ACTEMRA

PRODUCT(s) AFFECTED
- ACTEMRA INJ 80MG/4ML

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Active infection (including TB). Concurrent therapy with other biologic agent(s).

REQUIRED MEDICAL INFORMATION
Screening for latent tuberculosis is required. If results are positive, patient must have completed treatment or must currently be receiving treatment for latent tuberculosis. Evaluate for HBV risk and initiate treatment if appropriate. Must have an inadequate response or intolerance/contraindication to one TNF antagonist therapy.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
For renewals, patient must have responded to Actemra therapy (e.g., condition improved or stabilized).
ACTHAR

PRODUCT(s) AFFECTED
- H.P. ACTHAR INJ 80UNIT

COVERED USES
All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Supporting statement of diagnosis from the physician

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
ACTIMMUNE

PRODUCT(s) AFFECTED
- ACTIMMUNE INJ 2MU/0.5

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
ADAGEN

PRODUCT(s) AFFECTED
- ADAGEN INJ 250/ML

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Severe thrombocytopenia. Use in preparation for or in support of bone marrow transplantation.

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Use for direct replacement for deficient enzyme (no benefit achieved in patients with immunodeficiency due to other causes).
ADCIRCA

PRODUCT(s) AFFECTED
- ADCIRCA TAB 20MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Nitrate therapy

REQUIRED MEDICAL INFORMATION
PAH been confirmed by right heart catheterization.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
ALDURAZYME

PRODUCT(s) AFFECTED
- ALDURAZYME INJ 2.9MG/5M

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed by measurement of alpha-L-iduronidase activity (enzymatic assay) or DNA testing. For Scheie form of MPS I, must have at least 2 moderate to severe symptoms. Must demonstrate improvement in lung function in patients who have received at least 26 weeks of Aldurazyme on re-authorization.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A
CARE N’ CARE HEALTH PLAN
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ALPHA1-PROTEINASE INHIBITOR

PRODUCT(s) AFFECTED
- ARALAST NP INJ 400MG  GLASSIA INJ
  PROLASTIN-C INJ 1000MG  ZEMAIRA INJ 1000MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Patient has IgA deficiency with antibodies against IgA.

REQUIRED MEDICAL INFORMATION
Alpha1-proteinase inhibitor concentration is less than 11 micromoles per liter. The FEV1 level is between 35% and 60% predicted OR greater than 60% predicted. If the FEV1 is greater than 60% predicted, then the patient has experienced a rapid decline in lung function (ie, reduction of FEV1 more than 120 mL/year) that warrants treatment.

AGE RESTRICTION
18 years old and older

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
AMPHEMATINES

PRODUCT(s) AFFECTED
- AMPHETAMINE CAP 10MG ER  AMPHETAMINE CAP 15MG ER
  AMPHETAMINE CAP 20MG ER  AMPHETAMINE CAP 25MG ER
  AMPHETAMINE CAP 30MG ER  AMPHETAMINE CAP 5MG ER
  DEXTROAMPHET CAP 10MG ER  DEXTROAMPHET CAP 15MG ER
  DEXTROAMPHET CAP 5MG ER  DEXTROAMPHET TAB 10MG
  DEXTROAMPHET TAB 5MG  VYVANSE CAP 10MG
  VYVANSE CAP 20MG  VYVANSE CAP 30MG
  VYVANSE CAP 40MG  VYVANSE CAP 50MG
  VYVANSE CAP 60MG  VYVANSE CAP 70MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
MAOI concurrent use or within the last 14 days except if prescriber is a psychiatrist with experience prescribing both MAOI and amphetamine/dextroamphetamine drugs.

REQUIRED MEDICAL INFORMATION
Sleep studies for narcolepsy diagnosis

AGE RESTRICTION
3 years of age and older

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Consider benefits of use versus the potential risks of serious cardiovascular events
AMPYRA

PRODUCT(s) AFFECTED
- AMPYRA TAB 10MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Moderate to severe renal impairment (CrCL less than or equal to 50 mL/min), history of seizures

REQUIRED MEDICAL INFORMATION
Patient must demonstrate sustained walking impairment, but with the ability to walk 25 feet (with or without assistance) prior to starting Ampyra.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
To continue therapy, the patient must experience an improvement in walking speed or other objective measure of walking ability since starting Ampyra.
ANABOLIC STEROIDS

PRODUCT(s) AFFECTED
- OXANDROLONE TAB 10MG  OXANDROLONE TAB 2.5MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Known or suspected carcinoma of the prostate or breast (in male patients), carcinoma of the breast in women with hypercalcemia, pregnancy, nephrosis (the nephrotic phase of nephritis), hypercalcemia.

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
6 months

OTHER CRITERIA
N/A
ARANESP

PRODUCT(s) AFFECTED

- ARANESP INJ 100MCG SYRINGE
- ARANESP INJ 150MCG
- ARANESP INJ 200MCG VIAL
- ARANESP INJ 25MCG SYRINGE
- ARANESP INJ 200MCG SYRINGE
- ARANESP INJ 25MCG VIAL
- ARANESP INJ 300MCG SYRINGE
- ARANESP INJ 300MCG VIAL
- ARANESP INJ 40MCG SYRINGE
- ARANESP INJ 40MCG VIAL
- ARANESP INJ 60MCG SYRINGE
- ARANESP INJ 60MCG VIAL

COVERED USES

All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

Uncontrolled hypertension, hemoglobin greater than or equal to 13 g/dL

REQUIRED MEDICAL INFORMATION

All patients must meet the following criteria: 1) The pretreatment hemoglobin level is less than 10 g/dL (or less than or equal to 11 g/dL with clinical symptoms of anemia). 2) Once on therapy for 12 weeks, the hemoglobin must increase at least 1 g/dL in response to Aranesp. 3) Once on therapy, the hemoglobin should be maintained to a level below 12 g/dL and if the level exceeds 12 g/dL, the prescriber must reduce the dose. Patients with chronic kidney disease or those treated with myelosuppressive chemotherapy must have adequate iron stores or be receiving concomitant iron supplementation.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 weeks

OTHER CRITERIA

Patient is instructed by the prescriber to report any signs or symptoms of adverse cardiovascular or thrombotic events.
ARCALYST

PRODUCT(s) AFFECTED
- ARCALYST INJ 220MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Active or chronic infection. Concurrent therapy with other biologics.

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
12 years of age and older

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
For renewal, patient's condition must have improved or stabilized.
BOSULIF

PRODUCT(s) AFFECTED
- BOSULIF TAB 100MG
- BOSULIF TAB 500MG

COVERED USES
All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Signed statement of diagnosis from the physician, hepatic panel and CBC, trial and failure of imatinib or dasatinib and documentation of a 90 day response

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
BOTOX

PRODUCT(s) AFFECTED
- BOTOX INJ 100UNIT

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Cosmetic use. Hypersensitivity to any botulinum toxin preparation or any component of the formulation. Infection at the proposed injection site(s).

REQUIRED MEDICAL INFORMATION
For chronic migraine, initial treatment: inadequate response to at least 8 weeks of oral migraine preventative therapy unless contraindicated or not tolerated. For chronic migraine, continuation of treatment: 50 percent reduction in headache frequency since starting therapy.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Chronic migraine, initial treatment: 12 weeks. Plan year for all other indications.

OTHER CRITERIA
Monitored for life-threatening symptoms of spread of toxin effect from the injection site (e.g., breathing, swallowing difficulties)
BUPRENORPHINE

PRODUCT(s) AFFECTED
- BUPREN/NALOX SUB 2-0.5MG
- BUPRENORPHIN SUB 2MG
- SUBOXONE MIS 2-0.5MG
- BUPREN/NALOX SUB 8-2MG
- BUPRENORPHIN SUB 8MG
- SUBOXONE MIS 8-2MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Documentation that the member is not receiving other opioids

AGE RESTRICTION
For patients age 16 years and older, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D. For patients age 0 to 15 years, drug is not covered.

PRESCRIBER RESTRICTION
Prescribers must be certified through CSAT (The Center for Substance Abuse Treatment) of SAMHSA (Substance Abuse and Mental Health Services Administration) to prescribe Suboxone and Subutex

COVERAGE DURATION
Buprenorphine - one month (12 months if pregnant). Buprenorphine-naloxone - 12 months.

OTHER CRITERIA
Buprenorphine and buprenorphine-naloxone should be part of an overall treatment program. The patient should be monitored periodically.
CAYSTON

PRODUCT(s) AFFECTED
- CAYSTON INH 75MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Diagnosis of cystic fibrosis is confirmed by appropriate diagnostic or genetic testing. Confirmation of P. aeruginosa in cultures of the airways. For continuation of therapy in patients younger than 6 years of age, a clinical reason to continue therapy, such as symptomatic improvement, is required. For continuation of therapy in patients older than 6 years of age, pulmonary function tests have not deteriorated more than 10% from baseline or there is a clinical reason to continue therapy, such as symptomatic improvement.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
CELEBREX

PRODUCT(s) AFFECTED
- CELECOXIB CAP 100MG
- CELECOXIB CAP 200MG
- CELECOXIB CAP 400MG
- CELECOXIB CAP 50MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Post-operative pain following CABG surgery.

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
6 months for JRA, 12 months for dysmenorrhea, OA, RA, AS, 1 month for acute pain

OTHER CRITERIA
N\A
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CEREZYME

PRODUCT(s) AFFECTED
- CEREZYME INJ 400UNIT

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Concurrent therapy with Zavesca.

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed by bone marrow histology, DNA testing, or b-glucocerebrosidase enzyme assay (enzyme activity less than 30 percent). Must have at least one of following conditions: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly. Must demonstrate a decrease in liver and spleen volume and/or increase in platelet count and/or increase in Hgb concentration in patients who have received at least 24 months of Cerezyme therapy on re-authorization.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A

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Last Updated 03/22/2016
Effective 04/01/2016
CARE N’ CARE HEALTH PLAN
2016 Prior Authorization Criteria

CIMZIA

PRODUCT(s) AFFECTED
- CIMZIA KIT
  CIMZIA PREFL KIT 200MG/ML

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Active infection (including TB). Concurrent therapy with other biologics.

REQUIRED MEDICAL INFORMATION
Screening for latent TB infection and assessment for Hep B risk. For positive latent TB, patient must have completed treatment or is currently receiving treatment for LTBI. HBV infection ruled out or treatment initiated for positive infection. Rheumatoid arthritis (RA) - Must have an inadequate response to either Enbrel or Humira and one of the following: 1) inadequate response to methotrexate, 2) inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX or, 3) intolerance or contraindication to at least 2 nonbiologic DMARDs. Crohn's Disease - Must have an inadequate response or contraindication/intolerance to at least one oral corticosteroid and Humira.

AGE RESTRICTION
18 years of age and older

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Initial: 3 months for Crohn’s disease, 1 year for all other indications. Renewal: Plan Year

OTHER CRITERIA
For re-authorization, patient's condition must have improved or stabilized.
DRONABINOL

PRODUCT(s) AFFECTED
- DRONABINOL CAP 10MG
- DRONABINOL CAP 2.5MG
- DRONABINOL CAP 5MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
A. The diagnosis is documented as anorexia associated with weight loss in a patient with AIDS a. AND the patient has had an involuntary weight loss of greater than 10% of pre-illness baseline body weight or a body mass index (BMI) less than 20kg/m2 in the absence of a concurrent illness or medical condition other than HIV that may cause weight loss b. AND the patient has failed to respond to a 30-day drug regimen of megestrol (Megace) c. AND if the patient has received previous dronabinol therapy, he/she must show a positive response to therapy by maintaining or increasing their initial weight and/or muscle mass before initiating dronabinol therapy. B. The diagnosis is documented as nausea and vomiting associated with cancer chemotherapy in a cancer patient a. AND the patient is receiving a chemotherapy or radiation regimen b. AND the patient has had a full trial and failure through at least one cycle of chemotherapy with IV ondansetron AND at least one of the following oral anti-emetic agents: metoclopramide, promethazine, prochlorperazine, meclizine, trimethobenzamide, oral 5-HT3 receptor antagonists e. AND if the patient has received previous dronabinol therapy, he/she must show a positive response by showing a reduced incidence of emesis and/or nausea.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
6 months

OTHER CRITERIA
B vs D coverage determination per CMS guidelines
ELAPRASE

PRODUCT(s) AFFECTED
- ELAPRASE INJ 6MG/3ML

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed by DNA testing or enzymatic analysis (deficiency of iduronate 2-sulfatase enzyme activity).

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
EMPLICITI

PRODUCT(s) AFFECTED
- EMPLICITI INJ 400MG

COVERED USES
All medically Accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Diagnosis of Multiple myeloma and used in combination with lenalidomide and dexamethasone in patients who have received 1 to 3 prior therapies.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
Oncologist

COVERAGE DURATION
Plan Year

OTHER CRITERIA
None
ENBREL

PRODUCT(s) AFFECTED
- ENBREL INJ 25/0.5ML
- ENBREL INJ 50MG/ML
- ENBREL INJ 25MG
- ENBREL SRCLK INJ 50MG/ML

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Concomitant use with another biologic, active infection (including TB).

REQUIRED MEDICAL INFORMATION
Screening for latent TB infection and assessment for Hep B risk. For positive latent TB, patient must have completed treatment or is currently receiving treatment for LTBI. HBV infection ruled out or treatment initiated for positive infection. Rheumatoid arthritis - Must have one of following: 1) inadequate response to methotrexate (MTX), 2) inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX, 3) intolerance or contraindication to at least 2 nonbiologic DMARDs or, 4) use Humira as first-line therapy with MTX for severely active RA. Polyarticular JIA - Must have an inadequate response to at least one nonbiologic DMARD or intolerance/contraindication to at least 2 nonbiologic DMARDs. Psoriatic arthritis with predominantly peripheral symptoms - Must have an inadequate response to at least an 8-week maximum tolerated dose trial of at least 1 nonbiologic DMARD unless contraindicated or intolerant to such therapy. For plaque psoriasis - Must have more than 5% BSA affected or has crucial body areas (e.g., feet, hands, face, or genitals) affected. Must have an inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., phototherapy, calcipotriene, MTX, acitretin) unless contraindicated or intolerant to such therapies. Crohn's disease - Must have an inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., sulfasalazine, mesalamine, azathioprine, corticosteroids) unless contraindicated or intolerant to such therapies OR an inadequate response or intolerance to either Remicade or Cimzia.

AGE RESTRICTION
For psoriasis, patient must be 18 years of age or older

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Formulary ID 16384, Ver 9
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For continuation of therapy, patient's condition must have improved or stabilized.
# EPO

## PRODUCT(s) AFFECTED

<table>
<thead>
<tr>
<th>EPOGEN INJ 10000/ML</th>
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<tbody>
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<td>PROCRIT INJ 40000/ML</td>
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## COVERED USES

All FDA approved indications not otherwise excluded from Part D

## EXCLUSION CRITERIA

Uncontrolled hypertension

## REQUIRED MEDICAL INFORMATION

For use in an anemic patient prior to surgery, the patient must also receive concomitant iron supplementation. For other indications, all of the following criteria are required: 1) The pretreatment Hgb is less than or equal to 10 g/dL for initial authorization. 2) The patient is receiving concomitant iron supplementation if iron stores are inadequate. 3) The Hgb is maintained at or below 12 g/dL once on therapy. 4) Once on therapy for 12 weeks, the hemoglobin must increase at least 1 g/dL in response to epoetin alfa.

## AGE RESTRICTION

None

## PRESCRIBER RESTRICTION

None

## COVERAGE DURATION

12 weeks

## OTHER CRITERIA

N/A
ERWINAZE

PRODUCT(s) AFFECTED
- ERWINAZE INJ 10000UNT

COVERED USES
All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Supporting statement of diagnosis from the physician

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
ESBRIET

PRODUCT(s) AFFECTED
- ESBRIET CAP 267MG

COVERED USES
All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Appropriate diagnosis (idopathic pulmonary fibrosis [IPF]), monitoring (hepatiac function/LFTs)

AGE RESTRICTION
none

PRESCRIBER RESTRICTION
pulmonologist

COVERAGE DURATION
Plan Year

OTHER CRITERIA
None
PRODUCT(s) AFFECTED
- EXJADE TAB 125MG
  EXJADE TAB 250MG
  EXJADE TAB 500MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Creatinine clearance less than 40 mL/min or evidence of overt proteinuria, platelet count less than 50 x 10^9/L, advanced malignancy, high-risk myelodysplastic syndrome (MDS) with poor performance status, or concurrent use of deferoxamine or iron-containing products.

REQUIRED MEDICAL INFORMATION
The patient must meet all of the following criteria: 1) Diagnosis of transfusion-dependent anemia with chronic iron overload due to blood transfusions, 2) Patient will have baseline and monthly monitoring of serum ferritin, serum creatinine, creatinine clearance, serum transaminases, and bilirubin. OR For the treatment of chronic iron overload in patients 10 years and older with nontransfusion-dependent thalassemia syndromes

AGE RESTRICTION
2 years of age and older

PRESCRIBER RESTRICTION
Hematologist

COVERAGE DURATION
3 months

OTHER CRITERIA
N\A
FABRAZYME

PRODUCT(s) AFFECTED
- FABRAZYME INJ 35MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed with an enzyme assay measuring a deficiency of alpha-galactosidase enzyme activity or DNA testing.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
CARE N’ CARE HEALTH PLAN
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FARYDAK

PRODUCT(s) AFFECTED
- FARYDAK CAP 10MG
  FARYDAK CAP 15MG
  FARYDAK CAP 20MG

COVERED USES
All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
statement of diagnosis from physician

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
42735

OTHER CRITERIA
N\A
FULYZAQ

PRODUCT(s) AFFECTED
- FULYZAQ TAB 125MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
## GILOTRIF

### PRODUCT(s) AFFECTED
- GILOTRIF TAB 20MG
- GILOTRIF TAB 30MG
- GILOTRIF TAB 40MG

### COVERED USES
All medically accepted indications not otherwise excluded from Part D

### EXCLUSION CRITERIA
None

### REQUIRED MEDICAL INFORMATION
Supporting statement of diagnosis from the physician in patients with EGFR exon 19 deletions or exon 21 (L858R) substitution as detected by an FDA-approved test.

### AGE RESTRICTION
None

### PRESCRIBER RESTRICTION
None

### COVERAGE DURATION
Plan Year

### OTHER CRITERIA
N\A
PRODUCT(s) AFFECTED
- CHOR GONADOT INJ 10000UNT

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Fertility indications in females are excluded.

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
GROWTH HORMONE

PRODUCT(s) AFFECTED
- GENOTROPIN INJ 0.2MG
- GENOTROPIN INJ 0.6MG
- GENOTROPIN INJ 1.2MG
- GENOTROPIN INJ 1.6MG
- GENOTROPIN INJ 12MG
- GENOTROPIN INJ 2MG
- HUMATROPE INJ 12MG
- NORDITROPIN INJ 10/1.5ML
- NORDITROPIN INJ 5/1.5ML
- NUTROPIN AQ INJ 12MG
- NUTROPIN AQ INJ NUSPIN 5
- OMNITROPE INJ 10/1.5ML
- OMNITROPE INJ 5/1.5ML
- SAIZEN INJ 5MG
- SAIZEN INJ 8.8MG
- SAIZEN INJ 8.8MG EASY CLICK

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
For pediatric GHD in neonate with hypoglycemia: patient has a randomly assessed GH level less than 20 ng/mL, other causes of hypoglycemia have been ruled out, and other treatments have been ineffective. For all pediatric patients: patients have short stature or slow growth velocity and have been evaluated for other causes of growth failure. For pediatric GHD, patient has delayed bone age. For pediatric GHD without pituitary disease, patient failed 2 stimulation tests. For pediatric GHD with a pituitary or CNS disorder, patient has clinical evidence of GHD and low IGF-1/IGFBP3. For TS and SHOX patients: diagnosis confirmed by genetic testing. For CRI patients: metabolic, endocrine and nutritional abnormalities have been treated or stabilized and patient has not had a kidney transplant. For SGA: patient has a low birth weight or length for gestational age. For ISS: pediatric GHD has been ruled out with one stimulation test. For adult GHD, patient was assessed for other causes of GHD-like symptoms. For adult GHD without pituitary disease, patient failed 2 stimulation tests. For adult GHD with at least 3 pituitary hormone deficiencies (PHD) or panhypopituitarism: have a low IGF-1. For adult GHD with less than 3 PHD, low IGF-1 and failed one stimulation test. For renewal for pediatric patients, growing more than 2 cm per year and for PWS only: improved body composition. For renewal for adult patients: patient has seen clinical improvement and IGF-1 will be monitored.

AGE RESTRICTION

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For Turner syndrome and SGA, 2 years of age and older. For Noonan syndrome and SHOX, 3 years of age and older.

PRESCRIBER RESTRICTION
Endocrinologist, Pediatric Nephrologist, Gastroenterologist, Nutritional Support Specialist, Infectious Disease Specialist

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
HARVONI

PRODUCT(s) AFFECTED
- HARVONI TAB 90-400MG

COVERED USES
All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Must submit documentation of chronic hepatitis C genotype (confirmed by HCV RNA level within the last 6 months) and subtype. Must submit laboratory results within 6 weeks of initiating therapy including: 1) CBC w Platelets, 2) AST/ALT, 3)Total Bilirubin, 4)Serum Albumin, 5)PT/INR, 6)Serum Creatinine, and 7)GFR.

AGE RESTRICTION
Patient must be age 18 or over

PRESCRIBER RESTRICTION
Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist

COVERAGE DURATION
24 wks: Post liver transplant, treatment-experienced or cirrhosis, 12 wks: all other indications

OTHER CRITERIA
None
HEPSERA

PRODUCT(s) AFFECTED
- ADEFOV DIPIV TAB 10MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D, prophylaxis against HBV infection with liver transplantation.

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
A. The patient has been diagnosed with chronic hepatitis B. B. AND the patient has evidence of a positive HBsAg (+ or -) serological marker for greater than 6 months OR evidence by a liver biopsy showing chronic hepatitis. C. AND the patient has a Hepatitis B viral load greater than 20,000 IU/mL (100,000 copies per mL) except if for HBeAg-negative HBV, the viral load is greater than 2,000 IU per mL (10,000 copies per mL). D. AND the patient has elevations in liver aminotransferases (ALT or AST) that are two (2) times greater than normal OR normal liver aminotransferase (ALT or AST) levels with evidence of significant disease found on biopsy. E. AND the patient is not receiving Intron A. F. AND documented evidence of diagnosis, serological markers or liver biopsy, viral load and liver aminotransferases. G. If the patient has received previous Hepsera treatment, there is documented clinical improvement shown by a drop in viral load or reduction in the patient's liver aminotransferases. H. If patient has renal impairment dose to be reduced to 10mg every 48 hours for CrCl 30 to 49mL/min, 10mg every 72 hours for CrCl 10 to 29mL/min. I. Patient not to be taking tenofovir or PMPA concurrently.

AGE RESTRICTION
12 years and older

PRESCRIBER RESTRICTION
Gastroenterologist or infectious disease specialist or affiliated with an infectious disease or gastroenterology practice, or a primary care physician with experience in treating HBV.

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
**HRM EDITS**

**PRODUCT(s) AFFECTED**

- ALORA DIS 0.025MG  
  ALORA DIS 0.05MG  
- ALORA DIS 0.075MG  
  ALORA DIS 0.1MG  
- AMITRIPTYLIN TAB 100MG  
  AMITRIPTYLIN TAB 10MG  
- AMITRIPTYLIN TAB 150MG  
  AMITRIPTYLIN TAB 25MG  
- AMITRIPTYLIN TAB 50MG  
  AMITRIPTYLIN TAB 75MG  
- AMRIX CAP 30MG  
  ASCOMP/COD CAP 30MG  
- BENTYL INJ 10MG/ML  
  BENZTROPINE TAB 0.5MG  
- BENZTROPINE TAB 1MG  
  BENZTROPINE TAB 2MG  
- BUT/APAP/CAF CAP CODEINE  
  CARBINOXAMIN SOL 4MG/5ML  
- CARBINOXAMIN TAB 4MG  
  CARISOPR/ASA TAB 200-325  
- CARISOPRODOL TAB 250MG  
  CARISOPRODOL TAB 350MG  
- CARISOPRODOL TAB ASA/COD  
  CHLORZOXAZON TAB 500MG  
- CLEMASTINE TAB 2.68MG  
  CLIMARA PRO DIS WEEKLY  
- CLOMIPRAMINE CAP 25MG  
  CLOMIPRAMINE CAP 50MG  
- CLOMIPRAMINE CAP 75MG  
  COMBIPATCH DIS .05/.14  
- COMBIPATCH DIS .05/.25  
  CYCLOBENZAPR TAB 10MG  
- CYCLOBENZAPR TAB 5MG  
  CYCLOBENZAPR TAB 7.5MG  
- CYPROHEPTAD SYP 2MG/5ML  
  CYPROHEPTAD TAB 4MG  
- DICYCLOMINE CAP 10MG  
  DICYCLOMINE SOL 10MG/5ML  
- DICYCLOMINE TAB 20MG  
  DIGITEK TAB 0.25MG  
- DIGOXIN INJ 0.25MG/1  
  DIGOXIN SOL 50MCG/ML  
- DIGOXIN TAB 0.25MG  
  DIPHEN/ATROP LIQ 2.5/5  
- DIPHEN/ATROP TAB 2.5MG  
  DIPYRIDAMOLE TAB 25MG  
- DIPYRIDAMOLE TAB 50MG  
  DIPYRIDAMOLE TAB 75MG  
- DISOPYRAMIDE CAP 100MG  
  DISOPYRAMIDE CAP 150MG  
- DIVIGEL GEL 0.25MG  
  DOXEPIN HCL CAP 100MG  
- DOXEPIN HCL CAP 10MG  
  DOXEPIN HCL CAP 150MG  
- DOXEPIN HCL CAP 25MG  
  DOXEPIN HCL CAP 50MG  
- DOXEPIN HCL CAP 75MG  
  DOXEPIN HCL CON 10MG/ML  
- DUAVEE TAB 0.45-20  
  EDLUAR SUB 10MG  
- EDLUAR SUB 5MG  
  ENJUVIA TAB 0.3MG  
- ENJUVIA TAB 0.45MG  
  ENJUVIA TAB 0.9MG  
- ENJUVIA TAB 1.25MG  
  ERGOLOID MES TAB 1MG ORAL  
- ESTRADA/NORETH TAB 0.5-0.1  
  ESTRADA/NORETH TAB 1-0.5MG  
- ESTRADIOL DIS 0.025MG BIWEEKLY  
  ESTRADIOL DIS 0.025MG WEEKLY  
- ESTRADIOL DIS 0.0375MG BIWEEKLY  
  ESTRADIOL DIS 0.0375MG WEEKLY  
- ESTRADIOL DIS 0.05MG BIWEEKLY  
  ESTRADIOL DIS 0.05MG WEEKLY  
- ESTRADIOL DIS 0.06MG  
  ESTRADIOL DIS 0.075MG BIWEEKLY  
- ESTRADIOL DIS 0.075MG WEEKLY  
  ESTRADIOL DIS 0.1MG BIWEEKLY  
- ESTRADIOL DIS 0.1MG WEEKLY  
  ESTRADIOL TAB 0.5MG  
- ESTRADIOL TAB 1MG  
  ESTRADIOL TAB 2MG
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<th>Item Description</th>
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CARE N’ CARE HEALTH PLAN
2016 Prior Authorization Criteria

PROMETHAZINE SUP 25MG
PROMETHAZINE SUP 50MG
PROMETHAZINE SYP 6.25/5ML
PROMETHAZINE TAB 12.5MG
PROMETHAZINE TAB 25MG
PROMETHAZINE TAB 50MG
PROMETHEGAN SUP 25MG
PROMETHEGAN SUP 50MG
SILENOR TAB 6MG
SOMA TAB 250MG
SURMONTIL CAP 100MG
SURMONTIL CAP 25MG
SURMONTIL CAP 50MG
THIORIDAZINE TAB 100MG
THIORIDAZINE TAB 10MG
THIORIDAZINE TAB 25MG
TRIHEXYPHEN TAB 2MG
TRIHEXYPHEN TAB 5MG
TRIMETHOBENZ CAP 300MG
TRIMIPRAMINE CAP 100MG
TRIMIPRAMINE CAP 25MG
TRIMIPRAMINE CAP 50MG
ZALEPLON CAP 10MG
ZALEPLON CAP 5MG
ZOLPIDEM ER TAB 12.5MG
ZOLPIDEM ER TAB 6.25MG
ZOLPIDEM TAB 10MG
ZOLPIDEM TAB 5MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTION
For patients less than or equal to 64 years, claim will automatically pay.

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
HUMIRA

PRODUCT(s) AFFECTED
- HUMIRA INJ 10MG/0.2
- HUMIRA KIT 20MG/0.4
- HUMIRA PEN INJ CROHNS
- HUMIRA INJ 40MG/0.8
- HUMIRA PEN INJ 40MG/0.8

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Active infection (including TB), concurrent use with other biologics.

REQUIRED MEDICAL INFORMATION
Screening for latent TB infection and assessment for Hep B risk. For positive latent TB, patient must have completed treatment or is currently receiving treatment for LTBI. HBV infection ruled out or treatment initiated for positive infection. Rheumatoid arthritis - Must have one of following: 1) inadequate response to methotrexate (MTX), 2) inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX, 3) intolerance or contraindication to at least 2 nonbiologic DMARDs or, 4) use Humira as first-line therapy with MTX for severely active RA. Polyarticular JIA - Must have an inadequate response to at least one nonbiologic DMARD or intolerance/contraindication to at least 2 nonbiologic DMARDs. Psoriatic arthritis with predominantly peripheral symptoms - Must have an inadequate response to at least an 8-week maximum tolerated dose trial of at least 1 nonbiologic DMARD unless contraindicated or intolerant to such therapy. For plaque psoriasis - Must have more than 5% BSA affected or has crucial body areas (e.g., feet, hands, face, or genitals) affected. Must have an inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., phototherapy, calcipotriene, MTX, acitretin) unless contraindicated or intolerant to such therapies. Crohn's disease - Must have an inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., sulfasalazine, mesalamine, azathioprine, corticosteroids) unless contraindicated or intolerant to such therapies OR an inadequate response or intolerance to either Remicade or Cimzia.

AGE RESTRICTION
For psoriasis, patient must be 18 years of age and older

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Initial: 3 months for Crohn's disease and plan year for all other indications Renewal: Plan Year

OTHER CRITERIA
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For re-authorization, patient's condition must have improved or stabilized.
HUMIRA PEDIATRIC

PRODUCT(s) AFFECTED
- HUMIRA PEDIA INJ CROHNS 3 CT  HUMIRA PEDIA INJ CROHNS 6 CT

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Active infection (including TB), concurrent use with other biologics.

REQUIRED MEDICAL INFORMATION
Screening for latent TB infection and assessment for Hep B risk. For positive latent TB, patient must have completed treatment or is currently receiving treatment for LTBI. HBV infection ruled out or treatment initiated for positive infection. Polyarticular JIA - Must have an inadequate response to at least one nonbiologic DMARD or intolerance/contraindication to at least 2 nonbiologic DMARDs. Crohn's disease - Must have an inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., sulfasalazine, mesalamine, azathioprine, corticosteroids) unless contraindicated or intolerant to such therapies OR an inadequate response or intolerance to either Remicade or Cimzia.

AGE RESTRICTION

PRESCRIBER RESTRICTION

COVERAGE DURATION
Initial: 3 months for Crohn's disease and plan year for all other indications Renewal: Plan Year

OTHER CRITERIA
For re-authorization, patient's condition must have improved or stabilized.
HYSINGLA

PRODUCT(s) AFFECTED

- HYSINGLA ER TAB 100 MG
- HYSINGLA ER TAB 20 MG
- HYSINGLA ER TAB 40 MG
- HYSINGLA ER TAB 60 MG
- HYSINGLA ER TAB 80 MG
- HYSINGLA ER TAB 120 MG

COVERED USES

All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Must have severe pain requiring around the clock long term opioid, AND all of these: 1- ONE of the following formulary opioid options, hydrocodone IR, oxycodone IR, morphine IR, hydromorphone IR, methadone, OR oxymorphone IR are ineffective, not tolerated or inadequate for controlling pain AND fentanyl patches are ineffective, not tolerated, or inadequate for controlling pain 2-Must discontinue all other around-the-clock opioids when initiated 3-Care plan/agreement for opioid therapy has been established 4-Pt advised of risks and provides informed consent for chronic opioid therapy 5-Pt assessed for all these (i)pain severity (ii)suitability of non-opioids (iii)physical & emotional functional status (iv)risk of or current aberrant drug behavior 5-Prescriber will monitor for signs of misuse, abuse and addiction during therapy AND ONE of these: A-Opioid naive/non-tolerant must start at 10mg twice day for 7 days before titrating up OR B-Opioid tolerant, receiving one of these doses per day for at least 1 week: 60mg oral morphine, 25mcg transdermal fentanyl/hr, 30mg oral oxycodone, 8mg oral hydromorphone, 25mg oral oxymorphone

AGE RESTRICTION

Not covered if under 18 years of age.

PRESCRIBER RESTRICTION

Prescriber is knowledgeable in the use of potent opioids for the management of chronic pain

COVERAGE DURATION

90 days

OTHER CRITERIA

N\A
CARE N’ CARE HEALTH PLAN
2016 Prior Authorization Criteria

IBRANCE

PRODUCT(s) AFFECTED
- IBRANCE CAP 100MG
- IBRANCE CAP 125MG
- IBRANCE CAP 75MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Appropriate diagnosis (used in combination with letrozole for the treatment of postmenopausal women with estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced breast cancer)

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
42735

OTHER CRITERIA
N/A

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45
ICLUSIG

PRODUCT(s) AFFECTED
- ICLUSIG TAB 15MG
- ICLUSIG TAB 45MG

COVERED USES
All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
diagnosis trial and failure of another formulary TKI

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
365 days

OTHER CRITERIA
N\A
IMBRUVICA

PRODUCT(s) AFFECTED
- IMBRUVICA CAP 140MG

COVERED USES
All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Supporting statement of diagnosis from the physician

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A
INCRELEX

PRODUCT(s) AFFECTED
- INCRELEX INJ 40MG/4ML

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Epiphyseal closure, IV administration of Increlex, active malignancy, use in neonates, concurrent use with GH therapy, patient has secondary causes of IGF-1 deficiency.

REQUIRED MEDICAL INFORMATION
Prior to starting therapy, a height greater than 3 SD below the mean for chronological age and sex, and an IGF-1 level greater than or equal to 3 SD below the mean for chronological age and gender. One stimulation test showing patient has a normal or elevated GH level. For continuation of therapy, patient grew more than 2.5 cm/year.

AGE RESTRICTION
Between 2 and 20 years of age

PRESCRIBER RESTRICTION
Endocrinologist

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
ITRACONAZOLE

PRODUCT(s) AFFECTED
- ITRACONAZOLE CAP 100MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
A. ventricular dysfunction (e.g., congestive heart failure (CHF) or history of CHF) do not use for onychomycosis. B. If the patient is taking/receiving any of the following: concomitant use with drugs metabolized by CYP3A4 (e.g., cisapride, dofetilide, pimozide, quinidine)

REQUIRED MEDICAL INFORMATION
Patients with a diagnosis of blastomycosis, pulmonary or extrapulmonary OR patients with a diagnosis of histoplasmosis, including chronic cavitary pulmonary disease or disseminated, non-meningeal histoplasmosis OR patients with a diagnosis of aspergillosis, pulmonary or extrapulmonary OR patients with a diagnosis of onychomycosis of the toenail, with or without fingernail involvement, due to dermatophytes (tinea unguium) OR patients with a diagnosis of onychomycosis of the fingernail due to dermatophytes (tinea unguium). For onychomycosis, diagnosis has been confirmed with a fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy).

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
12 weeks

OTHER CRITERIA
N/A
IVIG

PRODUCT(s) AFFECTED
- CARIMUNE NF INJ 6GM
  GAMMALEX INJ 2.5GM
- GAMMAGARD SD INJ 5GM HU
  GAMUNEX-C INJ 1GM/10ML

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
IgA deficiency with antibody formation and a history of hypersensitivity. History of anaphylaxis or severe systemic reaction to human immune globulin. Presence of risk factor(s) for acute renal failure, unless the patient will receive IGIV products at the minimum concentration available and at the minimum rate of infusion practicable OR Gamunex/Gamunex-C is administered SC for PID.

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
CIDP diagnosis by a neurologist

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Gamunex/Gamunex-C: if administered SC outside of a controlled healthcare setting, appropriate treatment (eg, anaphylaxis kit) should be available for managing an acute hypersensitivity reaction.
KALYDECO

PRODUCT(s) AFFECTED
- KALYDECO PAK 50MG
  KALYDECO PAK 75MG
  KALYDECO TAB 150MG

COVERED USES
All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Cystic Fibrosis (Initial): Diagnosis of CF. Confirmed G551D mutation. (Reauthorization):
  Documentation of one of the following while on Kalydeco therapy: Improved lung function or stable
  lung function.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
42735

OTHER CRITERIA
N/A
KEYTRUDA

PRODUCT(s) AFFECTED
- KEYTRUDA INJ 100MG/4M 4ML

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
appropriate diagnosis, trial/failure of Yervoy, and if BRAF V600 mutation positive must also try a BRAF inhibitor.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
365 days

OTHER CRITERIA
N\A
KINERET

PRODUCT(s) AFFECTED
- KINERET INJ

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Active infection, concurrent therapy with other biologics.

REQUIRED MEDICAL INFORMATION
Must have one of following: 1) inadequate response to methotrexate (MTX), 2) inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX, 3) intolerance or contraindication to at least 2 nonbiologic DMARDs or, 4) use Kineret as first-line therapy with MTX for severely active RA. For Diagnosis of CAPs, Kineret will be approved.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
For re-authorization, patient's condition must have improved or stabilized.
KORLYM

PRODUCT(s) AFFECTED
- KORLYM TAB 300MG

COVERED USES
All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Pregnancy

REQUIRED MEDICAL INFORMATION
Supporting statement of diagnosis and relevant medical information from physician

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
KUVAN

PRODUCT(s) AFFECTED
- KUVAN POW 500MG
- KUVAN TAB 100MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Blood phenylalanine (Phe) levels. Pretreatment blood phenylalanine (Phe) levels greater than 10mg/dL if the patient is older than 12 years of age or greater than 6mg/dL if less than or equal to 12 years of age. Response to a therapeutic trial (greater than or equal to a 30% reduction in blood Phe levels) is required for long-term authorization.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
1 month initial, plan year on renewal

OTHER CRITERIA
Blood Phe levels should be checked after 1 week of therapy and periodically up to one month during a therapeutic trial.
LETAIRIS

PRODUCT(s) AFFECTED
- LETAIRIS TAB 10MG  LETAIRIS TAB 5MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Pregnancy

REQUIRED MEDICAL INFORMATION
NYHA class II or III symptoms. PAH been confirmed by right heart catheterization.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
UD or two appropriate contraceptive methods will be used for women of childbearing potential.
LEUKINE

PRODUCT(s) AFFECTED
- LEUKINE INJ 250MCG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Administration within 24 hours preceding or following chemotherapy or radiotherapy, hypersensitivity to yeast-derived products. For prophylaxis of febrile neutropenia: use to increase the chemotherapy dose intensity or dose schedule above established regimens. For treatment of febrile neutropenia, when patient receives Neulasta during the current chemotherapy cycle. For AML only, excessive (greater than or equal to 10%) leukemic myeloid blasts in the bone marrow or peripheral blood.

REQUIRED MEDICAL INFORMATION
For patients with nonmyeloid malignancies receiving myelosuppressive chemotherapy: Leukine may be used for the prevention of chemotherapy-induced febrile neutropenia if the patient experienced febrile neutropenia with a prior chemotherapy cycle OR the patient is at high risk (greater than 20%) or intermediate risk (10-20%) for developing febrile neutropenia. Patients at low risk (less than 10%) for developing febrile neutropenia may also receive Leukine for prophylaxis if there is a significant risk for serious medical consequences due to febrile neutropenia and the intent of chemotherapy is to prolong survival or cure the disease. Leukine is allowable for the treatment of febrile neutropenia in patients who have received prophylaxis with Leukine (or Neupogen) OR in patients at risk for infection-related complications. All patients must receive baseline and regular monitoring of complete blood counts and platelet counts.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
6 months

OTHER CRITERIA
N\A
LIDOCAINE TD

PRODUCT(s) AFFECTED
- LIDOCAINE PAD 5%

COVERED USES
All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Supporting statement of diagnosis from the physician

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
42735

OTHER CRITERIA
For the FDA-labeled indication of post-herpetic neuralgia, no additional criteria are required to be met. For diabetic neuropathy: the patient must have previous use and inadequate response or intolerance to any ONE neuropathic pain medication, including (but not limited to) Cymbalta and Lyrica that are labeled for neuropathic pain.
LUPRON

PRODUCT(s) AFFECTED

- LEUPROLIDE INJ 1MG/0.2
- LUPR DEP-PED INJ 15MG
- LUPRON DEPOT INJ 11.25MG
- LUPRON DEPOT INJ 3.75MG
- LUPRON DEPOT INJ 45MG
- LUPR DEP-PED INJ 11.25MG
- LUPR DEP-PED INJ 7.5MG
- LUPRON DEPOT INJ 22.5MG
- LUPRON DEPOT INJ 30MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Drug is excluded in Pregnant or breast feeding female patients.

REQUIRED MEDICAL INFORMATION
For prostate cancer: 1) allow therapy for locally advanced, recurrent or metastatic disease, 2) allow initial long-term neoadjuvant/concurrent/adjuvant ADT in combination with radiation therapy for clinically localized disease with high risk of recurrence, 3) allow initial short-term neoadjuvant/concurrent/adjuvant ADT in combination with radiation therapy for clinically localized disease with intermediate risk of recurrence or with brachytherapy for clinically localized disease with high risk of recurrence, or 4) allow neoadjuvant therapy in conjunction with brachytherapy in patients with a large prostate to shrink the prostate to an acceptable size for brachytherapy For endometriosis: patient must have completed a trial and failure of at least 2 of the following therapies: oral contraceptives, medroxyprogesterone, or danazol.

AGE RESTRICTION
For CPP, patient must be less than 12 years old if female and less than 13 years old if male.

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Prostate CA: 1 yr but 6 mos for short term use, Fibroids: 3 mos, Endometriosis: 6 mos, CPP: 1 yr

OTHER CRITERIA
N\A
LYNPARZA

PRODUCT(s) AFFECTED
- LYNPARZA CAP 50MG

COVERED USES
All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Appropriate diagnosis and testing for BRCA mutation (deleterious or suspected deleterious germline BRCA mutated (as detected by an FDA approved test) advanced ovarian cancer that has been treated with 3 or more prior lines of chemotherapy)

AGE RESTRICTION
none

PRESCRIBER RESTRICTION
none

COVERAGE DURATION
42735

OTHER CRITERIA
none
METHYLPHENIDATES

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COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
MAOI concurrent use or within the last 14 days

REQUIRED MEDICAL INFORMATION
Sleep studies for narcolepsy diagnosis

AGE RESTRICTION
6 years of age and older

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Consider benefits of use versus the potential risks of serious cardiovascular events.
MOZOBL

PRODUCT(s) AFFECTED
- MOZOBL INJ

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
6 months

OTHER CRITERIA
Mozobil is given in combination with granulocyte-colony stimulating factor
MYOZYME

PRODUCT(s) AFFECTED
- MYOZYME INJ 50MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed by DNA testing or an enzymatic assay showing a deficiency in acid alpha glucosidase.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
NAGLAZYME

PRODUCT(s) AFFECTED
- NAGLAZYME INJ 1MG/ML

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed by DNA testing or an enzymatic assay showing a deficiency in N-acetylgalactosamine activity. Patient must have at least one MPS VI symptom. For re-authorization of Naglazyme, patient must demonstrate improvement in walking and/or stair-climbing capacity.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
NEULASTA

PRODUCT(s) AFFECTED
- NEULASTA INJ 6MG/0.6M

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Treatment for febrile neutropenia, known hypersensitivity to filgrastim, use in the period 14 days before and 24 hours after administration of chemotherapy, use in patients with myeloid malignancy, use to increase the chemotherapy dose intensity or dose schedule beyond established regimens.

REQUIRED MEDICAL INFORMATION
For patients with non-myeloid malignancies receiving myelosuppressive chemotherapy: Neulasta may be used for the prevention of chemotherapy-induced febrile neutropenia if the patient experienced febrile neutropenia with a prior chemotherapy cycle OR the patient is at high risk (greater than 20%) or intermediate risk (10-20%) for developing febrile neutropenia. Patients at low risk (less than 10%) for developing febrile neutropenia may also receive Neulasta prophylaxis if there is a significant risk for serious medical consequences due to febrile neutropenia and the intent of chemotherapy is to prolong survival or cure the disease. All patients must receive baseline and regular monitoring of complete blood counts and platelet counts.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
6 months

OTHER CRITERIA
N/A
NEUPOGEN

PRODUCT(s) AFFECTED
- NEUPOGEN INJ 300/0.5
  NEUPOGEN INJ 300MCG 1.6ML
- NEUPOGEN INJ 300MCG 1ML
  NEUPOGEN INJ 480/0.8
- ZARXIO INJ 300/0.5
  ZARXIO INJ 480/0.8

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Administration within 24 hours preceding or following chemotherapy or radiotherapy, E coli hypersensitivity. For prophylaxis of febrile neutropenia: use to increase the chemotherapy dose intensity or dose schedule beyond established regimen. For treatment of febrile neutropenia, when patient receives Neulasta during the current chemotherapy cycle.

REQUIRED MEDICAL INFORMATION
For patients with nonmyeloid malignancies receiving myelosuppressive chemotherapy: Neupogen may be used for the prevention of chemotherapy-induced febrile neutropenia if the patient experienced febrile neutropenia with a prior chemotherapy cycle OR the patient is at high risk (greater than 20%) or intermediate risk (10-20%) for developing febrile neutropenia. Patients at low risk (less than 10%) for developing febrile neutropenia may receive Neupogen for prophylaxis if there is a significant risk for serious medical consequences due to febrile neutropenia and the intent of chemotherapy is to prolong survival or cure the disease. Neupogen is allowable for the treatment of febrile neutropenia in patients who have received prophylaxis with Neupogen (or Leukine) OR in patients at risk for infection-related complications. All patients must receive baseline and regular monitoring of complete blood counts and platelet counts.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
6 months

OTHER CRITERIA
N\A
NORTHERA

PRODUCT(s) AFFECTED
- NORTHERA CAP 100MG
- NORTHERA CAP 200MG
- NORTHERA CAP 300MG

COVERED USES
All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
statement of diagnosis

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
365 days

OTHER CRITERIA
N\A
NUDEXTA

PRODUCT(s) AFFECTED
- NUEDEXTA CAP 20-10MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Patient has amyotrophic lateral sclerosis (ALS) OR multiple sclerosis (MS)

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A
NUVIGIL

PRODUCT(s) AFFECTED
- NUVIGIL TAB 150MG
- NUVIGIL TAB 200MG
- NUVIGIL TAB 250MG
- NUVIGIL TAB 50MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
If diagnosis of Shift Work Sleep Disorder frequently (5 times or more per month) AND experience excessive sleepiness while working. If diagnosis of mild obstructive sleep apnea/hypopnea syndrome and whether patient is using and compliant with an oral appliance

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
OCTREOTIDE

PRODUCT(s) AFFECTED
- OCTREOTIDE INJ 1000MCG  
  OCTREOTIDE INJ 200MCG  
  OCTREOTIDE INJ 50MCG/ML  
  OCTREOTIDE INJ 100MCG  
  OCTREOTIDE INJ 500MCG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
OPDIVO

PRODUCT(s) AFFECTED
- OPDIVO INJ 40MG/4ML

COVERED USES
All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Diagnosis of unresectable or metastatic melanoma and disease progression following ipilimumab [Yervoy]) and testing for BRAF V600 mutation OR Diagnosis of metastatic squamous non-small cell lung cancer (NSCLC) with progression on or after platinum-based chemotherapy.

AGE RESTRICTION
none

PRESCRIBER RESTRICTION
none

COVERAGE DURATION
42735

OTHER CRITERIA
none
OPSUMIT

PRODUCT(s) AFFECTED
- OPSUMIT TAB 10MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Supporting statement of diagnosis and relevant medical information from physician

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
ORAL FENTANYL

PRODUCT(s) AFFECTED

- ABSTRAL SUB 100MCG
- ABSTRAL SUB 300MCG
- ABSTRAL SUB 600MCG
- FENTANYL OT LOZ 1200MCG
- FENTANYL OT LOZ 2000MCG
- FENTANYL OT LOZ 300MCG
- FENTANYL OT LOZ 400MCG
- FENTANYL OT LOZ 600MCG
- FENTANYL OT LOZ 800MCG
- FENTORA TAB 100MCG
- FENTORA TAB 200MCG
- FENTORA TAB 400MCG
- FENTORA TAB 600MCG
- FENTORA TAB 800MCG
- LAZANDA SPR 400MCG
- SUBSYS SPR 200MCG
- SUBSYS SPR 400MCG
- SUBSYS SPR 600MCG

COVERED USES

All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

Patients taking strong or moderate cytochrome P450 3A4 inhibitor(s) (e.g., aprepitant, clarithromycin, diltiazem, erythromycin, fosamprenavir, fluconazole, itraconazole, ketoconazole, nefazodone, nelfinavir, ritonavir, verapamil) who will not be monitored or have dosing adjustments made if necessary.

REQUIRED MEDICAL INFORMATION

None

AGE RESTRICTION

16 years of age and older (Actiq), 18 years of age and older all others

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

6 months

OTHER CRITERIA

N\A
ORENCIA

PRODUCT(s) AFFECTED
- ORENCIA INJ 125MG/ML
- ORENCIA INJ 250MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Active infection (including TB). Concurrent therapy with other biologics.

REQUIRED MEDICAL INFORMATION
Screening for latent TB infection and assessment for Hep B risk. For positive latent TB, patient must have completed treatment or is currently receiving treatment for LTBI. HBV infection ruled out or treatment initiated for positive infection. Rheumatoid arthritis - Must have one of following: 1) inadequate response to methotrexate (MTX), 2) inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX, 3) intolerance or contraindication to at least 2 nonbiologic DMARDs or, 4) use Orecia as first-line therapy with MTX for severely active RA. Polyarticular JIA - Must have an inadequate response to at least one nonbiologic DMARD or intolerance/contraindication to at least 2 nonbiologic DMARDs.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
For re-authorization, patient's condition must have improved or stabilized.
ORKAMBI

PRODUCT(s) AFFECTED
- ORKAMBI TAB 200-125

COVERED USES
All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Initial Therapy: Must have 1. diagnosis of cystic fibrosis (CF) with documented homozygous F508del mutation confirmed by FDA-approved CF mutation test AND 2. Baseline FEV1 greater than or equal to 40% AND 3. Baseline liver function tests (ALT/AST and bilirubin) provided AND 4. If less than 18 years of age, baseline ophthalmological exam completed Continuation of therapy: 1. Documentation patient is tolerating and responding to medication (i.e. improved FEV1, weight gain, decreased exacerbations, etc.) AND 2. Adherence to therapy is confirmed (supported by documentation from patients chart notes or electronic claim history) AND 3. Liver function tests (ALT/AST and bilirubin) provided with each renewal during first year of treatment and annually thereafter AND 4. ALT or AST does not exceed 5 times the upper limit of normal AND 5. ALT or AST does not exceed 3 times upper limit of normal with bilirubin greater than 2 times upper limit of normal

AGE RESTRICTION
Must be greater than or equal to 12 years of age

PRESCRIBER RESTRICTION
Must be prescribed by, or in conjunction with, a pulmonologist or is from a CF center accredited by the Cystic Fibrosis Foundation

COVERAGE DURATION
42735

OTHER CRITERIA
N\A
OSTEOPOROSIS

PRODUCT(s) AFFECTED
- FORTEO SOL 600/2.4

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Patient meets one of the following criteria: 1) Patient has experienced a prior fragility fracture, or 2) Patient had an inadequate response to an adequate trial of a bisphosphonate (one year) or patient has a contraindication or intolerance to bisphosphonate trial, or 3) Patient has 2 of the following risk factors for fracture: advanced age, parental history of fracture, low body mass index, current smoker, chronic alcohol use, rheumatoid arthritis, chronic steroid use, or other secondary cause of osteoporosis.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A
OXSORALEN

PRODUCT(s) AFFECTED
- METHOXSALEN CAP 10MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Aphakia, melanoma, or invasive squamous cell carcinoma

REQUIRED MEDICAL INFORMATION
The patient must be diagnosed with cutaneous T-cell lymphoma OR psoriasis AND if the diagnosis is psoriasis, the patient must have previous inadequate treatment response or intolerance or contraindication to at least one topical steroid.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
Dermatologist or Oncologist or affiliated with a dermatologist/oncologist practice

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
## PART B VS PART D

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**CARE N’ CARE HEALTH PLAN**  
*2016 Prior Authorization Criteria*

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<td>GENGRAF SOL 100MG/ML</td>
</tr>
<tr>
<td>FIRMAGON INJ 80MG</td>
<td>GRANISETRON INJ 1MG/ML</td>
</tr>
<tr>
<td>FIRMAGON INJ 80MG</td>
<td>HALAVEN INJ 1MG/2ML</td>
</tr>
<tr>
<td>FIRMAGON INJ 80MG</td>
<td>HERCEPTIN INJ 440MG</td>
</tr>
<tr>
<td>HYDROMORPHON INJ 10MG/ML</td>
<td>Ibandronate INJ 3MG/3ML</td>
</tr>
<tr>
<td>IDAMycin PFS INJ 5MG/5ML</td>
<td>IDARUBICIN INJ 5MG/5ML</td>
</tr>
<tr>
<td>IMOVAX RABIES INJ 2.5/ML</td>
<td>IMOVAX RABIES INJ 2.5/ML</td>
</tr>
<tr>
<td>INTRALIPID INJ 20%</td>
<td>INTRALIPID INJ 30%</td>
</tr>
<tr>
<td>INTRON-A INJ 10MU</td>
<td>INTRON-A INJ 18MU 1ML</td>
</tr>
<tr>
<td>INTRON-A INJ 18MU 3.8ML</td>
<td>INTRON-A INJ 50MU</td>
</tr>
<tr>
<td>IPRATROPIUM SOL 0.02%INH</td>
<td>IPRATROPIUM/ SOL ALBUTER</td>
</tr>
<tr>
<td>IRINOTECAN INJ 100/5ML</td>
<td>ISTODAX INJ 10MG</td>
</tr>
<tr>
<td>Ixempra KIT INJ 15MG</td>
<td>KEPIVANCE INJ 6.25MG</td>
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<tr>
<td>LEUCOVOR INJ 350MG</td>
<td>LEVALBUTEROL NEB 0.31MG</td>
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<tr>
<td>LEVALBUTEROL NEB 0.63MG</td>
<td>LEVALBUTEROL NEB 1.25/0.5</td>
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<tr>
<td>LINCOMYCIN INJ 300MG/ML</td>
<td>LINECOMYCIN INJ 300MG/ML</td>
</tr>
<tr>
<td>MESNA INJ 1GM</td>
<td>MIRCERA INJ 50MCG</td>
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<tr>
<td>METHOTREXATE INJ 1GM</td>
<td>MITOMYCIN INJ 20MG</td>
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<td>MIRCERA INJ 100MCg</td>
<td>MUSTARGEN INJ 10MG</td>
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<td>MIRCERA INJ 75MCg</td>
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<td>MIRCERA INJ 75MCg</td>
<td>MIRCERA INJ 75MCg</td>
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<tr>
<td>MYCOPHENOLAT CAP 250MG</td>
<td>MYCOPHENOLAT SUS 200MG/ML</td>
</tr>
<tr>
<td>MYCOPHENOLAT TAB 500MG</td>
<td>MYCOPHENOLIC TAB 180MG DR</td>
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</table>
CARE N’ CARE HEALTH PLAN
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MYCOPHENOLIC TAB 360MG DR NEBUPENT INH 300MG
NEPHRAMINE INJ 5.4% NULOJIX INJ 250MG
ONCASPAR INJ 750/ML ONDANSETRON INJ 40/20ML
ONDANSETRON INJ 4MG/2ML ONDANSETRON SOL 4MG/5ML
ONDANSETRON TAB 24MG ONDANSETRON TAB 4MG
ONDANSETRON TAB 4MG ODT ONDANSETRON TAB 8MG
ONDANSETRON TAB 8MG ODT OXALIPLATIN INJ 50MG
PACLITAXEL INJ 30MG/5ML PAMIDRONATE INJ 30/10ML
PAMIDRONATE INJ 6MG/ML PAMIDRONATE INJ 90/10ML
PLENAMINE INJ 15% PREMASOL SOL 10%
PREMASOL SOL 6% PROCALAMINE INJ 3%
PROGRAF INJ 5MG/ML PROLEUKIN INJ 22MU
PROSOL INJ 20% PULMICORT SUS 1MG/2ML
PULMOZYME SOL 1MG/ML RABAVER INJ
RAPAMUNE SOL 1MG/ML RECOMBIVA HB INJ 10MCG/ML
RECOMBIVA HB INJ 5MCG/0.5 SYRINGE RECOMBIVA HB INJ 5MCG/0.5 VAIL
RECOMBIVA-HB INJ 40MCG/ML REMODULIN INJ 10MG/ML
REMODULIN INJ 1MG/ML REMODULIN INJ 2.5MG/ML
REMODULIN INJ 5MG/ML SANDIMMUNE CAP 100MG
SANDIMMUNE CAP 25MG SANDIMMUNE SOL 100MG/ML
SIMULECT INJ 20MG SIROLIMUS TAB 0.5MG
SIROLIMUS TAB 1MG SIROLIMUS TAB 2MG
TACROLIMUS CAP 0.5MG TACROLIMUS CAP 1MG
TACROLIMUS CAP 5MG TAXOTERE INJ 20MG/ML
TET/DIP TOX INJ 2-2 LF THIOTEPA INJ 15MG
THYMOMEGLOBULN INJ 25MG TOBRAMYCIN NEB 300/5ML
TOPOSAR INJ 100/5ML TOPOTECAN INJ 4MG/4ML
TORISEL SOL 25MG/ML TPN ELECTROL INJ
TRAVASOL INJ 10% TREANDA INJ 25MG
TREANDA INJ 45/0.5ML TRELSTAR INJ 11.25MG
TREXALL TAB 10MG TRELSTAR MIX INJ 22.5MG
TREXALL TAB 5MG TREXALL TAB 7.5MG
TRISENOX SOL 10MG/10M TROPHAMINE INJ 10%
UVADEX INJ 20MCG/ML VECTIBIX INJ 100MG
VELCADE INJ 3.5MG VENTAVIS SOL 20MCG/ML
VINBLASTINE INJ 1MG/ML VINCASAR PFS INJ 1MG/ML
VINCRIStINE INJ 1MG/ML VINORELBINE INJ 10MG/ML
ZANOSAR INJ 1GM ZOLEDRONIC INJ 4MG/5ML
ZORTRESS TAB 0.25MG ZORTRESS TAB 0.5MG
ZORTRESS TAB 0.75MG

COVERED USES
This medication requires review for determination of coverage under Medicare Part B or Medicare Part D.

Formulary ID 16384, Ver 9
Last Updated 03/22/2016
Effective 04/01/2016
EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
None

OTHER CRITERIA
N\A
CARE N’ CARE HEALTH PLAN
2016 Prior Authorization Criteria

PCSK9 INHIBITOR

PRODUCT(s) AFFECTED
- PRALUENT INJ 150MG/ML
- PRALUENT INJ 75MG/ML
- REPATHA INJ 140MG/ML
- REPATHA SURE INJ 140MG/ML

COVERED USES
All medically accepted indications not otherwise excluded form Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
FOR PRALUENT: MUST MEET CRITERIA #1 OR #3. FOR REPATHA: MUST MEET CRITERIA #1, #2 OR #3. 1. Diagnosis of heterozygous familial hypercholesterolemia (HeFH) confirmed by genotyping OR Simon Broome criteria: Total cholesterol greater than 290mg/dL or LDL cholesterol greater than 190mg/dL, PLUS ONE OF THE FOLLOWING: Tendon xanthomas in patient, or 1st degree relative (parent, sibling, child), or 2nd degree relative (grandparent, uncle, aunt) OR DNA-based evidence of LDL receptor mutation, familial defective apo B-100, or PCSK9 mutation 2. Diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genotyping OR diagnosis based on the following: a. History of untreated LDL-C greater than 500 mg/dL AND xanthoma before 10 years of age OR b. Documentation of HeFH in both parents 3. Diagnosis of clinical atherosclerotic cardiovascular disease (CVD) as defined as one of the following: a. acute coronary syndrome, b. history of myocardial infarction, c. stable/unstable angina, d. coronary or other arterial revascularization, e. stroke, f. transient ischemic stroke (TIA), g. peripheral arterial disease presumed to be atherosclerotic region. AND MEETS CRITERIA #4, #5, and #6, 4. Provide baseline and current LDL-C 5. LDL-C greater than or equal to 100 mg/dL 6. Used in combination with maximally tolerated high-intensity statin OR MEETS CRITERIA #7 AND #8. 7. Statin intolerant 8. LDL-C greater than or equal to 100 mg/dL CONTINUING THERAPY: 1. Documented response to Praluent or Repatha, defined as ONE of the following: a. The patient is tolerating medication b. Will continue to be used in combination with maximally tolerated statin (unless statin intolerant).

AGE RESTRICTION
Repatha: 13 years of age or older for diagnosis HoFM, Diagnosis CVD or HeFH AND Praluent or Repatha : 18 years of age or older

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist

COVERAGE DURATION
Initial approval: 8 weeks, Renewal approval: Plan Year

Formulary ID 16384, Ver 9
Last Updated 03/22/2016
Effective 04/01/2016
OTHER CRITERIA
Initial approval: 8 weeks, Renewal approval: Plan Year
PEGASYS

PRODUCT(s) AFFECTED
- PEGASYS INJ
- PEGASYS INJ PROCLICK 135 MCG/0.5 ML
- PEGASYS INJ 180MCG/M
- PEGASYS INJ PROCLICK 180 MCG/0.5 ML

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Decompensated liver disease. Autoimmune hepatitis. Concomitant administration of didanosine with ribavirin in patients coinfected with HIV.

REQUIRED MEDICAL INFORMATION
Diagnosis of hepatitis C for initial therapy with Sovaldi in patients with genotype 3, 4, 5, or 6 OR retreatment of genotypes 2, 3, 4, 5, or 6. OR Diagnosis of chronic hepatitis B and evidence of hepatitis B viral replication and patient has been serum hepatitis B surface antigen (HBsAg)-positive for at least 6 months.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
ID specialist, Gastroenterologist, Oncologist

COVERAGE DURATION
HCV: 12 weeks to 72 weeks total depending on genotype and initial vs. renewal therapy. HBV: 48 weeks.

OTHER CRITERIA
Monitor for evidence of depression.
PEGINTRON

PRODUCT(s) AFFECTED
- PEG-INTRON KIT 120 RP  PEG-INTRON KIT 120MCG
- PEG-INTRON KIT 150 RP  PEG-INTRON KIT 150MCG
- PEG-INTRON KIT 50MCG PEG-INTRON KIT 50MCG RP
- PEG-INTRON KIT 80MCG PEG-INTRON KIT 80MCG RP

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Decompensated liver disease. Autoimmune hepatitis. Concomitant administration of didanosine with ribavirin in patients coinfected with HIV.

REQUIRED MEDICAL INFORMATION
Diagnosis of hepatitis C for initial therapy with Sovaldi in patients with genotype 3, 4, 5, or 6 OR retreatment of genotypes 2,3,4,5, or 6. HCV: Prior to initiating therapy, detectable levels of HCV RNA in the serum.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
ID specialist, Gastroenterologist, Oncologist

COVERAGE DURATION
12 weeks to a total 72 weeks depending on genotype and initial vs. renewal therapy.

OTHER CRITERIA
Monitor for evidence of depression.
CARE N’ CARE HEALTH PLAN
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PROLIA

PRODUCT(s) AFFECTED
- PROLIA SOL 60MG/ML

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Hypocalcemia

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Patient will be adequately supplemented with calcium and vitamin D.
PROMACTA

PRODUCT(s) AFFECTED
- PROMACTA TAB 12.5MG
  PROMACTA TAB 25MG
- PROMACTA TAB 50MG
  PROMACTA TAB 75MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
For new starts, at the time of diagnosis of ITP or hepatitis C infection associated thrombocytopenia, one of the following are required: 1) a pretreatment platelet count less than 30,000/microL or 2) a platelet count less than or equal to 50,000/microL with significant mucous membrane bleeding or risk factors for bleeding. Patients must be evaluated for other causes of thrombocytopenia and have had an insufficient response or intolerance to corticosteroids, or immunoglobulins, or splenectomy. For continuation of therapy, one of the following are required: 1) an increase in platelet count to greater than or equal to 50,000/microL or 2) an increase in platelet level that is sufficient to avoid clinically important bleeding after at least 4 weeks of Promacta at the maximum dose. For all patients receiving Promacta therapy, if platelets increase above 200,000/microL, therapy will be adjusted to maintain the minimal platelet count needed to reduce the risk for bleeding. Liver function must be assessed pretreatment and regularly throughout therapy. To continue Promacta therapy, alanine aminotransferase levels must not be greater than or equal to 3 times the upper limit of normal with any of the following characteristics: progressive, persistent, accompanied by increased bilirubin or symptoms of liver injury or evidence of hepatic decompensation.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
6 month initial, 12 month renewal if adequate platelet response, 3 month w/o platelet response

OTHER CRITERIA
N/A
PROVIGIL

PRODUCT(s) AFFECTED
- MODAFINIL TAB 100MG
- MODAFINIL TAB 200MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
If diagnosis of Shift Work Sleep Disorder frequently (5 times or more per month) AND experience excessive sleepiness while working. If diagnosis of mild obstructive sleep apnea/hypopnea syndrome and whether patient is using and compliant with an oral appliance

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A
REGRANEX

PRODUCT(s) AFFECTED
- REGRANEX GEL 0.01%

COVERED USES
All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Diabetic Neuropathic Ulcers: Diabetic patient with ulcer wound. Treatment will be given in combination with ulcer wound care (eg, debridement, infection control, and/or pressure relief).

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Diabetic Neuropathic Ulcers: Maximum 5 months.

OTHER CRITERIA
N\A
RELISTOR

PRODUCT(s) AFFECTED
- RELISTOR INJ 12/0.6ML SYRINGE  RELISTOR INJ 12/0.6ML VIAL
  RELISTOR INJ 8/0.4ML

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Mechanical gastrointestinal obstruction, known or suspected.

REQUIRED MEDICAL INFORMATION
A. Relistor is being prescribed for treatment of 1) opioid-induced constipation in adult patients with chronic non-cancer pain OR 2) opioid-induced constipation in adult patients with advanced illness who are receiving palliative care, when response to laxative therapy has not been sufficient. AND
B. patient must have previous trial/failure of polyethylene glycol.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
4 Months

OTHER CRITERIA
N\A
REVATIO

PRODUCT(s) AFFECTED
- SILDENAFIL TAB 20MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Nitrate therapy

REQUIRED MEDICAL INFORMATION
Diagnosis of pulmonary arterial hypertension (PAH), (WHO Group 1). PAH been confirmed by right heart catheterization. If patient is an infant, PAH diagnosed by Doppler echocardiogram.

AGE RESTRICTION

PRESCRIBER RESTRICTION

COVERAGE DURATION
Plan Year

OTHER CRITERIA
REVLIMID

PRODUCT(s) AFFECTED
- REVLIMID CAP 10MG
  REVLIMID CAP 15MG
- REVLIMID CAP 2.5MG
  REVLIMID CAP 20MG
- REVLIMID CAP 25MG
  REVLIMID CAP 5MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Pregnancy

REQUIRED MEDICAL INFORMATION
For active myeloma, patient meets one of the following: 1) Revlimid is used after at least one prior therapy or as salvage therapy. 2) Revlimid is used with dexamethasone as primary induction therapy or in combination with melphalan and prednisone in nontransplant candidates. 3) Revlimid is used as maintenance monotherapy following response to either stem cell transplant or primary induction therapy. For Low or Intermediate-1 Risk myelodysplastic syndrome (MDS): for those with 5q deletion, patients should have transfusion-dependent anemia or symptomatic anemia with clinically significant cytopenias. For those with non-5q deletion MDS and symptomatic anemia, patients should have failed to respond to epoetin alfa or darbepoetin or have a pretreatment serum erythropoietin levels greater than 500 mU/mL and a low probability of response to immunosuppressive therapy. For female patients of childbearing potential, pregnancy is excluded by 2 negative serum or urine pregnancy tests. For all patients, complete blood counts are monitored for hematologic toxicity while receiving Revlimid.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Male and female patients of child-bearing potential should be instructed on the importance of proper utilization of appropriate contraceptive methods for Revlimid use. Patients should be monitored for signs and symptoms of thromboembolism.
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REXULTI

PRODUCT(s) AFFECTED
- REXULTI TAB 0.25MG
- REXULTI TAB 1MG
- REXULTI TAB 3MG
- REXULTI TAB 4MG
- REXULTI TAB 0.5MG
- REXULTI TAB 2MG

COVERED USES
All Medically Accepted Indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Statement of Diagnosis from the prescriber and documented trial and failure, contraindication, or intolerance to aripiprazole

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
RIBAVIRIN

PRODUCT(s) AFFECTED
- REBETOL SOL 40MG/ML
- RIBAPAK PAK 800/DAY
- RIBASPHERE TAB 200MG
- RIBASPHERE TAB 600MG
- RIBAVIRIN CAP 200MG
- RIBAPAK PAK 1000/DAY
- RIBASPHERE CAP 200MG
- RIBASPHERE TAB 400MG
- RIBATAB TAB 1200/DAY
- RIBAVIRIN TAB 200MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Hemoglobin less than 8.5 g/dL. Hemoglobinopathy. History of unstable heart disease. Creatinine clearance less than 50 mL/minute and unwilling to use modified dose of ribavirin. Pregnancy (self or partner). Unwilling to use effective contraception. Coadministration with didanosine in HIV coinfected patients.

REQUIRED MEDICAL INFORMATION
Chart notes / written medical summary documenting diagnosis of Chronic HCV are required. Recent lab reports documenting elevated HCV RNA are required, along with genotype.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
ID specialist, gastroenterologist, or oncologist

COVERAGE DURATION
12 weeks to a total 72 weeks depending on genotype and initial vs. renewal therapy.

OTHER CRITERIA
Patient has been instructed to practice effective contraception during therapy and for six months after stopping ribavirin therapy.
RITUXAN

PRODUCT(s) AFFECTED
- RITUXAN INJ 100MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
History of severe skin or infusion reaction with Rituxan than cannot be appropriately managed, use in combination with another biologic agent

REQUIRED MEDICAL INFORMATION
For rheumatoid arthritis (RA): an inadequate response to MTX or another nonbiologic DMARD if MTX is contraindicated or not tolerated except when RA is severely active and frontline Rituxan therapy is warranted AND an inadequate response to a TNF antagonist (unless contraindicated). For continuation of RA therapy, improvement in clinical symptoms (may include improvement in tender and swollen joint count, mobility, or stiffness, or delay in progression of disease) is required from the last treatment course, which was at least 16 weeks earlier. Hematologic malignancies must be positive for CD20. Rituxan must be used in combination with chemotherapy for mantle cell lymphoma (or other agents), Burkitt's lymphoma, lymphoblastic lymphoma, and AIDS-related B-cell lymphoma. Induction therapy for Burkitt's lymphoma. Prior to initiating therapy, prescriber must have assessed the patient's risk for hepatitis B and, if appropriate, ruled out or initiated treatment for hepatitis B.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Monitored for pulmonary toxicity
SAMSCA

PRODUCT(s) AFFECTED
- SAMSCA TAB 15MG
- SAMSCA TAB 30MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Patients with anuria, patients requiring an urgent increase in serum sodium, patients unable to sense and respond to thirst, concomitant use of a strong CYP 3A inhibitor (e.g., clarithromycin, ketoconazole).

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Samsca must be initiated or re-initiated in a hospital setting.
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SANDOSTATIN LAR

PRODUCT(s) AFFECTED
- SANDOSTATIN KIT LAR 10MG
  SANDOSTATIN KIT LAR 20MG
  SANDOSTATIN KIT LAR 30MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Patient received initial treatment with Sandostatin Injection (not the Depot form) for at least 2 weeks and treatment with Sandostatin Injection was effective and tolerable.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
SEROSTIM

PRODUCT(s) AFFECTED
- SEROSTIM INJ 4MG
- SEROSTIM INJ 5MG
- SEROSTIM INJ 6MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Acute critical illness, active malignancy.

REQUIRED MEDICAL INFORMATION
Patient is on concurrent antiretroviral therapy and alternative causes of wasting have been ruled out or treated appropriately. For continuation of therapy, patients treated for 12 or more weeks with Serostim must show a response to therapy (body mass index has improved or stabilized).

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
12 weeks

OTHER CRITERIA
N/A
PRODUCT(s) AFFECTED
- SIMPONI INJ 50/0.5ML

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Active infection (including TB). Concurrent therapy with other biologics.

REQUIRED MEDICAL INFORMATION
Screening for latent TB infection and assessment for Hep B risk. For positive latent TB, patient must have completed treatment or is currently receiving treatment for LTBI. HBV infection ruled out or treatment initiated for positive infection. Rheumatoid arthritis - Must have one of following: 1) inadequate response to methotrexate (MTX), 2) inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX, 3) intolerance or contraindication to at least 2 nonbiologic DMARDs or, 4) use Simponi as first-line therapy with MTX for severely active RA. Ankylosing spondylitis - Inadequate response or intolerance/contraindication to at least 2 NSAIDs.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
For re-authorization, patient's condition must have improved or stabilized.
SOLVALDI

PRODUCT(s) AFFECTED
- SOVALDI TAB 400MG

COVERED USES
All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Must have genotype 1,2,3,4,5, or 6

AGE RESTRICTION
Patient must be age 18 or over.

PRESCRIBER RESTRICTION
Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist

COVERAGE DURATION
12,16,24, or 48 wks based on genotype, cirrhosis status, transplant status, & previous/concurrent tx

OTHER CRITERIA
For genotypes 2,3, 4, 5, and 6 patient must be taking ribavirin with Sovaldi.
SOMATULINE DEPOT

PRODUCT(s) AFFECTED
- SOMATULINE INJ 120/.5ML
- SOMATULINE INJ 60/0.2ML
- SOMATULINE INJ 90/0.3ML

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
SOMAVERT

PRODUCT(s) AFFECTED
- SOMAVERT INJ 10MG
  SOMAVERT INJ 15MG
  SOMAVERT INJ 20MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
IV administration of Somavert, concomitant use of Sandostatin or Somatuline.

REQUIRED MEDICAL INFORMATION
Diagnosis of acromegaly was confirmed by an elevated IGF-1 level or elevated GH level with a glucose tolerance test. Patient has tried and failed at least a 3 month trial of Sandostatin or Somatuline. For renewal, reduction in IGF-1 level from baseline.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
Endocrinologist

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A
SORIATANE

PRODUCT(s) AFFECTED
- ACITRETIN CAP 10MG
- ACITRETIN CAP 17.5MG
- ACITRETIN CAP 25MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Severely impaired liver function, severely impaired kidney function, chronic abnormally elevated blood lipid values, currently taking methotrexate or tetracycline.

REQUIRED MEDICAL INFORMATION
1. If the patient is female and able to bear children (e.g., no hysterectomy, not reached menopause, has achieved menses). AND 2. the patient is unresponsive to other therapies for this diagnosis OR the other therapies for the treatment of this diagnosis are contraindicated due to the clinical condition of the patient AND 3. pregnancy has been excluded as confirmed by 2 negative urine or serum pregnancy tests with a sensitivity of at least 25 mIU/mL. AND 4. the patient has chosen to use any of the following methods of contraception: one primary form (e.g., tubal ligation, partner’s vasectomy, intrauterine devices, birth control pills, injectable/implantable/insertable/topical hormonal birth control products) plus one secondary form (e.g., diaphragms, latex condoms, cervical caps) used in combination with a spermicide OR absolute abstinence AND 5. the patient has agreed to use her chosen form of contraception for at least 1 month before initiation of acitretin therapy, during acitretin therapy, and for at least 3 years after discontinuation of therapy AND 6. the patient has been advised that ethanol must not be ingested by female patients during acetretin treatment and for 2 months following therapy AND 7. the patient will have a negative pregnancy test on a monthly basis.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Female patient or guardian signed a Patient Agreement/Informed Consent.
STELARA

PRODUCT(s) AFFECTED
- STELARA INJ 45MG/0.5 STELARA INJ 90MG/ML

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Active infection (including tuberculosis), concurrent use with other biologics

REQUIRED MEDICAL INFORMATION
Screening for latent tuberculosis. If results are positive, patient must have completed treatment or is currently receiving treatment for latent tuberculosis. Must have more than 10% BSA affected or has crucial body areas (e.g., feet, hands, face) affected. Patient must have an inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., phototherapy, calcipotriene, methotrexate, acitretin) unless contraindicated or intolerant to such therapies. Approved for diagnosis of active psoriatic arthritis.

AGE RESTRICTION
18 years of age and older

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
For renewal, patient's condition must have improved or stabilized.
STIVARGA

PRODUCT(s) AFFECTED
- STIVARGA TAB 40MG

COVERED USES
All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Supporting statement of diagnosis from the physician

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
STRATTERA

PRODUCT(s) AFFECTED
- STRATTERA CAP 100MG STRATTERA CAP 10MG
  STRATTERA CAP 18MG STRATTERA CAP 25MG
  STRATTERA CAP 40MG STRATTERA CAP 60MG
  STRATTERA CAP 80MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
MAOI concurrent use or within the last 14 days

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
6 years of age and older

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Monitor for suicidality, clinical worsening, changes in behavior, blood pressure changes, heart rate changes, liver injury.
SYMLIN

PRODUCT(s) AFFECTED
- SYMLINPEN 60 INJ 1000MCG    SYMLINPEN 120 INJ 1000MCG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Severe hypoglycemia that required assistance during the past 6 months, gastroparesis, patient requires drug therapy to stimulate gastrointestinal motility, the presence of hypoglycemia unawareness (i.e., inability to detect and act upon the signs or symptoms of hypoglycemia).

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
The patient must have inadequate glycemic control (HbA1c greater than 7% but less than 9%) at initiation of therapy, patient currently receiving optimal mealtime insulin therapy. If taking Symlin in previous 6 months, patient demonstrated a reduction in HbA1c since initiating Symlin therapy.
TESTOSTERONES

PRODUCT(s) AFFECTED

- ANDRODERM DIS 2MG/24HR
- ANDROGEL GEL 20.25MG/1.25GM 1.62%
- ANDROGEL GEL PUMP 1.62%
- FORTESTA GEL 10MG/ACT
- TESTOSTERONE GEL 1%(25MG)
- ANDRODERM DIS 4MG/24HR
- ANDROGEL GEL 40.5MG/2.5GM 1.62%
- AXIRON SOL 30MG/ACT
- TESTIM GEL 1%(50MG)

COVERED USES

All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

Female, prostate cancer, breast cancer.

REQUIRED MEDICAL INFORMATION

Before the start of testosterone therapy patient has (or patient currently has) a confirmed low testosterone level (i.e. total testosterone less than 300 ng/dL, free or bioavailable, testosterone less than 5 ng/dL) or absence of endogenous testosterone.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Plan Year

OTHER CRITERIA

N/A
THALOMID

PRODUCT(s) AFFECTED
- THALOMID CAP 100MG
- THALOMID CAP 150MG
- THALOMID CAP 200MG
- THALOMID CAP 50MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Pregnancy

REQUIRED MEDICAL INFORMATION
For active myeloma, patient meets one of the following: 1) Thalomid is used as salvage or palliative therapy. 2) Thalomid is used for newly diagnosed disease or as primary induction therapy in combination with dexamethasone or in combination with melphalan and prednisone in nontransplant candidates. 3) Thalomid is used as maintenance monotherapy following response to either stem cell transplant or primary induction therapy. For female patients of childbearing potential, pregnancy is excluded by a negative pregnancy test.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Patients are monitored for signs and symptoms of thromboembolism. Male and female patients of child-bearing potential are instructed on the importance of proper utilization of appropriate contraceptive methods.
TOPICAL IMMUNOSUPPRESSANT

PRODUCT(s) AFFECTED
- ELIDEL CRE 1%  
  TACROLIMUS OIN 0.03%
  TACROLIMUS OIN 0.1%

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
A. The diagnosis is documented as atopic dermatitis or eczema. B. AND patients must be at least 2 years of age C. AND patients who have completed a documented trial and failure of at least two medium or higher potency topical steroids or have documented intolerance or unresponsiveness to medium or higher potency topical steroids D. AND patients have been advised that Elidel and tacrolimus should only be used to treat the immediate problem and then should be stopped when the condition improves.

AGE RESTRICTION
Elidel and tacrolimus 0.03%: 2 years of age and older, tacrolimus 0.1%: 16 years of age and older

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A
TRACLEER

PRODUCT(s) AFFECTED
- TRACLEER TAB 125MG
- TRACLEER TAB 62.5MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
AST/ALT level greater than 3 times upper limit of normal (ULN). Pregnancy. Concomitant use of cyclosporine A or glyburide.

REQUIRED MEDICAL INFORMATION
PAH confirmed by right heart catheterization. NYHA Class II-IV symptoms.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Female patients of childbearing potential must use more than one method of contraception concurrently.
TYSABRI

PRODUCT(s) AFFECTED
- TYSABRI INJ 300/15ML

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Tysabri will be used as monotherapy. For MS, inadequate response or intolerance to other MS therapies.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
MS - 12 months. CD, initial - 3 months, renewal - 12 months.

OTHER CRITERIA
For Crohn's disease renewal, patient's condition has improved or stabilized on treatment.
TYZEKA

PRODUCT(s) AFFECTED
- TYZEKA TAB 600MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
A. The patient has been diagnosed with chronic hepatitis B. B. AND the patient has evidence of a positive HBsAg (+ or -) serological marker for greater than 6 months OR evidence by a liver biopsy showing chronic hepatitis. C. AND the patient has a Hepatitis B viral load greater than 20,000 IU/mL (100,000 copies per mL) except if for HBeAg-negative HBV, the viral load is greater than 2,000 IU per mL (10,000 copies per mL). D. AND the patient has elevations in liver aminotransferases (ALT or AST) that are two (2) times greater than normal OR normal liver aminotransferase (ALT or AST) levels with evidence of significant disease found on biopsy. E. AND the patient has been tested for HIV and is negative. F. AND if the patient has received previous Tyzeka treatment, there is documented clinical improvement shown by a drop in viral load or reduction in the patient's liver aminotransferases. G. AND the patient is not receiving duplicate therapy that includes Baraclude, Epivir and/or Intron A. H. AND evidence of diagnosis, serological markers or liver biopsy, viral load, and liver aminotransferases is documented in patient's chart.

AGE RESTRICTION
16 years of age and older

PRESCRIBER RESTRICTION
Infectious Disease specialist or Gastroenterologist or affiliated with an infectious disease or gastroenterology practice or a primary care physician with experience in treating HBV

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
VIMPAT

PRODUCT(s) AFFECTED

- VIMPAT INJ 200MG/20
- VIMPAT TAB 100MG
- VIMPAT TAB 200MG
- VIMPAT SOL 10MG/ML
- VIMPAT TAB 150MG
- VIMPAT TAB 50MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Supporting statement of diagnosis from the physician

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Plan Year

OTHER CRITERIA

N/A
VPRIV

PRODUCT(s) AFFECTED
- VPRIV INJ 400UNIT

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Concomitant use of miglustat (Zavesca)

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed by bone marrow histology, DNA testing, or measurement of beta-glucocerebrosidase enzyme activity of less than 30 percent. Patient must have at least one of the following conditions as a result of Type 1 Gaucher disease: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly. Patients who have previously received 24 months of VPRIV therapy must have one of the following responses to continue therapy: 1) A decrease in liver and spleen volume 2) An increase in platelet count, or 3) An increase in hemoglobin concentration.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A
CARE N’ CARE HEALTH PLAN  
2016 Prior Authorization Criteria

XENAZINE

PRODUCT(s) AFFECTED
- TETRABENAZIN TAB 12.5MG  TETRABENAZIN TAB 25MG
  XENAZINE TAB 12.5MG  XENAZINE TAB 25MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Patients with untreated or inadequately treated depression or who are actively suicidal, history of hepatic disease, use in combination with MAO inhibitors or reserpine (or it has been less than 20 days since reserpine was discontinued).

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
CARE N’ CARE HEALTH PLAN
2016 Prior Authorization Criteria

XGEVA

PRODUCT(s) AFFECTED
- XGEVA INJ

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Uncorrected hypocalcemia

REQUIRED MEDICAL INFORMATION
1.) Patient has bone metastases from a solid tumor. To prevent hypocalcemia, patients will receive concurrent calcium and vitamin D supplementation as needed. OR 2.) Patient has giant cell tumor of the bone that is unresectable or where surgical resection is likely to result in severe morbidity. OR 3.) Patient has hypercalcemia of malignancy refractory to bisphosphonate therapy

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A
CARE N’ CARE HEALTH PLAN
2016 Prior Authorization Criteria

XIFAXAN

PRODUCT(s) AFFECTED
- XIFAXAN TAB 200MG
- XIFAXAN TAB 550MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
18 years of age and older (Xifaxan 550mg)

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Hepatic encephalopathy-6 months

OTHER CRITERIA
N\A
XOLAIR

PRODUCT(s) AFFECTED
- XOLAIR SOL 150MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Patient must meet all of the following criteria for Xolair use: 1) Patient has evidence of reversible disease (demonstrates at least 20 percent improvement in PEF with a short-acting bronchodilator challenge). 2) Patient has experienced two or more asthma exacerbations per month within the last three months. 3) Patient had a positive skin test to at least one perennial aeroallergen. 4) Baseline IgE level at or above 30 IU/mL. 5) Patient's asthma is inadequately controlled despite adherent use of inhaled corticosteroids. 6) Patient had an inadequate response to a trial of a leukotriene modifier or long-acting beta2-agonist (unless patient demonstrates intolerance to the therapeutic trial).

AGE RESTRICTION
12 years of age and older

PRESCRIBER RESTRICTION
Pulmonologist, allergist or immunologist

COVERAGE DURATION
Plan Year

OTHER CRITERIA
To continue therapy, patients must demonstrate an improvement in asthma control with use of Xolair.
XTANDI

PRODUCT(s) AFFECTED
- XTANDI CAP 40MG

COVERED USES
All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
Supporting statement of diagnosis from the physician and prior trial and failure of docetaxel

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N\A
PRODUCT(s) AFFECTED

- XYREM SOL 500MG/ML

COVERED USES

All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

If the patient is taking/receiving any of the following: anxiolytics, sedatives, hypnotics, barbiturates, benzodiazepines or ethanol.

REQUIRED MEDICAL INFORMATION

A. The diagnosis is documented as excessive daytime sleepiness with symptoms that limit their ability to perform normal daily activities OR the diagnosis is documented as cataplexy (a condition characterized by weak or paralyzed muscles) in patients with narcolepsy. C. AND if the patient has received prior treatment with Xyrem, the patient must experience a decrease in daytime sleepiness and/or cataplexy in a narcoleptic patient.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

3 months

OTHER CRITERIA

N\A
ZAVESCA

PRODUCT(s) AFFECTED
- ZAVESCA CAP 100MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Severe renal impairment. Pregnancy.

REQUIRED MEDICAL INFORMATION
Diagnosis confirmed by bone marrow histology, DNA testing, or b-glucocerebrosidase enzyme assay (enzyme activity less than 30 percent). Trial of enzyme replacement therapy (ERT) or ERT is not a therapeutic option (eg, allergy, poor venous access). Female patients of childbearing age will use an effective method of contraception. Female patients of childbearing age will be educated about the potential hazards associated with Zavesca use in pregnancy (ie, potential harm to fetus). Must demonstrate a decrease in liver and spleen volume and/or increase in platelet count and/or increase in Hgb concentration in patients who received at least 24 months of Zavesca therapy.

AGE RESTRICTION
18 years of age and older

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
N/A
ZORBTIVE

PRODUCT(s) AFFECTED
- ZORBTIVE INJ 8.8MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Active malignancy (newly diagnosed or recurrent), acute critical illness due to complications following open heart or abdominal surgery, accidental trauma or acute respiratory failure

REQUIRED MEDICAL INFORMATION
For continuation of therapy, patient show a response to Zorbtive therapy (e.g., requirements for nutritional support have decreased or the patient’s weight has stabilized or increased).

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
4 weeks initial, 4 weeks renewal (up to a lifetime maximum of 8 weeks)

OTHER CRITERIA
N\A
ZYTIGA

PRODUCT(s) AFFECTED
- ZYTIGA TAB 250MG

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
None

PRESCRiber RESTRICTION
None

COVERAGE DURATION
Plan Year

OTHER CRITERIA
Used in combination with prednisone. Received prior chemotherapy containing docetaxel.