved indications  
 No Exclusion Criteria  
 Diagnosis and previous agents tried and failed for constipation.  
 No Age Restrictions  
 No Prescriber Restrictions  
 4 months initially  
 Member must have a diagnosis of opioid-induced constipation AND member must have advanced, life-limiting illness AND trial and failure of a course of traditional laxatives for treatment of the constipation.

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
  
**Age Restrictions**  
**Prescriber Restrictions**  
  
**Duration of Approval**  
**Other Information we may Require:**

### Remicade

All FDA approved indications  
 No Exclusion Criteria  
 Diagnosis for initial auth, a negative Tuberculin PPD (purified protein derivative) test or QuantiFERON blood test, and no evidence of infection. For continued auth, chart doc submitted from the provider showing that the member's diagnosis has improved based upon the prescriber's assessment while on therapy and no evidence of infection.  
 6 or older for Crohn's disease and 18 or older for other conditions.  
 Confirming diagnosis by a rheumatologist or a dermatologist or gastroenterologist based upon diagnosis  
 365 days

**For a diagnosis of Rheumatoid Arthritis:** Member must have a diagnosis of moderately to severely active rheumatoid arthritis, an adequate trial of at least 3 months, of methotrexate with an inadequate response. Members with significant side effects/toxicity or have a contraindication to methotrexate, must have an adequate trial of at least 3 months of leflunomide, hydroxychloroquine, minocycline, or sulfasalazine with an inadequate response, significant side effect/toxicity, or have a contraindication to these therapies. Member must currently not be using a TNF-blocking agent or other biologic agents in combination with Remicade. **For a diagnosis of Psoriatic Arthritis:** Member must have a diagnosis of moderate to severely active psoriatic arthritis. For members with dominant peripheral disease: Must have an adequate trial of at least 3 months with at least 2 NSAIDs at anti-inflammatory target dose, with an inadequate response, significant side effects/toxicity, or have a contraindication to these therapies AND have an adequate trial of at least 3 months, of a conventional systemic therapy (methotrexate, cyclosporine, sulfasalazine, or leflunomide) with an inadequate response, significant side effects/toxicity, or have a contraindication to these therapies. For members with dominant axial disease: Must have an adequate trial of at least 3 months with at least 2 NSAIDs at anti-inflammatory target dose, with an inadequate response, significant side effects/ toxicity, or have a contraindication to these therapies. Member must currently not be using a TNF-blocking agent or other biologic agents in combination with Remicade. **For a diagnosis of Ankylosing Spondylitis:** Member must have a diagnosis of active ankylosing spondylitis. For members with dominant axial disease: Member must have an adequate trial of at least 3 months with at least 2 NSAIDs at anti-inflammatory target dose, with an inadequate response, significant side effects/toxicity, or have a contraindication to these therapies. For members with dominant peripheral disease: Must have an adequate trial of at least 3 months with at least 2 NSAIDs at anti-inflammatory target dose, with an inadequate response, significant side effects/toxicity, or have a contraindication to these therapies AND Member must have an adequate trial of a conventional systemic therapy (sulfasalazine or methotrexate) with an inadequate response, significant side effects /toxicity, or have a contraindication to this therapy. Member must currently not be using a TNF-blocking agent or other biologic agents in combination with Remicade. **For a diagnosis of Plaque Psoriasis:** The following criteria must be met: Member must have a diagnosis of chronic severe plaque psoriasis, have a minimum body surface area involvement of  $\geq 10\%$  (members with plaque psoriasis of palms, soles, head and neck, or genitalia are not required to have a minimum body surface area involvement), have

## Prior Authorization Criteria

an adequate trial of topical treatments, phototherapy, or photochemotherapy with an inadequate response, significant side effects /toxicity, or have a contraindication to these therapies. Member must have an adequate trial of at least 3 months of a conventional systemic therapy (methotrexate, cyclosporine, or acitretin) with an inadequate response, significant side effects /toxicity, or have a contraindication to these therapies. Member must currently not be using a TNF-blocking agent or other biologic agents in combination with Remicade, no evidence of infection **For a diagnosis of Crohn's disease:** The following criteria must be met: Member must have a diagnosis of moderate to severely active Crohn's disease or fistulizing Crohn's disease, have an adequate trial of conventional therapy including corticosteroids or at least 3 months of immunosuppressants (e.g., azathioprine, 6-mercaptopurine) with an inadequate response, significant side effects/toxicity, or have a contraindication to these therapies. Member must currently not be using a TNF-blocking agent or other biologic agents in combination with Remicade. **For a diagnosis of Ulcerative Colitis:** The following criteria must be met: Member must have an adequate trial of conventional therapy including corticosteroids, at least 3 months of 5-ASA agents (e.g., Sulfasalazine, Mesalamine), or at least 3 months of immunosuppressants (azathioprine, 6-mercaptopurine) with inadequate response, significant side effects/toxicity, or have a contraindication to these therapies. Member must currently not be using a TNF-blocking agent or other biologic agent in combination with Remicade. Remicade will be approved based upon the above criteria for an initial period of 1 year. **Reauthorization Criteria:** All prior authorization renewals will be reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. Authorization may be extended at one-year intervals based upon documentation from the provider that the member's disease has improved based upon the prescriber's assessment while on therapy and no evidence of infection.

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### Remodulin

All FDA-approved indications  
 No Exclusion Criteria  
 Diagnosis and confirmed diagnosis by right heart catheterization. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy  
 No Age Restrictions  
 Cardiologist or pulmonologist.  
 90 days initially.  
 Member has a confirmed diagnosis of PAH with WHO functional class II-IV symptoms.  
 Additional yearly authorizations may be granted upon review of chart documentation from the prescriber indicating that the member's condition has improved as a result of therapy.

### Age Restrictions

### Prescriber Restrictions

### Duration of Approval

### Other Information we may Require:

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### Revatio

All FDA-approved indications  
 No Exclusion Criteria.  
 Diagnosis and confirmed diagnosis by right heart catheterization. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy  
 No Age Restrictions  
 Cardiologist or pulmonologist  
 90 days initially.  
 Member has a confirmed diagnosis of PAH with WHO functional class II-IV symptoms AND member is NOT currently taking a nitrate product. Additional yearly authorizations may be granted upon review of chart documentation from the prescriber indicating that the member's condition has improved as a result of therapy.

### Age Restrictions

### Prescriber Restrictions

### Duration of Approval

### Other Information we may Require:

## Prior Authorization Criteria

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### Revlimid

All FDA-approved indications  
 No Exclusion Criteria.  
 Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.  
 No Age Restrictions  
 No Prescriber Restrictions  
 180 days  
 Myelodysplastic syndrome transfusion-dependent anemia due to low or intermediate-1 risk myelodysplastic syndromes associated with a deletion 5q cytogenetic abnormality with or without other cytogenetic abnormality or combination therapy with dexamethasone for multiple myeloma patients who have received at least one prior therapy or combination therapy with dexamethasone for multiple myeloma patients as first-line therapy.

### Age Restrictions

### Prescriber Restrictions

### Duration of Approval

### Other Information we may Require:

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### Risperdal Consta

All FDA-approved indications  
 No Exclusion Criteria  
 Diagnosis  
 No Age Restrictions  
 No Prescriber Restrictions  
 6 months initially  
 The member must have a diagnosis of schizophrenia or bipolar disorder, the member must have tried and failed or have a history of non-compliance with two oral antipsychotics, and evidence of tolerability to oral risperidone. Risperdal Consta will be approved based on the above criteria for an initial period of 6 months. Authorization may be extended at one-year intervals based upon documentation from the provider that the member's disease has improved based upon the prescriber's assessment while on therapy

### Age Restrictions

### Prescriber Restrictions

### Duration of Approval

### Other Information we may Require:

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### Rituxan

All FDA approved indications  
 PML or history of PML  
 Diagnosis. Re-treatment will be authorized upon review of chart documentation from the prescriber indicating that the member's condition has improved as a result of therapy.  
 Member must be 18 years of age or older.  
 Rheumatologist or transplant specialist based on diagnosis.  
 1 course within 16 week period.  
**For the diagnosis of rheumatoid arthritis:** Member must have a diagnosis of moderately to severely active rheumatoid arthritis, must have an adequate trial of at least 3 months of methotrexate with an inadequate response, must have an adequate trial of at least 3 months, of a TNF-blocking agent with an inadequate response, significant side effects/toxicity, or a have a contraindication to these therapies, must be on concurrent methotrexate therapy. Member must currently not be using a TNF-blocking agent or other biologic agents in combination with Rituxan, must currently not have progressive multifocal leukoencephalopathy (PML) or have a history of PML. **Reauthorization Criteria for rheumatoid arthritis:** Authorization may be extended based upon review of documentation from the prescriber indicating that the member's condition has improved as a result of therapy. Authorization will not be granted until 16 weeks has passed since the initial treatment. **For Renal and/or Pancreatic Transplant Desensitization in Combination with IVIG:** Member must currently not have PML or have a history of PML. Member must be awaiting kidney and/or pancreas transplant requiring desensitization as defined by the following criteria: For deceased donor transplants: Panel reactive antibody (PRA) level >30% OR PRA <30% with a previous kidney and/or pancreas transplant. For living donor transplants: Positive crossmatch OR Positive donor-specific antibody using Luminex<sup>®</sup> assay. **Reauthorization Criteria for desensitization in renal or**

### Age Restrictions

### Prescriber Restrictions

### Duration of Approval

### Other Information we may Require:

## Prior Authorization Criteria

**pancreatic transplant candidates:** Additional authorization for another course of treatment (with the above regimen) will be considered in 6 months if the member has not yet received a renal and/or pancreatic transplant. Authorization will not be granted until 6 months have passed since the initial treatment.

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Duration of Approval**  
**Other Information we may Require:**

### Samsca

All FDA-approved indications  
 No Exclusion Criteria.  
 Diagnosis  
 No Age Restrictions  
 Endocrinologist or Nephrologist  
 Every 3 months  
 Member must have a diagnosis of hypervolemic or euvolemic hyponatremia and either serum sodium less than 125 mEq/L or symptomatic hyponatremia with failure to fluid restriction, Samsca must be initiated and titrated in a hospital setting with close serum sodium monitoring, the member must not be anuric and the member must be able to sense and respond appropriately to thirst. For continuation, chart documentation from the prescriber is required showing the rationale for continuation of therapy and indicating that the member's condition has improved as a result of therapy.

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
**Age Restrictions**  
**Prescriber Restrictions**  
  
**Duration of Approval**  
**Other Information we may Require:**

### Sandostatin LAR

All FDA-approved indications  
 No Exclusion Criteria  
 Diagnosis  
 18 or older for acromegaly  
 By or in consultation with an endocrinologist, hematologist, oncologist, or palliative care specialist depending upon diagnosis.  
 90 days for acromegaly and 60 days for other diagnoses.  
 For a diagnosis of acromegaly: Sandostatin LAR must be prescribed by or in consultation with an endocrinologist, member must have a confirmed diagnosis of acromegaly to include the following baseline (pre-treatment) labs: elevated serum IGF-1 level for patient's gender and age range. Laboratory reference range must be provided AND elevated growth hormone (GH) level defined as a GH level greater than or equal to 1ng/mL during oral glucose tolerance test (OGTT), and member must have an inadequate response to surgery or radiation therapy, or documentation that these therapies are not appropriate. For a diagnosis of severe diarrhea and flushing episodes associated with metastatic carcinoid tumors member must be prescribed by or in consultation with a hematologist, oncologist, endocrinologist, or palliative care specialist and member must have a diagnosis a metastatic carcinoid tumor with associated severe diarrhea and flushing episodes. For a diagnosis of profuse watery diarrhea associated with vasoactive intestinal peptide secreting tumors member must be prescribed by or in consultation with a hematologist, oncologist, endocrinologist, or palliative care specialist and member must have a diagnosis of vasoactive intestinal peptide secreting tumors with associated profuse watery diarrhea. All prior authorizations renewals will be reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. Authorizations may be extended at one-year intervals based upon documentation from the provider that the member's disease has improved based upon the prescriber's assessment while on therapy.

## Prior Authorization Criteria

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Duration of Approval**  
**Other Information we may Require:**

### Savella

All FDA approved indications  
 No Exclusion Criteria  
 Diagnosis  
 No Age Restrictions  
 No Prescriber Restrictions  
 365 days  
 For fibromyalgia: chart documentation showing the diagnosis of fibromyalgia with a history of widespread pain involving the extremities for three months and localized area of tenderness and trial and failure of two agents unless documented intolerance or contraindication to the agents: gabapentin at a dose of at least 1200 mg daily which is documented in pharmacy claims or through physician chart documentation and tricyclic antidepressants (i.e., amitriptyline) OR muscle relaxants (i.e., cyclobenzaprine) and physician chart documentation showing trial of exercise or physical therapy.

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Duration of Approval**  
**Other Information we may Require:**

### Seroquel/Seroquel XR

All FDA approved indications  
 No Exclusion Criteria  
 Diagnosis  
 No Age Restrictions  
 No Prescriber Restrictions  
 365 days  
 Member with a diagnosis of schizophrenia, member with a diagnosis of bipolar I disorder, or members with members with a diagnosis of Major Depressive Disorder who have failed both mono and combination antidepressant therapy which includes the following: an adequate trial and failure or an inadequate response, duration of at least 4 weeks, or intolerance to monotherapy with 2 different antidepressant therapies AND either of the following: trial and failure or an inadequate response, duration of at least 4 weeks, or intolerance to a single trial of combination antidepressant therapy OR trial and failure or an inadequate response, duration of at least 4 weeks, or intolerance to a single trial of an antidepressant with augmentation therapy.

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Duration of Approval**  
**Other Information we may Require:**

### Serostim

All FDA approved indications  
 No Exclusion Criteria  
 Diagnosis  
 No Age Restrictions  
 No Prescriber Restrictions  
 Up to 48 weeks per year.  
 UPMC Health Plan covers Somatropin (Serostim) for the diagnosis of HIV-associated wasting/cachexia for those members who meet all of the following criteria: Member must have clear documentation of HIV infection with serum antibodies to HIV. Member must have failed treatment with at least one other medication used for HIV-wasting (i.e., Marinol<sup>®</sup> (dronabinol), Megace<sup>®</sup> (megestrol)) as documented by the treating provider unless contraindications exist. Member must be compliant with his/her antiretroviral medications. Member must have a documented involuntary weight loss of at least 10% from baseline pre-morbid weight or to a BMI < 20, in the absence of a concurrent illness or medical condition other than HIV infection that would explain these findings. Member should be receiving adequate caloric intake and nutritional counseling. Member must not have active malignancy other than Kaposi's Sarcoma. If the above criteria are met, authorization will be granted for 12 weeks initially. If needed, cases will be reviewed with a health care specialist from the PACT Clinic (local AIDS clinic) to assist in making a decision to provide therapy

## Prior Authorization Criteria

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Duration of Approval**  
**Other Information we may Require:**

### Somatuline Depot

All FDA-approved indications  
 No Exclusion Criteria  
 Diagnosis  
 18 or older  
 By or in consultation with an endocrinologist.  
 90 days  
 Member must have a confirmed diagnosis of acromegaly to include the following baseline (pre-treatment) labs: elevated serum IGF-1 level for patient's gender and age range. Laboratory reference range must be provided AND elevated growth hormone (GH) level defined as a GH level greater than or equal to 1ng/mL during oral glucose tolerance test (OGTT). Member must have an inadequate response to surgery or radiation therapy or documentation that these therapies are not appropriate. All prior authorizations renewals will be reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. Authorizations may be extended at one-year intervals based upon documentation from the provider that the member's disease has improved based upon the prescriber's assessment while on therapy.

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Duration of Approval**  
**Other Information we may Require:**

### Somavert

All FDA-approved indications  
 No Exclusion Criteria  
 Diagnosis  
 18 or older  
 By or in consultation with an endocrinologist  
 90 days  
 Member must have a confirmed diagnosis of acromegaly to include the following baseline (pre-treatment) labs: elevated serum IGF-1 level for patient's gender and age range. Laboratory reference range must be provided AND elevated growth hormone (GH) level defined by a GH level greater than or equal to 1ng/mL during oral glucose tolerance test (OGTT). Member must have an inadequate response to surgery or radiation therapy, or documentation that these therapies are not appropriate and member must have an inadequate response to medical therapy (octreotide, Sandostatin LAR, Somatuline Depot) or documentation that these therapies are not appropriate. All prior authorizations renewals will be reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. Authorizations may be extended at one-year intervals based upon documentation from the provider that the member's disease has improved based upon the prescriber's assessment while on therapy

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Duration of Approval**  
**Other Information we may Require:**

### Sporanox

All FDA approved indications  
 No Exclusion Criteria  
 Diagnosis  
 No Age Restrictions  
 No Prescriber Restrictions  
 90 days/year for onychomycosis. For other diagnoses, dependent upon recommended duration of therapy  
 Sporanox will be approved for onychomycosis in a diabetic, transplant, or immunocompromised member, or, onychomycosis causing severe debilitating foot pain (supported by chart documentation), or fungal infections on trunk of body such as tinea that are too large to treat with topical cream, or, diagnosis of oral thrush that has not responded to oral nystatin, or diagnosis of esophageal candidiasis.

## Prior Authorization Criteria

<b>PA_GroupNm:</b>	<b>Sprycel</b>
<b>Covered Uses for this Drug</b>	All FDA-approved indications
<b>Coverage Excluded Reasons</b>	No Exclusion Criteria.
<b>Information Required</b>	Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.
<b>Age Restrictions</b>	No Age Restrictions
<b>Prescriber Restrictions</b>	No Prescriber Restrictions
<b>Duration of Approval</b>	180 days
<b>Other Information we may Require:</b>	Adults with chronic, accelerated, or myeloid or lymphoid blast phase Chronic Myeloid Leukemia (CML) resistant or intolerant to prior therapy including imatinib (Gleevec) or Ph+ chromosome-positive ALL resistant or intolerant to prior therapy.
<b>PA_GroupNm:</b>	<b>Stelara</b>
<b>Covered Uses for this Drug</b>	All FDA approved indications
<b>Coverage Excluded Reasons</b>	No exclusion criteria
<b>Information Required</b>	Diagnosis
<b>Age Restrictions</b>	Member must be 18 years of age or older
<b>Prescriber Restrictions</b>	Dermatologist
<b>Duration of Approval</b>	365 days
<b>Other Information we may Require:</b>	Member must have a negative Tuberculin PPD (purified protein derivative) test, and have a diagnosis of moderate to severe plaque psoriasis that involves a minimum body surface area involvement of greater than or equal to 10% (members with plaque psoriasis of palms, soles, head and neck or genitalia are not required to have a minimum body surface area involvement). Member must have an adequate trial of topical treatment, phototherapy, or photochemotherapy with inadequate response, significant side effects or toxicity, or have a contraindication to these therapies. Member must have an adequate trial of at least 3 months of a conventional systemic therapy (mtx,cyclosporine, or acitretin) w an inadequate response, significant side effects or toxicity, or have a contraindication to these therapies, and no evidence of infection, and not currently be using a TNF-blocking agent, other biologic agent, immunosuppressant, or phototherapy in combination with Stelara. Requests for increased dosing frequency will be approved if a partial response was observed after a 24 week trial at the recommended every 12 week dosing frequency. All prior authorization renewals will be reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. Authorization may be extended at one-year intervals based upon documentation from the provider that the member's disease has improved based upon the prescriber's assessment while on therapy and no evidence of infection.

## Prior Authorization Criteria

<b>PA_GroupNm:</b>	<b>Suboxone and Subutex</b>
<b>Covered Uses for this Drug</b>	All FDA-approved indications
<b>Coverage Excluded Reasons</b>	No Exclusion Criteria.
<b>Information Required</b>	Diagnosis.
<b>Age Restrictions</b>	No Age Restrictions
<b>Prescriber Restrictions</b>	No Prescriber Restrictions
<b>Duration of Approval</b>	1 month initially then every 3 months.
<b>Other Information we may Require:</b>	<p>Buprenorphine/naloxone and buprenorphine will be covered for an initial period of 1 month for the treatment of opioid dependence. <b>For continuation:</b> Member must have a diagnosis of opioid dependence, must be compliant with therapy for the previous month as evidenced in the member's pharmacy claim history showing that the member has received some level of continuous therapy AND as documented by a buprenorphine-positive urine drug screen. A call will be placed to the prescriber to determine the current dose regimen if necessary. (All non-compliance issues will be forwarded to a UPMC Health Plan Medical Director for review). Member must have a recent negative quarterly urine drug screen which includes testing for opiates (including oxycodone) and other illicit drugs (such as cocaine, heroin, marijuana). Documentation of the recent drug test must be provided. Member should be referred or enrolled and consistently participating in formal behavioral health counseling and/or substance abuse counseling. Initial treatment must be performed with a licensed Drug and Alcohol (D &amp; A) or a behavioral health provider. Member must not have attempted to fill any opioid prescriptions during this initial period as indicated by their drug claim history. Benzodiazepines will be covered for the initial approval period to allow time to taper benzodiazepine therapy. For all requests, the combination buprenorphine/naloxone product (Suboxone) will be authorized. In addition to the above criteria, an exception for the buprenorphine-only product (Subutex) will be made for the following two reasons: 1.) If the member is pregnant; 2.) If the member provides documentation of an intolerance to Naloxone. Continuation authorizations will be for a period of 3 months. Buprenorphine/naloxone and buprenorphine have quantity limits of 120 tablets per 30 days for the 2mg dose and 90 tablets per 30 days for the 8mg dose to allow for efficient dosing up to the maximum recommended dose. <b>Reauthorization Criteria:</b> All prior authorization renewals will be reviewed on a 3 month basis to determine the Medical Necessity for continuation of therapy. Authorization may be extended at 3 month intervals based upon chart documentation from the provider that the member's disease has improved based upon the prescriber's assessment while on therapy. In addition, for continuation: Member must be compliant with therapy for the previous 3 months as evidenced in the member's pharmacy claim history showing that the member has received some level of continuous therapy AND as documented by a buprenorphine-positive urine drug screen. A call will be placed to the prescriber to determine the current dose regimen if necessary. (All non-compliance issues will be forwarded to a UPMC Health Plan Medical Director for review). Member must have a recent negative quarterly urine drug screen which includes testing for opiates (including oxycodone) and other illicit drugs. Documentation of the recent drug test must be provided. Member should be participating in at least monthly formal behavioral health counseling, substance abuse counseling or an addiction recovery program. Documentation must be provided. After a period of 1 year, less formal programs would be allowed as participation. Member must not have attempted to fill any opioid prescriptions or benzodiazepines during this authorization period as indicated by their drug claim history</p>

## Prior Authorization Criteria

### PA\_GroupNm:

#### Covered Uses for this Drug

#### Coverage Excluded Reasons

#### Information Required

#### Age Restrictions

#### Prescriber Restrictions

#### Duration of Approval

#### Other Information we may

#### Require:

### Sucraid

All FDA approved indications

No Exclusion Criteria

Diagnosis

5 months or older.

Gastroenterologist, Endocrinologist, or Genetic Specialists

1 month initially then annually.

Must have a diagnosis of congenital sucrase-isomaltase deficiency characterized by stool pH less than 6, an increase in breath hydrogen of greater than 10ppm when challenged w sucrose after fasting, and negative lactose breath test OR diagnosis of congenital sucrase-isomaltase deficiency characterized by low sucrase activity on duodenal biopsy AND other disaccharidases normal on same duodenal biopsy.

### PA\_GroupNm:

#### Covered Uses for this Drug

#### Coverage Excluded Reasons

#### Information Required

#### Age Restrictions

#### Prescriber Restrictions

#### Duration of Approval

#### Other Information we may

#### Require:

### Sutent

All FDA-approved indications

No Exclusion Criteria

Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.

No Age Restrictions

No Prescriber Restrictions

180 days.

Gastrointestinal (GI) stromal tumors refractory to imatinib (Gleevec) or in patients intolerant to imatinib (Gleevec) or advanced renal cell carcinoma.

### PA\_GroupNm:

#### Covered Uses for this Drug

#### Coverage Excluded Reasons

#### Information Required

#### Age Restrictions

#### Prescriber Restrictions

#### Duration of Approval

#### Other Information we may

#### Require:

### Synagis

All FDA approved indications

No Exclusion Criteria

Diagnosis.

Under 24 months at the start of RSV season.

No Prescriber Restrictions

Maximum of 5 doses per RSV season, with the following exception: Infants 32 weeks, 0 days – 34 weeks, 6 days gestational age and 3 months of age or less will be approved for a maximum of 3 doses or until they have reached 3 months (90 days) of age, whichever comes first.

Covered for: children under the age of 24 months at the beginning of Respiratory Syncytial Virus (RSV) season with Chronic Lung Disease (CLD) who have required medical treatment such as oxygen, bronchodilator, diuretic or corticosteroid therapy, for CLD within 6 months before the start of RSV season. Children under the age of 24 months at the beginning of RSV season with hemodynamically significant congenital heart disease including congestive heart failure (CHF), severe pulmonary hypertension, or cyanotic heart disease. Premature infants' recommendations are based upon gestational age: Less than 28 weeks, 6 days gestational age and 12 months of age or less at the start of RSV season; 29 weeks, 0 days – 31 weeks, 6 days gestational age and 6 months of age or less at the start of RSV season; 32 weeks, 0 days – 34 weeks, 6 days gestational age and 3 months of age or less at the start of RSV season with ONE of the following two risk factors: Day care attendance; Sibling younger than 5 years of age.

## Prior Authorization Criteria

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### Tarceva

All FDA-approved indications  
 No Exclusion Criteria.  
 Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.  
 No Age Restrictions  
 No Prescriber Restrictions  
 180 days.  
 Locally advanced or metastatic non-small cell lung cancer after failure of at least one prior chemotherapy regimen or first-line treatment in combination with gemcitabine (Gemzar) in patients with locally advanced, unresectable or metastatic pancreatic cancer or locally advanced or metastatic non-small cell lung cancer after failure of at least one prior chemotherapy regimen or maintenance treatment of patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) whose disease has not progressed after four cycles of platinum-based first-line chemotherapy.

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### Targretin

All FDA-approved indications  
 No Exclusion Criteria.  
 Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy  
 No Age Restrictions  
 No Prescriber Restrictions  
 180 days  
 Cutaneous manifestations of T-cell lymphoma in patients who are refractory to at least one prior systemic therapy.

### Age Restrictions

### Prescriber Restrictions

### Duration of Approval

**Other Information we may  
 Require:**

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### Tasigna

All FDA-approved indications  
 No Exclusion Criteria.  
 Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.  
 No Age Restrictions  
 No Prescriber Restrictions  
 180 days  
 Diagnosis of Adult Ph+ CML in chronic phase or accelerated phase resistant to or intolerant to prior therapy including imatinib (Gleevec) or adult patients with newly diagnosed Ph+ chronic phase CML.

### Age Restrictions

### Prescriber Restrictions

### Duration of Approval

**Other Information we may  
 Require:**

## Prior Authorization Criteria

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Duration of Approval**  
**Other Information we may Require:**

### Thalomid

All FDA-approved indications  
 No Exclusion Criteria  
 Diagnosis  
 No Age Restrictions  
 No Prescriber Restrictions  
 6 months  
 Thalomid will be approved for the following FDA-approved indications: patients with newly diagnosed multiple myeloma in combination with dexamethasone, acute treatment of cutaneous manifestations of moderate to severe erythema nodosum leprosum (ENL), maintenance therapy for prevention and suppression of the cutaneous manifestations of ENL recurrence. Thalomid will be approved for the following off-label indications: elderly and non-transplant eligible patients with newly diagnosed multiple myeloma in combination with melphalan and prednisone, transplant eligible patients with newly diagnosed multiple myeloma in combination with bortezomib (Velcade) and dexamethasone. All prior authorization renewals will be reviewed to determine the Medical Necessity for continuation of therapy. Authorization may be extended based upon chart documentation from the provider that the member's disease has improved based upon the prescriber's assessment while on therapy.

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
  
**Age Restrictions**  
**Prescriber Restrictions**  
**Duration of Approval**  
**Other Information we may Require:**

### Tracleer

All FDA-approved indications  
 No Exclusion Criteria.  
 Diagnosis and confirmed diagnosis by right heart catheterization. For continue authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.  
 No Age Restrictions  
 Cardiologist or pulmonologist.  
 90 days initially  
 Member has a confirmed diagnosis of PAH with WHO functional class II, III or IV symptoms AND member is NOT currently taking glyburide or cyclosporine AND member has had baseline liver function tests (ALT, AST) prior to initiation of therapy AND if a member is a woman of childbearing potential, she has had a baseline negative pregnancy test prior to initiation of therapy.

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Duration of Approval**  
**Other Information we may Require:**

### Triptan

All FDA-approved indications  
 No Exclusion Criteria.  
 Documented pharmacy claims history of prior therapy with oral sumatriptan  
 No Age Restrictions  
 No Prescriber Restrictions  
 365 Days  
 N/A

## Prior Authorization Criteria

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### Tykerb

All FDA-approved indications  
 No Exclusion Criteria.  
 Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.

**Age Restrictions**

No Age Restrictions

**Prescriber Restrictions**

No Prescriber Restrictions

**Duration of Approval**

180 days

**Other Information we may Require:**

Combination therapy with capecitabine (Xeloda) for treatment of advanced or metastatic breast cancer whose tumors overexpress (HER2) AND who have had prior therapy with: anthracycline, taxane, or trastuzumab (Herceptin).

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### Tysabri

All FDA-approved indications  
 Member must not have or have had progressive multifocal leukoencephalopathy (PML).  
 Diagnosis.

**Age Restrictions**

Must be greater than 18 years of age.

**Prescriber Restrictions**

Must be prescribed by a neurologist or gastroenterologist dependent upon the diagnosis who is registered with the TOUCH Prescribing program.

**Duration of Approval**

90 days initially for Crohn's disease and 365 days for MS.

**Other Information we may Require:**

For MS, member must have a diagnosis of relapsing forms of multiple sclerosis, member must have previously had an inadequate response or cannot tolerate other multiple sclerosis therapies, including interferon beta-1a, interferon beta-1b, and glatiramer acetate, member must not have or have had progressive multifocal leukoencephalopathy (PML), member should not be receiving chronic immunosuppressant or immunomodulatory therapy (including interferon beta-1a, interferon beta-1b, and glatiramer acetate since natalizumab is indicated as monotherapy) or have systemic medical conditions resulting in significant compromised immune system function. For Crohn's disease, member must have a diagnosis of moderately to severely active Crohn's disease with evidence of inflammation, member must have previously had an inadequate response or cannot tolerate conventional therapies such as aminosalicylates (i.e., sulfasalazine, mesalamine), corticosteroids or immunomodulators (i.e., azathioprine, 6-mercaptopurine) AND TNF-alpha inhibitors, member must not have or have had progressive multifocal leukoencephalopathy (PML), member should not be receiving chronic immunosuppressant or immunomodulatory therapy (including 6-mercaptopurine, azathioprine, cyclosporine, methotrexate, or inhibitors of TNF-alpha) or have systemic medical conditions resulting in significant compromised immune system function.

### PA\_GroupNm:

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### Ventavis

All FDA-approved indications  
 No Exclusion Criteria  
 Confirmed diagnosis by right heart catheterization

**Age Restrictions**

No Age Restrictions

**Prescriber Restrictions**

Cardiologist or pulmonologist

**Duration of Approval**

90 days initially

**Other Information we may Require:**

Member must have a confirmed diagnosis of PAH with WHO functional class III or IV symptoms. Additional yearly authorizations may be granted upon review of chart documentation from the prescriber indicating that the member's condition has improved as a result of therapy.

## Prior Authorization Criteria

### **PA\_GroupNm:**

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### **Votrient**

All FDA-approved indications  
 No Exclusion Criteria.  
 Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.

**Age Restrictions**

No Age Restrictions

**Prescriber Restrictions**

No Prescriber Restrictions

**Duration of Approval**

180 days

**Other Information we may Require:**

Must have a diagnosis of advanced renal cell carcinoma.

### **PA\_GroupNm:**

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### **VPRIV**

All FDA-approved indications  
 No Exclusion Criteria  
 Diagnosis

**Age Restrictions**

No Age Restrictions

**Prescriber Restrictions**

Prescribed by a physician that specializes in the treatment of inherited metabolic disorders or a center that specializes in the treatment of Gaucher disease, or in consultation with these specialties.

**Duration of Approval**

365 Days

**Other Information we may Require:**

Diagnosis of Gaucher Disease with any of the following: Anemia, Thrombocytopenia, Bone disease, Hepatomegaly, or Splenomegaly. All prior authorization renewals will be reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. Authorization may be extended at one-year intervals based upon documentation from the provider that the member's disease has improved based upon the prescriber's assessment while on therapy.

### **PA\_GroupNm:**

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**

### **Xenazine**

All FDA approved indications

**Information Required**

Member must not be actively suicidal or have uncontrolled depression or currently using a monoamine oxidase inhibitor or reserpine.

**Age Restrictions**

Diagnosis

**Prescriber Restrictions**

18 years of age or older

**Duration of Approval**

Neurologist

**Other Information we may Require:**

365 days

Member must have a diagnosis of chorea associated with Huntington's Disease. Authorizations may be extended at one-year intervals based upon chart documentation from the prescriber that the member's disease has improved based upon the prescriber's assessment while on therapy and documentation that the member is being monitored for depression and suicidal ideation. Requests for doses above 50mg/day will also require documentation from the prescriber showing inadequate efficacy of lower doses and slow titration of tetrabenazine dose with close monitoring of side effects.

## Prior Authorization Criteria

### **PA\_GroupNm:**

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### **Xolair**

All FDA approved indications  
 No Exclusion Criteria  
 Diagnosis, IgE level, positive skin or RAST test to a perennial aeroallergen for initial authorization. For continued authorization, chart documentation from the provider must be submitted to indicate that the member's disease has improved based upon the prescriber's assessment while on therapy.  
 12 years of age or older  
 No Prescriber Restrictions  
 365 days  
 Xolair will approved for adults and adolescents (12 years of age and older) with moderate to severe persistent asthma on concomitant asthma therapy within the past year, and have a positive skin or RAST test to a perennial aeroallergen. An IgE (greater than 30 IU/ml or more) level must be provided.

**Age Restrictions**

**Prescriber Restrictions**

**Duration of Approval**

**Other Information we may  
 Require:**

### **PA\_GroupNm:**

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### **Xyrem**

All FDA approved indications  
 No Exclusion Criteria  
 Diagnosis and sleep studies for initial authorization. For continued authorization, chart documentation from the provider must be submitted to indicate that the member's disease has improved based upon the provider's assessment while on therapy.  
 No Age Restrictions  
 No Prescriber Restrictions  
 365 days  
 Xyrem will be covered for a diagnosis of cataplexy associated with narcolepsy demonstrated by supporting chart documentation or sleep studies OR a diagnosis of excessive daytime sleepiness (EDS) associated with narcolepsy demonstrated by polysomnographic evaluation or chart documentation supporting clinical history of narcolepsy.

**Age Restrictions**

**Prescriber Restrictions**

**Duration of Approval**

**Other Information we may  
 Require:**

### **PA\_GroupNm:**

**Covered Uses for this Drug**  
**Coverage Excluded Reasons**  
**Information Required**

### **Zolinza**

All FDA-approved indications  
 No Exclusion Criteria  
 Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy  
 No Age Restrictions  
 No Prescriber Restrictions  
 180 days  
 Cutaneous T-cell lymphoma (CTCL) in patients who have progressive, persistent or recurrent disease on or following 2 systemic therapies.

**Age Restrictions**

**Prescriber Restrictions**

**Duration of Approval**

**Other Information we may  
 Require:**

## Prior Authorization Criteria

**PA\_GroupNm:****Zorbtive****Covered Uses for this Drug**

All FDA approved indications

**Coverage Excluded Reasons**

Members with active malignancy.

**Information Required**

Diagnosis

**Age Restrictions**

Must be at least 18 year of age.

**Prescriber Restrictions**

No Prescriber Restrictions

**Duration of Approval**

4 weeks.

**Other Information we may****Require:**

Member must be at least 18 years of age. However, members under the age of 18 with a confirmed diagnosis of short bowel syndrome will be considered on a case-by-case basis in consultation with the Medical Director. Chart documentation must be submitted indicating that the member has a diagnosis of short bowel syndrome, defined as follows: member must have documented malabsorption from the small intestine that is marked by diarrhea, malnutrition, and steatorrhea and that results from resection of the small intestine and member must have a small intestine less than 200 cm in length and member must have an intact stomach and duodenum as well as greater than or equal to 30% of functioning colon with at least 15 cm of intact jejunum and/or ileum or member must have an intact stomach and duodenum as well as less than 30% functioning colon with at least 90 cm intact jejunum and/or ileum. Member should also be receiving adequate nutritional support as determined by their Provider.