Prior Authorization Requirements

Effective: 01/01/2017
Essence Advantage (HMO), Essence Advantage Plus (HMO), CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
5HT3 ANTI-NAUSEA AGENT BVD DETERMINATION

DRUG NAME
GRANISETRON HCL | ONDANSETRON HCL | ONDANSETRON ODT

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
ABATACEPT IV

DRUG NAME
ORENCIA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
RENEWAL: RHEUMATOID ARTHRITIS, JUVENILE IDIOPATHIC ARTHRITIS: PATIENT HAS EXPERIENCED OR MAINTAINED A 20% IMPROVEMENT IN TENDER OR SWOLLEN JOINT COUNT WHILE ON THERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
RHEUMATOID ARTHRITIS, JUVENILE IDIOPATHIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.

COVERAGE DURATION
INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA
INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. JUVENILE IDIOPATHIC ARTHRITIS (JIA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH KINERET (ANAKINRA) OR A TNF (TUMOR NECROSIS FACTOR) INHIBITOR SUCH AS HUMIRA, ENBREL, CIMZIA, REMICADE, SIMPONI, OR SIMPONI ARIA.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
ABATACEPT SQ

DRUG NAME
ORENCIA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
RENEWAL: RHEUMATOID ARTHRITIS: PATIENT HAS EXPERIENCED OR MAINTAINED A 20% IMPROVEMENT OR GREATER IN TENDER OR SWOLLEN JOINT COUNT WHILE ON THERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
RHEUMATOID ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.

COVERAGE DURATION
INITIAL: 4 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA
INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL WITH HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENTS SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH KINERET (ANAKINRA), OR A TNF (TUMOR NECROSIS FACTOR) INHIBITOR: HUMIRA, ENBREL, CIMZIA, REMICADE, SIMPONI, OR SIMPONI ARIA.
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
ABIRATERONE

DRUG NAME
ZYTIGA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
ADALIMUMAB

DRUG NAME
HUMIRA | HUMIRA PEDIATRIC CROHN'S | HUMIRA PEN | HUMIRA PEN CROHN'S-UC-HS

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
AFATINIB DIMALEATE

DRUG NAME
GILOTRIF

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
ALECTINIB

DRUG NAME
ALECENSA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
ALIROCUMAB

DRUG NAME
PRALUENT PEN | PRALUENT SYRINGE

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
18 YEARS OF AGE AND OLDER.

PREScriBER RESTriCTIONS
CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST

COVERAGE DURATION
INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA
MUST HAVE A LDL CHOLESTEROL LEVEL GREATER THAN 100MG/DL WHILE ON MAXIMAL DRUG TREATMENT FOR THE PAST 2 MONTHS AND ONE OF THE FOLLOWING DIAGNOSES: (1) HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH) DETERMINED BY SIMON BROOME DIAGNOSTIC CRITERIA FOR HEFH OR A SCORE OF 6 OR GREATER ON THE DUTCH LIPID NETWORK CRITERIA FOR HEFH OR (2) HISTORY OF ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD) AS DOCUMENTED BY PHYSICIAN ATTESTATION. PATIENT MUST NOT HAVE CONCURRENT USE OF REPATHA OR OTHER PCSK9 AGENT. INITIAL THERAPY: FOR STATIN TOLERANT PATIENTS: MUST HAVE TAKEN ATORVASTATIN OR ROSUVASTATIN FOR THE PAST 2 MONTHS. FOR STATIN INTOLERANT PATIENTS: DOCUMENTATION OF STATIN INTOLERANCE BY
Prior Authorization Requirements

ONE OF THE FOLLOWING: (1) PHYSICIAN ATTESTATION, (2) PATIENT HAS TRIED ROSUVASTATIN, ATORVASTATIN, OR STATIN THERAPY AT ANY DOSE AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY). PATIENTS WITH CONTRAINDICATIONS TO STATINS INCLUDING ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT OR HYPERSENSITIVITY REACTIONS WILL BE APPROVED FOR PRALUENT THERAPY WITHOUT REQUIREMENT OF DOCUMENTATION OF STATIN INTOLERANCE. RENEWAL CRITERIA: RECEIVING PRIOR PRALUENT THERAPY FOR THE PAST 6 MONTHS AND NO CLAIMS FOR REPATHA, JUXTAPI, OR KYNAMRO SINCE PRALUENT APPROVAL.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
ANAKINRA

DRUG NAME
KINERET

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS), CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
APREMILAST

DRUG NAME
OTEZLA

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
APREPITANT BVD DETERMINATION

DRUG NAME
EMEND

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
ASFOTASE

DRUG NAME
STRENSIQ

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
ATEZOLIZUMAB

DRUG NAME
TECENTRIQ

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
AXITINIB

DRUG NAME
INLYTA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
TRIAL OF AT LEAST ONE SYSTEMIC THERAPY FOR THE TREATMENT OF RCC SUCH AS NEXAVAR (SORAFENIB), TORISEL (TEMSIROLIMUS), SUTENT (SUNITINIB), VOTRIENT (PAZOPANIB), OR AVASTIN (BEVACIZUMAB) IN COMBINATION WITH INTERFERON.
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
BACILLUS OF CALMETTE AND GUERIN VACCINE BVD DETERMINATION

DRUG NAME
BCG VACCINE (TICE STRAIN)

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE DEPENDING UPON THE
CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE
USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION

BECAPLERMIN

DRUG NAME
REGANEX

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
BEDAQUILINE FUMARATE

DRUG NAME
SIRTURO

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
18 YEARS OF AGE AND OLDER.

PREScriber restrictions

COVERAGE DURATION
24 WEEKS

OTHER CRITERIA
SIRTURO USED IN COMBINATION WITH AT LEAST 3 OTHER ANTIBIOTICS FOR THE TREATMENT OF PULMONARY MULTI-DRUG RESISTANT TUBERCULOSIS.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
BELIMUMAB

DRUG NAME
BENLYSTA

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
BELINOSTAT

DRUG NAME
BELEODAQ

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
BEVACIZUMAB

DRUG NAME
AVASTIN

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
BEXAROTENE

DRUG NAME
BEXAROTENE | TARGRETIN

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
BORTEZOMIB

DRUG NAME
VELCADE

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
BOSUTINIB

DRUG NAME
BOSULIF

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
CML: BCR-ABL MUTATIONAL ANALYSIS CONFIRMING THAT BOTH T315I AND V299L MUTATIONS ARE NOT PRESENT.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
BOTULINUM NEUROTOXIN

DRUG NAME
BOTOX

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
COSMETIC DIAGNOSIS: WRINKLES.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
MIGRAINE HEADACHE: TRIAL OF TWO OF THE FOLLOWING: BETA BLOCKERS, TRICYCLIC ANTIDEPRESSANTS, OR VALPROIC ACID. OVERACTIVE BLADDER: TRIAL OF OR CONTRAINDICATION TO THE USE OF ONE ANTICHOLINERGIC MEDICATION SUCH AS ORAL OXYBUTYNIN, ORAL OXYBUTYNIN ER, TOLTERODINE, TOLTERODINE ER, TOVIAZ, TROSPUIM, OR TROPSIUM ER.
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
C1 ESTERASE INHIBITOR

DRUG NAME
CINRYZE

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST, IMMUNOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
CABOZANTINIB

DRUG NAME
COMETRIQ

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
CABOZANTINIB S-MALATE - CABOMETYX

DRUG NAME
CABOMETYX

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PATIENT HAS RECEIVED PRIOR ANTIANGIOGENIC THERAPY (E.G., SUTENT [SUNITINIB], VOTRIENT [PAZOPANIB], INLYTA [AXITINIB], NEXAVAR [SORAFENIB])
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
CANAKINUMAB

DRUG NAME
ILARIS

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
CANNABINOID

DRUG NAME
DRONABINOL

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
B VS D COVERAGE CONSIDERATION. PART D COVERAGE CONSIDERATION FOR A DIAGNOSIS OF NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY REQUIRES A TRIAL OF OR CONTRAINDICATION TO CONVENTIONAL ANTIEMETIC THERAPIES SUCH AS ONDANSETRON, STEROIDS INDICATED FOR EMESIS OR EMEND. NO ADDITIONAL REQUIREMENTS FOR A DIAGNOSIS OF ANOREXIA ASSOCIATED WITH WEIGHT LOSS IN PATIENTS WITH AIDS.
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
CERITINIB

DRUG NAME
ZYKADIA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
POSITIVE FOR ANAPLASTIC LYMPHOMA KINASE (ALK) FUSION ONCOGENE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
CERTOLIZUMAB PEGOL

DRUG NAME
CIMZIA

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
CLOBAZAM

DRUG NAME
ONFI

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
TRIAL OF LAMOTRIGINE OR TOPIRAMATE. REQUESTS FOR ORAL SUSPENSION APPROVABLE IF PATIENT IS UNABLE TO SWALLOW OR IS UNDER THE AGE OF 5 YEARS.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
COBIMETINIB FUMARATE

DRUG NAME
COTELLIC

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
CORTICOSTEROID BVD DETERMINATION

DRUG NAME
CORTISONE ACETATE | DEXAMETHASONE | HYDROCORTISONE |
METHYL PREDNISOLONE | PREDNISOLONE SODIUM PHOSPHATE | PREDNISONE

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
CRIZOTINIB

DRUG NAME
XALKORI

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
CYCLOPHOSPHAMIDE BVD DETERMINATION

DRUG NAME
CYCLOPHOSPHAMIDE

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE DEPENDING UPON THE
CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE
USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
CYCLOSPORINE OPHTHALMIC

DRUG NAME
RESTASIS

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED OR RECOMMENDED BY AN OPHTHALMOLOGIST, OPTOMETRIST OR RHEUMATOLOGIST.

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
DABRAFENIB MESYLATE

DRUG NAME
TAFINLAR

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
DACLATASVIR

DRUG NAME
DAKLINZA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
HCV RNA LEVEL WITHIN PAST 6 MONTHS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

COVERAGE DURATION
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

OTHER CRITERIA
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL WITH PREFERRED FORMULARY ALTERNATIVE HARVONI OR SOVALDI (REGIMEN WITH A SINGLE DIRECT ACTING ORAL AGENT) WHERE THAT REGIMEN IS LISTED AS AN ACCEPTABLE REGIMEN FOR THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS
Prior Authorization Requirements

THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). NO APPROVALS FOR CONCURRENT USE WITH ANY OF THESE (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER) MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, OR RIFAMPIN. APPROVAL FOR INTERFERON INELIGIBLE PATIENTS - INTERFERON INELIGIBILITY INCLUDES CONCURRENT DIAGNOSIS OF AUTOIMMUNE HEPATITIS OR OTHER AUTOIMMUNE DISORDER, A KNOWN HYPERSENSITIVITY REACTION (SUCH AS URTICARIA, ANGIOEDEMA, BRONCHOCONSTRICTION AND ANAPHYLAXIS TO ALPHA INTERFERONS, PEG, OR ANY COMPONENT OF PEGINTERFERON), DOCUMENTED DEPRESSION, DECOMPENSATED HEPATIC DISEASE: A BASELINE NEUTROPHIL COUNT BELOW 1,500 PER MICROLITER, A BASELINE PLATELET COUNT BELOW 90,000, OR A BASELINE HEMOGLOBIN BELOW 10G/DL THAT HAS NOT RESPONDED TO TREATMENT.
Essence Advantage (HMO), Essence Platinum (HMO-POS), CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
DALFAMPRIDINE

DRUG NAME
AMPYRA

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
DARATUMUMAB

DRUG NAME
DARZALEX

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
CONCURRENT THERAPY WITH A PROTEASOME INHIBITOR OR AN IMMUNOMODULATORY AGENT

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
DASATINIB

DRUG NAME
SPRYCEL

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PREVIOUSLY-TREATED CHRONIC MYELOID LEUKEMIA (CML) REQUIRES BCR-ABL MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, V299L, T315A, F317L/V/I/C.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
DENOSUMAB-XGEVA

DRUG NAME
XGEVA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
DIAGNOSIS OF MULTIPLE MYELOMA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
DICHLORPHENAMIDE

DRUG NAME
KEVEYIS

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
DICLOFENAC EPOLAMINE

DRUG NAME
FLECTOR

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
DIMETHYL FUMARATE

DRUG NAME
TECFIDERA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
DROXIDOPA

DRUG NAME
NORTHERA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
BLOOD PRESSURE READINGS WHILE THE PATIENT IS SITTING AND ALSO WITHIN 3 MINUTES OF STANDING FROM A SUPINE (LYING FACE UP) POSITION AT BASELINE AND RENEWAL.

AGE RESTRICTIONS
18 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR CARDIOLOGIST

COVERAGE DURATION
INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA
INITIAL: DIAGNOSIS OF ORTHOSTATIC HYPOTENSION AS DOCUMENTED BY A DECREASE OF AT LEAST 20 MMHG IN SYSTOLIC BLOOD PRESSURE OR 10 MMHG DIASTOLIC BLOOD PRESSURE WITHIN THREE MINUTES AFTER STANDING FROM A SITTING POSITION. RENEWAL: PATIENT HAD AN INCREASE IN SYSTOLIC BLOOD PRESSURE FROM BASELINE OF AT LEAST 10 MMHG UPON STANDING FROM A SUPINE (LAYING FACE UP) POSITION.
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
ELBASVIR/GRAZOPREVIR

DRUG NAME
ZEPATIER

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.

EXCLUSION CRITERIA
MODERATE OR SEVERE LIVER IMPAIRMENT (CHILD PUGH B OR C)

REQUIRED MEDICAL INFORMATION
HCV RNA LEVEL WITHIN PAST 6 MONTHS. FOR GENOTYPE 1A TESTING FOR NS5A RESISTANCE-ASSOCIATED POLYMORPHISMS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

COVERAGE DURATION
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

OTHER CRITERIA
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL WITH PREFERRED FORMULARY ALTERNATIVE HARVONI WHERE HARVONI REGIMEN IS LISTED AS AN ACCEPTABLE REGIMEN FOR THE SPECIFIC GENOTYPE
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

PER AASLD/IDSA GUIDANCE UNLESS PATIENT HAS CHRONIC KIDNEY DISEASE,
STAGE 4 OR 5. NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT
PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER
RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE
RECOMMENDATION). PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE
FOLLOWING: PHENYTOIN, CARBAMAZEPINE, RIFAMPIN, EFAVIRENZ,
ATAZANAVIR, DARUNAVIR, LOPINAVIR, SACHINAVIR, TIPRANAVIR,
CYCLOSPORINE, NAFCILLIN, KETOCONAZOLE, MODAFINIL, BOSENTAN,
ETRAVIRINE, ELVITEGRAVIR/COBICISTAT/EMTRICITABINE/TENOFOVIR,
ATORVASTATIN AT DOSES ABOVE 20MG PER DAY OR ROSUVASTATIN AT DOSES
GREATER THAN 10MG PER DAY. NO CONCURRENT USE WITH SOVALDI.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
ELIGLUSTAT TARTRATE

DRUG NAME
CERDELGA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION

ELOTUZUMAB

DRUG NAME
EMPLICITI

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PREScriber restrictions

coverage duration
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
ELTROMBOPAG

DRUG NAME
PROMACTA

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
ENDOTHELIN RECEPTOR ANTAGONISTS

DRUG NAME
LETAIRIS | OPSUMIT | TRACLEER

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST

COVERAGE DURATION
INITIAL AND RENEWAL: 12 MONTHS

OTHER CRITERIA
INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. LETAIRIS: PATIENT DOES NOT HAVE IDIOPATHIC PULMONARY FIBROSIS (IPF) TRACLEER: PATIENT DOES NOT HAVE ELEVATED LIVER ENZYMES (ALT, AST) MORE THAN 3 TIMES UPPER LIMIT OF NORMAL (ULN) OR INCREASES IN BILIRUBIN BY 2 OR MORE TIMES ULN. PATIENT IS NOT CONCURRENTLY TAKING CYCLOSPORINE A OR GLYBURIDE. RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
ENZALUTAMIDE

DRUG NAME
XTANDI

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PREScriber restrictions

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
TRIAL OF OR CONTRAINDICATION TO ZYTIGA (ABIRATERONE ACETATE) IS ALSO REQUIRED IN PATIENTS WHO DO NOT HAVE A CONTRAINDICATION OR INTOLERANCE TO PREDNISONE.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
ERLOTINIB

DRUG NAME
TARCEVA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
ERYTHROPOIESIS STIMULATING AGENTS - EPOETIN ALFA

DRUG NAME
EPOGEN | PROCRIT

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
ERYTHROPOIESIS STIMULATING AGENTS -MIRCERA

DRUG NAME
MIRCERA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESRICBER RESTRICTIONS

COVERAGE DURATION
ANEMIA DUE TO CKD WITH OR WITHOUT DIALYSIS: 12 MONTHS.

OTHER CRITERIA
TRIAL OF PROCRIT. PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
ETANERCEPT

DRUG NAME
ENBREL

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
EVEROLIMUS

DRUG NAME
AFINITOR | AFINITOR DISPERZ

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
ADVANCED RENAL CELL CARCINOMA (RCC): TRIAL OF OR CONTRAINDICATION TO SUTENT OR NEXAVAR.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
EVOLOCUMAB

DRUG NAME
REPATHA SURECLICK | REPATHA SYRINGE

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
FENTANYL NASAL SPRAY

DRUG NAME
LAZANDA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
CANCER: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPiod PAIN MEDICATION (SUCH AS MORPHINE SULFATE SR, OXYCODONE SR, OR FENTANYL). EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE (1) IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT (SUCH AS MORPHINE SULFATE IR, OXYCODONE/ASPIRIN, OXYCODONE/ACETAMINOPHEN, CODEINE/ACETAMINOPHEN, HYDROMORPHONE, OR MEPERIDINE) OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES AND TRIAL OR CONTRAINDICATION TO GENERIC FENTANYL CITRATE LOZENGE.
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
FENTANYL TRANSMUCOSAL AGENTS - FENTANYL CITRATE

DRUG NAME
FENTANYL CITRATE

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
CANCER: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE
OPIOID PAIN MEDICATION (SUCH AS MORPHINE SULFATE SR, OXYCODONE SR, OR
FENTANYL). EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE (1)
IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT (SUCH AS MORPHINE SULFATE IR,
OXYCODONE/ASPIRIN, OXYCODONE/ACETAMINOPHEN,
CODEINE/ACETAMINOPHEN, HYDROMORPHONE, OR MEPERIDINE) OR MEMBER
HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
FINGOLIMOD

DRUG NAME
GILENYA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
GEFITINIB

DRUG NAME
IRESSA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
GLATIRAMER ACETATE

DRUG NAME
COPAXONE | GLATOPA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
GLYCEROL PHENYLIBUTYRATE

DRUG NAME
RAVICTI

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
TRIAL OF OR CONTRAINDICATION TO SODIUM PHENYLIBUTYRATE (BUPHENYL).
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
GOLIMUMAB IV

DRUG NAME
SIMPONI ARIA

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
GOLIMUMAB SQ

DRUG NAME
SIMPONI

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
HEPATITIS B VACCINE BVD DETERMINATION

DRUG NAME
ENGEX-B ADULT | ENGERIX-B PEDIATRIC-adolescent | RECOMBIVAX HB

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE DEPENDING UPON THE
CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE
USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - ANTI-INFECTIVE

DRUG NAME
NITROFURANTOIN | NITROFURANTOIN MONO-MACRO

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
TRIAL OF (UNLESS CONTRAINDICATED TO) SULFAMETHOXAZOLE/TRIMETHOPRIM (TMP-SMX) OR TRIMETHOPRIM. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING A TRIAL OF SULFAMETHOXAZOLE/TRIMETHOPRIM (TMP-SMX) OR TRIMETHOPRIM.
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS -
BENZTROPINE_TRIHEXYPHENIDYL

DRUG NAME
BENZTROPINE MESYLATE | COGENTIN | TRIHEXYPHENIDYL HCL

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING PRESCRIBER ACKNOWLEDGEMENT.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - HYDROXYZINE

DRUG NAME
HYDROXYZINE HCL | HYDROXYZINE PAMOATE

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - PROMETHAZINE

DRUG NAME
PHENADOZ | PROMETHAZINE HCL | PROMETHEGAN

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: TRIAL OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE. ANXIETY: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - BUSPIRONE, PAROXETINE, DULOXETINE, OR VENLAFAXINE. NAUSEA AND VOMITING: PRESCRIBER ACKNOWLEDGEMENT OR AWARENESS THAT THE REQUESTED MEDICATION IS LABELED AS A HIGH-RISK MEDICATION FOR PATIENTS 65 YEARS AND OLDER. MOTION SICKNESS: TRIAL OR CONTRAINDICATION TO MECLIZINE. HOSPICE PATIENTS WILL BE APPROVED WITHOUT TRIAL OF FORMULARY ALTERNATIVES NOR REQUIRING PRESCRIBER ACKNOWLEDGEMENT.
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - BARBITURATE COMBINATIONS

DRUG NAME
ALLZITAL | ASCOMP WITH CODEINE | BUTALB-ACETAMINOPH-CAFF-CODEIN |
BUTALB-CAFF-ACETAMINOPH-CODEINE | BUTALBITAL COMPOUND-CODEINE |
BUTALBITAL-ACETAMINOPHEN | BUTALBITAL-ACETAMINOPHEN-CAFFE |
BUTALBITAL-ASPIRIN-CAFFEINE | TENCON | ZEBUTAL

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING PRESCRIBER ACKNOWLEDGEMENT.
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - CARDIOVASCULAR

DRUG NAME
GUANFACINE HCL

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA

HYPERTENSION: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - BENAZEPRIL, BENAZEPRIL/HYDROCHLOROTHIAZIDE, CAPTOPRIL, CAPTOPRIL/HYDROCHLOROTHIAZIDE, ENALAPRIL, ENALAPRIL/HYDROCHLOROTHIAZIDE, FOSINOPRIL, FOSINOPRIL/HYDROCHLOROTHIAZIDE, LISISNOPRIL, LISISNOPRIL/HYDROCHLOROTHIAZIDE, QUINAPRIL, QUINAPRIL/HYDROCHLOROTHIAZIDE, RAMIPRIL, MOEXIPRIL, MOEXIPRIL/HYDROCHLOROTHIAZIDE, PERINDOPRIL ERBUMINE, TRANDOLAPRIL, TRANDOLAPRIL/VERAPAMIL, LOSARTAN, LOSARTAN/HYDROCHLOROTHIAZIDE, IRBESARTAN, IRBESARTAN/HYDROCHLOROTHIAZIDE, OLMESARTAN, OLMESARTAN/HYDROCHLOROTHIAZIDE,
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

OLMESARTAN/AMLODIPINE/HYDROCHLOROTHIAZIDE, VALSARTAN,
VALSARTAN/HYDROCLOROTHIAZIDE, DILTIAZEM HCL, DILTIAZEM SUSTAINED
RELEASE, VERAPAMIL, VERAPAMIL SUSTAINED RELEASE, ATENOLOL,
ATENOLOL/CHLORTHALIDONE, BISOPROLOL,
BISOPROLOL/HYDROCHLOROTHIAZIDE, CARVEDILOL, METOPROLOL TARTRATE,
NADOLOL, ACEBUTOLOL, BETAXOLOL, LABETALOL, METOPROLOL SUCCINATE,
METOPROLOL/HYDROCHLOROTHIAZIDE, PINDOLOL, PROPRANOLOL,
PROPRANOLOL/HYDROCHLOROTHIAZIDE, SOTALOL, TIMOLOL MALEATE.
HOSPICE PATIENTS ARE APPROVED WITHOUT A TRIAL OF FORMULARY
ALTERNATIVES.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - CENTRAL NERVOUS SYSTEM - THIORIDAZINE

DRUG NAME
THIORIDAZINE HCL

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
SCHIZOPHRENIA - PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING PRESCRIBER ACKNOWLEDGEMENT.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - DIGOXIN

DRUG NAME
DIGITEK | DIGOXIN | LANOXIN

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIGOXIN LEVEL

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
APPROVAL FOR MEMBERS STABLE ON DOSES GREATER THAN 125 MCG PER DAY WITH DOCUMENTED THERAPEUTIC DIGOXIN LEVEL TAKEN WITHIN THE PAST YEAR. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING DIGOXIN LEVELS.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - ESTROGEN

DRUG NAME
COMBIPATCH | DUAVEE | ESTRADIOL | ESTRADIOL-NORETHINDRONE ACETAT | ESTROPIPATE | FYAVOLV | JINTELI | MENEST | MIMVEY | MIMVEY LO | NORETHINDRON-ETHINYL ESTRADIOL | PREMARIN | PREMPHASE | PREMPRO

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
VULVAR/VAGINAL ATROPHY, OSTEOPOROSIS AND VASOMOTOR SYMPTOMS OF MENOPAUSE: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS LABELED AS HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. ALL OTHER FDA APPROVED INDICATIONS NOT PREVIOUSLY MENTIONED IN THIS SECTION, SUCH AS PALLIATIVE TREATMENT, AND HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING PRESCRIBER ACKNOWLEDGEMENT.
Essence Advantage (HMO), Essence Platinum (HMO-POS), 
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - SULFONYLUREAS

DRUG NAME
GLYBURIDE | GLYBURIDE MICRONIZED | GLYBURIDE-METFORMIN HCL

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
TRIAL OF GLIMEPIRIDE, GLIPIZIDE, OR PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS LABELED AS HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT A TRIAL OF FORMULARY ALTERNATIVES.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - INDOMETHACIN

DRUG NAME
INDOMETHACIN

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
A TRIAL OF ONE OF THE FOLLOWING FORMULARY ALTERNATIVES (UNLESS CONTRAINDICATED) IS REQUIRED: 1) CELECOXIB FOR PATIENTS WITH OSTEOARTHRITIS, RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS OR ACUTE PAIN, 2) TRANSDERMAL DICLOFENAC FOR PATIENTS WITH ACUTE PAIN, 3) TOPICAL DICLOFENAC FOR PATIENTS WITH PAIN FROM OSTEOARTHRITIS, 4) COLCHICINE FOR PATIENTS WITH A DIAGNOSIS OF GOUT. A TRIAL OF COLCHICINE WILL BE ACCEPTED IN LIEU OF A FORMULARY NSAID FOR PATIENTS WITH GOUT. A TRIAL OF FORMULARY ALTERNATIVES IS NOT REQUIRED FOR INDOMETHACIN INJECTION PRESCRIBED FOR PATIENTS WITH PATENT DUCTUS ARTERIOSUS. PRESCRIPTIONS WRITTEN BY A RHEUMATOLOGIST DO NOT REQUIRE A TRIAL OF FORMULARY ALTERNATIVES. HOSPICE PATIENTS WILL BE APPROVED WITHOUT A TRIAL OF FORMULARY ALTERNATIVES.
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - NON-BENZODIAZEPINE

DRUG NAME
ESZOPICLONE | ZALEPLON | ZOLPIDEM TARTRATE | ZOLPIDEM TARTRATE ER

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
TRIAL OF SILENOR AND ROZEREM OR PRESCRIBER ACKNOWLEDGEMENT/ AWARENESS THAT THE DRUG IS LABELED AS HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING A TRIAL OF FORMULARY ALTERNATIVES (SILENOR AND ROZEREM) OR PRESCRIBER ACKNOWLEDGEMENT.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - SKELETAL MUSCLE RELAXANTS

DRUG NAME
CARISOPRODOL | CHLORZOXAZONE | CYCLOBENZAPRINE HCL | METAXALL | METAXALONE | METHOCARBAMOL

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING PRESCRIBER ACKNOWLEDGEMENT.
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - TCA

DRUG NAME
AMITRIPTYLINE HCL | CLOMIPRAMINE HCL | DOXEPIN HCL | IMIPRAMINE HCL |
IMIPRAMINE PAMOATE | PERPHENAZINE-AMITRIPTYLINE | SURMONTIL |
TRIMIPRAMINE MALEATE

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY-BENZODIAZEPINE SEDATIVE HYPNOTICS

DRUG NAME
ESTAZOLAM | FLURAZEPAM HCL | TEMAZEPAM | TRIAZOLAM

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
TRIAL OF SILENOR AND ROZEREM OR PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS LABELED AS HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING A TRIAL OF FORMULARY ALTERNATIVES (SILENOR AND ROZEREM) OR PRESCRIBER ACKNOWLEDGEMENT.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
HYDROXYPROGESTERONE CAPROATE-DELALUTIN GENERIC

DRUG NAME
HYDROXYPROGESTERONE CAPROATE

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
IBRUTINIB

DRUG NAME
IMBRUVICA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
IDEALISIB

DRUG NAME
ZYDELI

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS), CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
IMATINIB MESYLATE

DRUG NAME
IMATINIB MESYLATE

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
IMIQUIMOD - ALDARA

DRUG NAME
IMIQUIMOD

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
IMMUNE GLOBULIN BVD DETERMINATION

DRUG NAME
CARIMUNE NF NANOFILTERED | FLEBOGAMMA DIF | GAMASTAN S-D | GAMMAGARD LIQUID | GAMMAPLEX | GAMUNEX-C | OCTAGAM | PRIVIGEN

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
IMMUNOSUPPRESSANT BVD DETERMINATION

DRUG NAME
ASTAGRAF XL | AZATHIOPRINE | AZATHIOPRINE SODIUM | CELLCEPT |
CYCLOSPORINE | CYCLOSPORINE MODIFIED | ENVARSUS XR | GENGRAF |
MYCOPHENOLATE MOFETIL | MYCOPHENOLIC ACID | NULOJIX | PROGRAF |
RAPAMUNE | SIROLIMUS | TACROLIMUS | ZORTRESS

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
INFLIXIMAB

DRUG NAME
REMICADE

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
INFUSIBLE DRUG BVD DETERMINATION

DRUG NAME
ABELCET | ACYCLOVIR SODIUM | ADRUCIL | AMBISOME | AMPHOTERICIN B | BLEOMYCIN SULFATE | CLADRIBINE | DOXORUBICIN HCL LIPOSOME | FLUOROURACIL | GANCICLOVIR SODIUM | IFOSFAMIDE | METHOTREXATE | METHOTREXATE SODIUM | TORISEL | VINBLASTINE SULFATE | VINCASAR PFS | VINCISTINE SULFATE

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
INTERFERON ALFA-2B

DRUG NAME
INTRON A

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEPATITIS C: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST,
PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G.
HEPATOLOGIST). NO REQUIREMENT FOR OTHER FDA APPROVED INDICATIONS.

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
LIMITED TO 1 YEAR OF THERAPY EXCEPT 18 MONTHS FOR FOLLICULAR
LYMPHOMA. HEPATITIS C GENOTYPE 1, 2, 3, 4, 5, OR 6: REQUIRES A TRIAL OF OR
CONTRAINDICATION TO PEGINTERFERON ALFA-2A OR PEGINTERFERON ALFA-2B
USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
INTERFERONS FOR MS-AVONEX, PLEGRIDY, REBIF

DRUG NAME
AVONEX | AVONEX ADMINISTRATION PACK | AVONEX PEN | PLEGRIDY | PLEGRIDY PEN | REBIF | REBIF REBIDOSE

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
INTERFERONS FOR MS-BETASERON, EXTAVIA

DRUG NAME
BETASERON | EXTAVIA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
TRIAL WITH TWO OF THE FOLLOWING AGENTS FOR MULTIPLE SCLEROSIS: AUBAGIO, AVONEX, GILENYA, PLEGRIDY, REBIF, TECFIDERA, AND GLATIRAMER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
IPILIMUMAB

DRUG NAME
YERVOY

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
INITIAL: UNRESECTABLE/METASTATIC MELANOMA: 3 MO ADJUVNT MELANOMA: 6 MO RENEWAL: ADJUVNT MELANOMA: 6 MO

OTHER CRITERIA
RENEWAL FOR ADJUVANT MELANOMA: NO EVIDENCE OF DISEASE RECURRENCE (DEFINED AS THE APPEARANCE OF ONE OR MORE NEW MELANOMA LESIONS: LOCAL, REGIONAL OR DISTANT METASTASIS)
Prior Authorization Requirements

EFFECTIVE DATE:  01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
IVACAFTOR

DRUG NAME
KALYDECO

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
HOMOZYGOUS FOR F508DEL MUTATION IN CFTR GENE.

REQUIRED MEDICAL INFORMATION
CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.

AGE RESTRICTIONS
6 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
IVACAFTOR - GRANULE PACKETS

DRUG NAME
KALYDECO

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
F508DEL MUTATION IN CFTR GENE.

REQUIRED MEDICAL INFORMATION
CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS. PATIENT WEIGHT.

AGE RESTRICTIONS
2 YEARS OF AGE TO 5 YEARS OF AGE

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
IXAZOMIB

DRUG NAME
NINLARO

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
IXEKIZUMAB

DRUG NAME
TALTZ AUTOINJECTOR | TALTZ SYRINGE

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
LEDIPASVIR-SOFOSBUVIR

DRUG NAME
HARVONI

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE
AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA
LABELING.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
HCV RNA LEVEL WITHIN PAST 6 MONTHS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN
SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A
SPECIALY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY
HEALTHCARE OUTCOMES) MODEL.

COVERAGE DURATION
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

OTHER CRITERIA
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT PATIENT HAS
LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED
COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE
RECOMMENDATION). PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE,
RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, SIMEPREVIR, SOFOSBUVIR
(AS A SINGLE AGENT), STRIBILD (ELVITAGRAVIR/COBICISTAT/EMTRICITABINE
/TENOFOVIR), OR TIPRANAVIR/RITONAVIR.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
LENALIDOMIDE

DRUG NAME
REVLIMID

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
LENVATINIB MESYLATE

DRUG NAME
LENVIMA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PREScriBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
LIDOCAINE

DRUG NAME
LIDOCAINE

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL COVERAGE CONSIDERATION FOR DIABETIC NEUROPATHY.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
LOMITAPIDE

DRUG NAME
JUXTAPID

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
LUMACAFTOR-IVACAFTOR

DRUG NAME
ORKAMBI

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
MEPOLIZUMAB

DRUG NAME
NUCALA

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
METHOTREXATE BVD DETERMINATION

DRUG NAME
METHOTREXATE | TREXALL

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION

METHYLNALTREXONE

DRUG NAME

RELISTER

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

ADVANCED ILLNESS: OPIOID-INDUCED CONSTIPATION. CHRONIC NON-CANCER PAIN: THE PATIENT HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS FOR PATIENTS RECEIVING PALLIATIVE CARE, 12 MONTHS FOR PATIENTS WITH CHRONIC, NON-CANCER PAIN.

OTHER CRITERIA

ADVANCED OR TERMINAL ILLNESS: PATIENT IS RECEIVING PALLIATIVE CARE. CHRONIC NON-CANCER PAIN: THE PATIENT HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS AND HAD A PREVIOUS TRIAL OF OR CONTRAINDICATION TO NALOXEGOL (MOVANTIK).
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
MIFEPRISTONE

DRUG NAME
KORLYM

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
MIPOMERSEN

DRUG NAME
KYNAMRO

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS), CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
MODAFINIL AND ARMODAFINIL - NUVIGIL

DRUG NAME
ARMODAFINIL

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA

NARCOLEPSY: TRIAL OF AT LEAST ONE OF THE FOLLOWING (UNLESS ALL ARE CONTRAINDIATED): AMPHETAMINE-DEXTROAMPHETAMINE IR, DEXTROAMPHETAMINE SULFATE IR, DEXTROAMPHETAMINE SULFATE ER, METHYLPHENIDATE IR, OR METHYLPHENDATE ER.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
NATALIZUMAB

DRUG NAME
TYSABRI

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
CROHN'S DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST.

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

OTHER CRITERIA
MULTIPLE SCLEROSIS: PREVIOUS TRIAL OF TWO OF THE FOLLOWING PREFERRED AGENTS FOR MULTIPLE SCLEROSIS: AUBAGIO, AVONEX, GILENYA, PLEGRIDY, REBIF, TECFIDERA, OR GLATIRAMER. CROHN'S DISEASE: PREVIOUS TRIAL OF HUMIRA FOLLOWED BY CIMZIA. NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH A TNF (TUMOR NECROSIS FACTOR) INHIBITOR: ENBREL, CIMZIA, REMICADE, SIMPONI OR SIMPONI ARIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
NEBULIZER BVD DETERMINATION

DRUG NAME
ACETYLCYSTEINE | ALBUTEROL SULFATE | BETHKIS | BUDESONIDE | CROMOLYN SODIUM | IPRATROPIUM BROMIDE | NEBUPENT | PULMOZYME | TOBRAMYCIN | VIRAZOLE

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
NETUPITANT-PALOSETRON BVD DETERMINATION

DRUG NAME
AKYNZE0

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
NILOTINIB

DRUG NAME
TASIGNA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
NINTEDANIB ESYLATE

DRUG NAME
OFEV

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
NIVOLUMAB

DRUG NAME
OPDIVO

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
MELANOMA: OPDIVO IS NOT APPROVED FOR COMBINATION THERAPY WITH
TAFINLAR, MEKINIST (TRAMETINIB), COTELLLIC (COBIMETINIB), OR ZELBORAF.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
OLAPARIB

DRUG NAME
LYNPARZA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
OMACETAXINE

DRUG NAME
SYNRIBO

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
INDUCTION: 3 MONTHS. POST INDUCTION OR RENEWAL: 3 TO 12 MONTHS

OTHER CRITERIA
CML INDUCTION THERAPY: TRIAL OF OR CONTRAINDICATION TO AT LEAST TWO
OF THE FOLLOWING AGENTS: GLEEVEC, SPRYCEL, TASIGNA, BOSULIF OR ICLUSIG.
APPROVAL FOR POST-INDUCTION THERAPY DURATION WILL DEPEND ON THE
PATIENT’S HEMATOLOGIC RESPONSE, DEFINED AS AN ABSOLUTE NEUTROPHIL
COUNT (ANC) GREATER THAN OR EQUAL TO 1.5 X 10^9/L, PLATELETS GREATER
THAN OR EQUAL TO 100 X 10^9/L WITHOUT BLOOD BLASTS OR THE PATIENT HAS
BONE MARROW BLASTS AT LESS THAN 5 PERCENT. APPROVAL IS FOR 12 MONTHS
IF HEMATOLOGIC RESPONSE IS MET. IF NOT MET, APPROVAL IS FOR 3 MONTHS.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
OMALIZUMAB

DRUG NAME
XOLAIR

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
OMBITASVIR-PARITAPREVIR-RITONAVIR

DRUG NAME
TECHNIVIE

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.

EXCLUSION CRITERIA
CIRRHOSIS, MODERATE OR SEVERE LIVER IMPAIRMENT (CHILD-PUGH B OR C).

REQUIRED MEDICAL INFORMATION
HCV RNA LEVEL WITHIN PAST 6 MONTHS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

COVERAGE DURATION
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

OTHER CRITERIA
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
TRIAL WITH PREFERRED FORMULARY ALTERNATIVE HARVONI WHERE HARVONI REGIMEN IS LISTED AS AN ACCEPTABLE REGIMEN FOR THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. NO APPROVAL FOR REQUESTS WHERE PROVIDER
Prior Authorization Requirements

ATTESTS THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). MUST BE USED CONCURRENTLY WITH RIBAVIRIN UNLESS PATIENT IS TREATMENT NAIVE AND HAS CONTRAINDICATION TO RIBAVIRIN. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER): ALFUZOSIN, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, RIFAMPIN, ERGOTAMINE DIHYDROERGOTAMINE, ERGONOVINE, METHYLERGONOVINE, ETHINYL ESTRADIOL CONTAINING MEDICATIONS (SUCH AS COMBINED ORAL CONTRACEPTIVES, NUVARING, ORTHO EVRA OR XULANE TRANSDERMAL PATCH SYSTEM), LOVASTATIN, SIMVASTATIN, PIMOZIDE, EFAVIRENZ (ATRIPLA, SUSTIVA), REVATIO (SILDENAFIL DOSE OF 20MG AND/OR DOSED TID FOR PAH), TRIAZOLAM, ORAL MIDAZOLAM, LOPINAVIR/РИТОНАВИР, РИЛВИРАПІН, САЛМЕТЕРОЛ.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
OMBITASVIR-PARITAPREVIR-RITONAVIR-DASABUVIR

DRUG NAME
VIEKIRA PAK

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.

EXCLUSION CRITERIA
DECOMPENSATED CIRRHOSIS, MODERATE OR SEVERE LIVER IMPAIRMENT (CHILD-PUGH B OR C).

REQUIRED MEDICAL INFORMATION
HCV RNA LEVEL WITHIN PAST 6 MONTHS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

COVERAGE DURATION
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

OTHER CRITERIA
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL WITH PREFERRED FORMULARY ALTERNATIVE HARVONI WHERE HARVONI REGIMEN IS LISTED AS AN ACCEPTABLE REGIMEN FOR THE SPECIFIC GENOTYPE
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

PER AASLD/IDSA GUIDANCE. NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: ALFUZOSIN, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, GEMFIBROZIL, RIFAMPIN, ERGOTAMINE, DIHYDROERGOTAMINE, ERGONOVINE, METHYLERGONOVINE, ETHINYL ESTRADIOL CONTAINING MEDICATIONS (SUCH AS COMBINED ORAL CONTRACEPTIVES, NUVARING, ORTHO EVRA OR XULANE TRANSDERMAL PATCH SYSTEM), ST. JOHN’S WORT, LOVASTATIN, SIMVASTATIN, PIMOZIDE, EFAVIRENZ, REVATIO, TRIAZOLAM, ORAL MIDAZOLAM, DARUNAVIR/RITONAVIR, LOPINAVIR/RITONAVIR, RILVIRIPINE, SALMETEROL.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
OPIOID DEPENDENCY - BUPRENORPHINE/NALOXONE

DRUG NAME
BUNAVAIL | BUPRENORPHINE-NALOXONE | SUBOXONE | ZUBSOLV

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
OPIOID DEPENDENCY AGENTS

DRUG NAME
BUPRENORPHINE HCL

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
OSIMERTINIB MESYLATE

DRUG NAME
TAGRISSO

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION

OXYMETHOLONE

DRUG NAME
ANADROL-50

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
CARCINOMA OF THE PROSTATE OR BREAST IN MALE PATIENTS, CARCINOMA OF THE BREAST IN FEMALES WITH HYPERCALCEMIA, WOMEN WHO ARE OR MAY BECOME PREGNANT, NEPHROSIS OR THE NEPHROTIC PHASE OF NEPHRITIS, HYPERSENSITIVITY TO THE DRUG AND SEVERE HEPATIC DYSFUNCTION.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION

PALBOCICLIB

DRUG NAME

IBRANCE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
PALIVIZUMAB

DRUG NAME
SYNAGIS

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
PANITUMUMAB

DRUG NAME
VECTIBIX

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
PANOBINOSTAT

DRUG NAME
FARYDAK

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
PARATHYROID HORMONE

DRUG NAME
NATPARA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
PAZOPANIB

DRUG NAME
VOTRIENT

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

DRUG NAME
ADCIRCA | SILDENAFIL

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION - IV

DRUG NAME
SILDENAFIL CITRATE

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
PEG-INTERFERON ALFA-2A

DRUG NAME
PEGASYS | PEGASYS PROCLICK

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
HCV RNA LEVEL WITHIN PAST 6 MONTHS.

AGE RESTRICTIONS

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

COVERAGE DURATION
HBV: 48 WEEKS. HCV: CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.

OTHER CRITERIA
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE. FOR REQUESTS FOR USE OF PEGINTERFERON AS PART OF A COMBINATION REGIMEN WITH OTHER HEPATITIS C VIRUS (HCV) ANTIVIRAL DRUGS: TRIAL WITH PREFERRED FORMULARY ALTERNATIVE HARVONI OR SOVALDI (REGIMEN WITH A SINGLE DIRECT ACTING ORAL AGENT) WHERE THAT REGIMEN IS LISTED AS AN ACCEPTABLE REGIMEN FOR THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE.
Prior Authorization Requirements

NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). HEPATITIS C: CONCURRENT USE OF RIBAVIRIN.
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
PEG-INTERFERON ALFA-2B

DRUG NAME
PEGINTRON

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE
AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA
LABELING.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
HCV RNA LEVEL WITHIN PAST 6 MONTHS.

AGE RESTRICTIONS

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

COVERAGE DURATION
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.

OTHER CRITERIA
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.
FOR REQUESTS FOR USE OF PEGINTERFERON AS PART OF A COMBINATION
REGIMEN WITH OTHER HEPATITIS C VIRUS (HCV) ANTIVIRAL DRUGS: TRIAL WITH
PREFERRED FORMULARY ALTERNATIVE HARVONI OR SOVALDI (REGIMEN WITH A
SINGLE DIRECT ACTING ORAL AGENT) WHERE THAT REGIMEN IS LISTED AS AN
ACCEPTABLE REGIMEN FOR THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE.
NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT PATIENT HAS
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). HEPATITIS C: CONCURRENT USE OF RIBAVIRIN.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
PEG-INTERFERON ALFA-2B-SYLATRON

DRUG NAME
SYLATRON

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
OVERALL DURATION OF THERAPY LIMITED TO 5 YEARS.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
PEMBROLIZUMAB

DRUG NAME
KEYTRUDA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PATIENTS WITH UNRESECTABLE OR METASTATIC MELANOMA: NO CONCURRENT REQUESTS FOR YERVOY, TAFINLAR, OR ZELBORAF
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION

PENICILLAMINE

DRUG NAME
CUPRIMINE

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

RHEUMATOID ARTHRITIS: HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

WILSONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST.
CYSTINURIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
RHEUMATOID ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

WILSONS DISEASE: GENETIC TESTING FOR ATP7B MUTATIONS. REQUIRES PREVIOUS TRIAL OR CONTRAINDICATION TO DEPEN.
CYSTINURIA: REQUIRES PREVIOUS TRIAL OR CONTRAINDICATION TO DEPEN AND THIOLA.
RHEUMATOID ARTHRITIS: REQUIRES DIAGNOSIS BY THE PRESENCE OF NEPHROLITHIASIS AND 1 OR MORE OF THE FOLLOWING: STONE ANALYSIS SHOWING PRESENCE OF CYSTEINE, IDENTIFICATION OF PATHOGENOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, POSITIVE FAMILY HISTORY OF CYSTINURIA WITH POSITIVE CYANIDE-NITROPRUSSIDE SCREEN.
RHEUMATOID ARTHRITIS: REQUIRES PREVIOUS TRIAL OR CONTRAINDICATION TO DEPEN.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
PENICILLAMINE-DEPEN

DRUG NAME
DEPEN

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
RHEUMATOID ARTHRITIS: HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
WILSONS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A HEPATOLOGIST.
CYSTINURIA: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
RHEUMATOID ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
WILSONS DISEASE: GENETIC TESTING FOR ATP7B MUTATIONS. CYSTINURIA: REQUIRES DIAGNOSIS BY THE PRESENCE OF NEPHROLITHIASIS AND 1 OR MORE OF THE FOLLOWING: STONE ANALYSIS SHOWING PRESENCE OF CYSTEINE, IDENTIFICATION OF PATHOGENOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, POSITIVE FAMILY HISTORY OF CYSTINURIA WITH POSITIVE CYANIDE-NITROPRUSSIDE SCREEN
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
PERTUZUMAB

DRUG NAME
PERJETA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
PIMAVANERIN

DRUG NAME
NUPLAZID

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
18 YEARS OR OLDER

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST,
GERIATRICIAN, OR A BEHAVIORAL HEALTH SPECIALIST (SUCH AS A
PSYCHIATRIST).

COVERAGE DURATION
INITIAL 12 MONTHS. RENEWAL 12 MONTHS.

OTHER CRITERIA
RENEWAL REQUIRES THAT THE PATIENT HAS EXPERIENCED AN IMPROVEMENT IN
PSYCHOSIS SYMPTOMS FROM BASELINE AND DEMONSTRATES A CONTINUED NEED
FOR TREATMENT.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
PIRFENIDONE

DRUG NAME
ESBRIET

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
PharmaCare Advantage (HMO), PharmaCare Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
POMALIDOMIDE

DRUG NAME
POMALYST

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
PONATINIB

DRUG NAME
ICLUSIG

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
PRAMLI NTIDE

DRUG NAME
SYMLINPEN 120 | SYMLINPEN 60

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
TYPE I OR TYPE II DIABETES: REQUIRING INSULIN OR CONTINUOUS INSULIN INFUSION (INSULIN PUMP) FOR GLYCEMIC CONTROL

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
PYRIMETHAMINE

DRUG NAME
DARAPRIM

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
QUININE SULFATE

DRUG NAME
QUININE SULFATE

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
RABIES VACCINE BVD DETERMINATION

DRUG NAME
IMOVAX RABIES VACCINE | RABAVERT

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE DEPENDING UPON THE
CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE
USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
RAMUCIRUMAB

DRUG NAME
CYRAMZA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
REGORAFENIB

DRUG NAME
STIVARGA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR COLORECTAL CANCER: TRIAL OF OR CONTRAINDICATION TO AN ANTI-VEGF THERAPY SUCH AS AVASTIN OR ZALTRAP AND A FLUOROPYRIMIDINE-, OXALIPLATIN- AND IRINOTECAN-BASED CHEMOTHERAPY SUCH AS FOLFOX, FOLFOXIRI, FOLFIRI,CAPEOX, INFUSIONAL 5-FU/LV OR CAPECITABINE. IF APPLICABLE, A TRIAL OF OR CONTRAINDICATION TO AN ANTI-EGFR THERAPY SUCH AS ERBITUX OR VECTIBIX IS ALSO REQUIRED FOR KRAS WILD TYPE COLORECTAL CANCER. FOR GIST, A TRIAL OF OR CONTRAINDICATION TO GLEEVEC AND SUTENT IS REQUIRED.
Essence Advantage (HMO), Essence Platinum (HMO-POS), CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
RIFAXIMIN

DRUG NAME
XIFAXAN

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
TRAVELERS' DIARRHEA: 1 FILL IN 1 MONTH.

OTHER CRITERIA


**Essence Advantage (HMO), Essence Platinum (HMO-POS), CoxHealth Medicare Plus (HMO)**

**Prior Authorization Requirements**

**EFFECTIVE DATE:** 01/01/2017

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**RIFAXIMIN-HEPATIC ENCEPHALOPATHY**

**DRUG NAME**

**XIFAXAN**

**COVERED USES**

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

TREATMENT OF HEPATIC ENCEPHALOPATHY (HE): HEPATOLOGIST. IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D): GASTROENTEROLOGIST.

**COVERAGE DURATION**

HEPATIC ENCEPHALOPATHY: 12 MO IRRITABLE BOWEL SYNDROME WITH DIARRHEA: INITIAL: 12 WKS. RENEWAL: 12 MO

**OTHER CRITERIA**

INITIAL: HEPATIC ENCEPHALOPATHY (HE): TRIAL OF LACTULOSE OR CONCURRENT LACTULOSE THERAPY. IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D): TRIAL WITH DICYCLOMINE (UNLESS CONTRAINDIATED) RENEWAL: ISB-D: ALL OF THE FOLLOWING CRITERIA MUST HAVE BEEN MET: AT LEAST 10 WEEKS HAVE PASSED SINCE THE LAST TREATMENT COURSE OF RIFAXIMIN, AND PATIENT HAS EXPERIENCED AT LEAST 30% DECREASE IN ABDOMINAL PAIN (ON A 0-10 POINT PAIN SCALE), AND PATIENT HAS EXPERIENCED AT LEAST 50% REDUCTION IN THE NUMBER OF DAYS PER WEEK WITH A STOOL CONSISTENCY OF MUSHY STOOL (BRISTOL STOOL SCALE TYPE 6) OR ENTIRELY LIQUID STOOL (BRISTOL STOOL SCALE TYPE 7).
Essence Advantage (HMO), Essence Platinum (HMO-POS), CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
RIOCIGUAT

DRUG NAME
ADEMPAS

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
RITUXIMAB

DRUG NAME
RITUXAN

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
RUXOLITINIB

DRUG NAME
JAKAFI

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
SEBELIPASE ALFA

DRUG NAME
KANUMA

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
SECUKINUMAB

DRUG NAME
COSENTYX (2 SYRINGES) | COSENTYX PEN (2 PENS)

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
SELEXIPAG

DRUG NAME
UPTRAVI

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST

COVERAGE DURATION
INITIAL AND RENEWAL: 12 MONTHS

OTHER CRITERIA
INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS
Essence Advantage (HMO), Essence Platinum (HMO-POS), CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
SILTUXIMAB

DRUG NAME
SYLVANT

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
SIMEPREVIR

DRUG NAME
OLYSIO

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
HCV RNA LEVEL WITHIN PAST 6 MONTHS. FOR ALL GENOTYPE 1A: NS3 80K POLYMORPHISM LAB TEST AT BASELINE.

AGE RESTRICTIONS
18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS
GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (FOR EXAMPLE HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

COVERAGE DURATION
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

OTHER CRITERIA
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL WITH PREFERRED FORMULARY ALTERNATIVE HARVONI WHERE HARVONI REGIMEN IS LISTED AS AN ACCEPTABLE REGIMEN FOR THE SPECIFIC GENOTYPE
Prior Authorization Requirements

PER AASLD/IDSA GUIDANCE. NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). PATIENT MUST NOT BE TAKING ANY OF THE FOLLOWING INTERACTING MEDICATIONS: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ERYTHROMYCIN (DOES NOT INCLUDE TOPICAL FORMULATIONS), CLARITHROMYCIN, TELITHROMYCIN, ITRACONAZOLE, KETOCONAZOLE, POSaconazole, FLUCONAZOLE (DOES NOT INCLUDE TOPICAL FORMULATIONS), VORICONAZOLE, DEXAMETHASONE, CISAPRIDE, CYCLOSPORINE, ROSUVASTATIN DOSE ABOVE 10MG, ATORVASTATIN DOSE ABOVE 40MG, OR ANY OF THE FOLLOWING HIV MEDICATIONS: COBICISTAT-CONTAINING MEDS (E.G., STRIBILD), ANY HIV PROTEASE INHIBITOR (ATAZANAVIR, FOSAMPRENNAVIR, LOPINAVIR, INDINAVIR, NELFINAVIR, SAQUINAVIR, OR TIPRANNAVIR) RITONAVIR, DARUNAVIR/RITONAVIR, DELAVIRIDINE, ETRAVIRINE, NEVIRAPINE, EFAVIRENZ). PATIENT MUST ALSO NOT BE TAKING AMIODARONE IF ON COMBINATION REGIMEN OF SOVALDI AND OLSYIO.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
SOFOSBUVIR

DRUG NAME
SOVALDI

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS), CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
SOMATROPIN - GROWTH HORMONE

DRUG NAME
HUMATROPE | OMNITROPE | SAIZEN | ZOMACTON

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS), CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
SOMATROPIN - SEROSTIM

DRUG NAME
SEROSTIM

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES

REQUIRED MEDICAL INFORMATION
HIV/WASTING: MEETS CRITERIA OF WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, OR 7.5 % OVER 6 MONTHS, OR 5PERCENT BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BCM LESS THAN 23% (WOMEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BMI LESS THAN 20 KG PER METER SQUARED.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, NUTRITIONAL SUPPORT SPECIALIST (SBS), OR INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
HIV/WASTING: CURRENTLY ON ANTIRETROVIRAL THERAPY. IF CURRENTLY ON GROWTH HORMONE, PATIENT HAS SHOWN CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT OR IF NOT ON GROWTH HORMONE, PATIENT HAS HAD INADEQUATE RESPONSE TO PREVIOUS THERAPY. (I.E. EXERCISE TRAINING, NUTRITIONAL SUPPLEMENTS, APPETITE STIMULANTS, OR ANABOLIC STEROIDS).
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
SOMATROPIN - ZORBTIVE

DRUG NAME
ZORBTIVE

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
SOMATROPIN-NORDITROPIN AND GENOTROPIN

DRUG NAME
GENOTROPIN | NORDITROPIN FLEXPRO

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
SOMATROPIN-NUTROPIN AND NUTROPIN AQ

DRUG NAME
NUTROPIN AQ | NUTROPIN AQ NUSPIN

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
SONIDEGIB

DRUG NAME
ODOMZO

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
BASELINE SERUM CREATINE KINASE (CK) AND SERUM CREATININE LEVELS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
SORAFENIB TOSYLATE

DRUG NAME
NEXAVAR

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
SUNITINIB MALATE

DRUG NAME
SUTENT

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
GASTROINTESTINAL STROMAL TUMORS (GIST): TRIAL OF OR CONTRAINDICATION TO GLEEVEC.
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
TADALAFIL

DRUG NAME
CIALIS

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
ERECTILE DYSFUNCTION WITHOUT DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
TRIAL OF ONE FORMULARY ALPHA BLOCKER (SUCH AS DOXAZOSIN, TERAZOSIN,
TAMSULOSIN OR ALFUZOSIN) AND ONE FORMULARY 5-ALPHA-REDUCTASE (SUCH
AS FINASTERIDE OR DUTASTERIDE). APPLIES TO 2.5MG AND 5MG STRENGTHS
ONLY.
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
TASIMELTEON

DRUG NAME
HETLIOZ

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
TEDUGLUTIDE

DRUG NAME
GATTEX

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
18 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PATIENT IS DEPENDENT ON INTRAVENOUS PARENTERAL NUTRITION DEFINED AS REQUIRING PARENTERAL NUTRITION AT LEAST THREE TIMES PER WEEK.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
TERIFLUNOMIDE

DRUG NAME
AUBAGIO

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
TESTOSTERONE

DRUG NAME
ANDRODERM | ANDROGEL | AXIRON | TESTOSTERONE | TESTOSTERONE CYPIONATE | TESTOSTERONE ENANTHATE

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
MALE HYPOGONADISM CONFIRMED BY EITHER: 1) LAB CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL OF LESS THAN 300 NG/DL OR 2) A LOW TOTAL SERUM TESTOSTERONE LEVEL AS INDICATED BY A LAB RESULT WITH A REFERENCE RANGE OBTAINED WITHIN 90 DAYS, OR 3) A FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 PG/ML.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
LIFETIME OF MEMBERSHIP IN PLAN

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
TETRABENAZINE

DRUG NAME
TETRABENAZINE

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
NEUROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
THALIDOMIDE

DRUG NAME
THALOMID

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
TOCILIZUMAB IV

DRUG NAME
ACTEMRA

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
TOCILIZUMAB SQ

DRUG NAME
ACTEMRA

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE:  01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
TOFACITINIB

DRUG NAME
XELJANZ | XELJANZ XR

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
TOPICAL TRETINOIN

DRUG NAME
TRETINOIN | TRETINOIN MICROSPHERE

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
TOTAL PARENTAL NUTRITION AGENT BVD DETERMINATION

DRUG NAME

AMINO ACIDS | AMINOSYN II | AMINOSYN II WITH ELECTROLYTES | AMINOSYN WITH ELECTROLYTES | AMINOSYN-HBC | AMINOSYN-PF | AMINOSYN-RF | CLINIMIX | CLINIMIX E | CLINISOL | DEXTROSE IN WATER | FREAMINE HBC | HEPATAMINE | INTRALIPID | NEPHRAMINE | NUTRILIPID | PREMASOL | PROCALAMINE | PROSOL | TRAVASOL | TROPHAMINE

COVERED USES

THIS DRUG MAY BE COVERED UNDER MEDICARE DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
TRAMETINIB DIMETHYL SULFOXIDE

DRUG NAME
MEKINIST

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
TRASTUZUMAB

DRUG NAME
HERCEPTIN

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
BREAST CANCER, METASTATIC BREAST CANCER, GASTRIC CANCER: HER2 POSITIVE

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
B VS D COVERAGE CONSIDERATION.
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
TREPROSTINIL DIOLAMINE

DRUG NAME
ORENITRAM ER

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.

COVERAGE DURATION
INITIAL AND RENEWAL: 12 MONTHS

OTHER CRITERIA
INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. PATIENT DOES NOT HAVE SEVERE HEPATIC IMPAIRMENT. PREVIOUS TREATMENT WITH UPTRA VIR AND PREVIOUS OR CURRENT TREATMENT WITH ONE OF THE FOLLOWING: A PHOSPHODIESTERASE-5 INHIBITOR (E.G., REVATIO [SILDENAFIL] OR ADCIRCA [TADALAFIL]) OR AN ENDOTHELIN RECEPTOR ANTAGONIST (E.G., TRACLEER [BOSENTAN], LETAIRIS [AMBRISENTAN]), OR OPSUMIT [MACITENTAN]).
TRIAL OF 2 FORMULARY AGENTS (UPTRAVI AND A PHOSPHODIESTERASE-5 INHIBITOR OR ENDOTHELIN RECEPTOR ANTAGONIST) IS NOT REQUIRED IF THE PATIENT WAS PREVIOUSLY STABLE ON ORENITRAM. RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS.
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
TREPROSTINIL INHALED

DRUG NAME
TYVASO

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS III-IV SYMPTOMS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST

COVERAGE DURATION
INITIAL AND RENEWAL: 12 MONTHS

OTHER CRITERIA
THIS DRUG MAYBE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION. NEBULIZER THERAPY IS COVERED UNDER PART B FOR PATIENTS WHO ARE USING THE MEDICATION VIA A NEBULIZER IN THEIR OWN HOME. THOSE WHO ARE NOT USING IT IN THEIR HOME WILL BE COVERED UNDER PART D. INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS.
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
TREPROSTINIL SODIUM INJECTABLE

DRUG NAME
REMODULIN

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
TRIFLURIDINE/TIPRACIL

DRUG NAME
LONSURF

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
USTEKINUMAB

DRUG NAME
STELARA

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
VANDETRANIB

DRUG NAME
CAPRELSA

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
VEMURAFENIB

DRUG NAME
ZELBORAF

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
BRAFV600E MUTATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
VENETOCLAX

DRUG NAME
VENCLEXTA | VENCLEXTA STARTING PACK

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
NONE

REQUIRED MEDICAL INFORMATION
NONE

AGE RESTRICTIONS
NONE

PRESCRIBER RESTRICTIONS
NONE

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
NONE
Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
VISMODEGIB

DRUG NAME
ERIVEDGE

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Essence Advantage (HMO), Essence Platinum (HMO-POS),
CoxHealth Medicare Plus (HMO)

Prior Authorization Requirements

EFFECTIVE DATE: 01/01/2017

PRIOR AUTHORIZATION GROUP DESCRIPTION
ZIV-AFLIBERCEPT

DRUG NAME
ZALTRAP

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA