2014 Medicare Prior Authorization Criteria

Last Modified: 09.30.2014
Last Submitted to CMS: 09.02.2014

POLICY NAME:
ABILIFY MAINTENA
Affected Medications: ABILIFY MAINTENA (aripiprazole suspension, reconstituted)
Effective Date: 08/01/2013
Last Review Date: 5/22/2013
Part D: Yes Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Diagnosis of schizophrenia and on maintenance treatment **AND** ☐ The patient has a history of non-compliance and/or refuses to utilize oral medication. **AND** ☐ The patient has received at least **ONE** of the following: ☐ oral aripiprazole (Abilify), ☐ Abilify Maintena or ☐ Abilify solution.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐	N/A
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Psychiatrist or receiving input from a psychiatry practice	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ACTEMRA
Affected Medications: ACTEMRA (tocilizumab)
Effective Date: 01/01/2014
Last Review Date: 7/18/2012
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ FDA approved indication must be documented in the member's chart notes within the most recent **6** months. ☐ Documentation of complete & current treatment course required. ☐ For treatment of RA: ☐ Laboratory test must confirm diagnosis of Rheumatoid Arthritis: ☐ Anti-Cyclic Citrullinated Peptide Antibody(anti-CCP) **OR** Rheumatoid Factor (RF) ☐ Negative Latent TB screening with either by TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to request. **OR** ☐ For positive latent TB, patient must have completed or receiving treatment for LTBI. ☐ For systemic-onset JIA, pediatric patients must have active systemic features (e.g., fever) **AND** inadequate response, contraindication or intolerance to corticosteroids.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	Rheumatoid Arthritis (RA) ☐ **Initial approval** ☐ Patient has failed at least 12 weeks of therapy of at least **2 DMARDs** (hydroxychloroquine, leflunomide, methotrexate, minocycline, sulfasalazine) **AND** ☐ Patient has failed at least 12 weeks of therapy of **another** biologic agent: abatacept (Orencia), rituximab(Rituxin), tocilizumab(Actemra), adalimumab (Humira), entanercept(Enbrel), infliximab(Remicade), certolizumab(Cimzia), golimumab(Simponi ☐ **Subsequent approval** requires documentation of treatment success. ☐ Treatment success/failure must be documented with one of the following instruments: DAS, SDAI, CDAI, RADAI, PAS, PASII, RAPID, ESR, CRP, GAS, **Visual Analog Scale**, ACR20	**YES** / NO
Exclusion Criteria:	☐ Concurrent use of: abatacept (Orencia), rituximab(Rituxin), tocilizumab(Actemra), adalimumab (Humira), entanercept(Enbrel), infliximab(Remicade), certolizumab(Cimzia), golimumab(Simponi) ☐ Prior intolerance or allergic reaction to requested medication ☐ Positive test for tuberculosis, active HZV	YES / **NO**

Age Restriction:	☐ For indication of systemic-onset JIA, may approve for children and adolescents 18 years of age or younger. ☐ For RA, ≥ 18 years old	**YES** / NO
Prescriber Restrictions:		N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
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POLICY NAME:
ACTIMMUNE
Affected Medications: ACTIMMUNE (Interferon Gamma 1 b)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ FDA approved indication must be documented in the member's chart notes within the most recent 12 months ☐ Patient's BSA must be documented along with the prescribed dose.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ADCIRCA
Affected Medications: ADCIRCA (tadalafil)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ NYHA Functional Class II or III symptoms. ☐ PAH (WHO Group 1) was confirmed by right heart catheterization **OR** by Doppler echocardiography.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Patient requires nitrate therapy on a regular or intermittent basis.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ADEMPAS
Affected Medications: ADEMPAS (riociguat)
Effective Date: 03/01/2014
Last Review Date: 09/23/2013
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	CTEPH ☐ Diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH) PAH ☐ Diagnosis of symptomatic pulmonary arterial hypertension (PAH) WHO Group 1	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	CTEPH ☐ Documentation of failure of, or inability to receive pulmonary endarterectomy surgery ☐ Current therapy with anticoagulants PAH ☐ The following supportive care should be considered: anticoagulants, diuretics oxygen, digoxin Failure of the following therapy classes: ☐ PDE5 inhibitors AND ☐ Endothelin receptor antagonists OR prostanoids ☐ Subsequent approval requires documentation of treatment success: ☐ Defined by exercise endurance ☐ Echocardiographic testing ☐ Hemodynamic testing ☐ BNP, functional class	N/A
Exclusion Criteria:	☐ Pregnancy ☐ Creatinine clearance ≤15 ml/min ☐ Severe hepatic impairment ☐ Concomitant use with nitrates (such as amyl nitrite) ☐ Concomitant use with PDE inhibitors (such as sidenafil, tadalafil, or vardenafil)	YES / **NO**
Age Restriction:	☐ Age > 18 years	**YES** / NO
Prescriber	☐ Prescribed by or in consultation with a cardiologist or a pulmonologist	**YES** / NO

Restrictions:	☐	
Coverage Duration:	☐ Initial approval = 6 months ☐ Subsequent approval = 12 months, unless otherwise specified	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
AFINTOR DISPENZ
Affected Medications: Afinitor Disperz (Everolimus tablets for oral suspension)
Effective Date: 03/01/2014
Last Review Date: 09/23/2013
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Subependymal Giant Cell Astrocytoma (SEGA) diagnosis.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Patient has SEGA associated with a tuberous sclerosis complex (TSC) that requires therapeutic intervention but is not a candidate for curative surgical resection	N/A
Exclusion Criteria:	☐ Advanced hormone receptor-positive, human epidermal growth receptor 2-negative breast cancer, advanced neuroendocrine tumors of pancreatic origin, advanced renal cell carcinoma, renal angiomyolipoma with tuberous sclerosis complex, renal transplantation.	YES / **NO**
Age Restriction:	☐ ≥1 years	N/A
Prescriber Restrictions:	☐ Must be prescribed by or in consultation with an oncologist	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
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POLICY NAME:
ALPHA1-PROTEINASE INHIBITOR
Affected Medications: ARALAST NP, GLASSIA, PROLASTIN-C, ZEMAIRA
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Alpha-1 antitrypsin (AAT) deficiency-associated panniculitis.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ For AAT deficiency with emphysema (or COPD), ☐ approve in patients with baseline (pretreatment) alpha1-antitrypsin serum concentration ≤ 11 microM (11 micromol/L) or 80 mg/Dl **AND** ☐ FEV1 ≤ 65% **OR** FEV1 reduction of ≥ 120mL/year	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Use in the management of cystic fibrosis, ☐ COPD without alpha1-antitrypsin deficiency, ☐ alpha1-antitrypsin deficiency without lung disease (even if deficiency-induced hepatic disease is present), OR ☐ bronchiectasis (without alpha1-antitrypsin deficiency), ☐ patients with IgA deficiency (≤ 15mg/dL) or IgA antibody deficiency	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
AMPYRA
Affected Medications: AMPYRA (dalfampridine)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Plus patient already started on dalfampridine extended-release for Multiple Sclerosis (MS).	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Documentation of dosing and patient renal function (height / weight and serum creatinine **OR** eGFR **OR** CrCl) ☐ If dosage > 20mg per day, then documentation supporting using greater than maximum recommeded FDA dose.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ For initial approval for MS, authorize for 90 days. ☐ After up to 90 days of dalfampridine extended-release therapy, if MS patient has had a response to therapy as determined by prescribing physician (eg, increased walking distance, improved leg/limb strength, improvement in activities of daily living), then an additional authorization is allowed.	**YES** / NO
Exclusion Criteria:	☐ History of seizures, ☐ Dose > 10 mg twice daily **OR** ☐ Creatinine clearance ≤ 50 mL/min.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ If prescribed by, or in consultation with, an MS specialist.	**YES** / NO
Coverage Duration:	☐ Initial Approval = 90 days. ☐ Subsequent Approval = 12 months, if patient had a response.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ANAGRELIDE
Affected Medications: AGRYLIN, ANAGRELIDE
Effective Date: 01/01/2014
Last Review Date: 7/18/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Patient has a diagnosis of thrombocythemia secondary to a myeloproliferative disorder.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Severe hepatic impairment.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Oncologist or hematologist	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ANTIHEMOPHILIC FACTOR (FACTOR VIII) CONCENTRATES
Affected Medications: Advate®, Helixate® FS, Kogenate® FS, Recombinate™, Xyntha™, Hemofil®M, Monoclate-P®
Effective Date: 01/01/2014
Last Review Date: 11/14/2012
Part D: No Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part B. ☐ Acquired Hemophilia A.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Hemophilia A – Primary Prophylaxis** ☐ Factor VIII levels <1% of normal (age 2+) **Hemophilia A – Secondary Prophylaxis** ☐ History of intracranial hemorrhage Factor ☐ Levels <1% and one or more joint bleeds ☐ Children under age 2 with Severe Hemophilia A (Factor VIII < 1% normal) who have had one or more joint bleeds, and for whom the benefits of prophylaxis outweigh the risk of central venous line use (if applicable) **Hemophilia A – High Risk Prophylaxis** ☐ For minor and major non-elective surgical procedures **Immune Tolerance Induction (ITI)** ☐ Inhibitor titer <10 Bethesda Units before start of ITI therapy	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	**Primary and Secondary Prophylaxis:** ☐ All trough level monitoring must be recorded in chart notes **ITI** ☐ may continue until inhibitor levels approach zero (<0.6 BU/mL) and factor levels show normal recovery (>66%) and/or FVIII half-life is normal (>6h)	**YES** / NO
Exclusion Criteria:	**Exclusions for ITI** ☐ Adults who have failed an adequate course of ITI treatment in the past (at least 3 consecutive months of ITI terminated due to documented failure) ☐ Adults who have had measurable inhibitor levels for 5+ years and who have never undergone ITI treatment ☐ History of anaphylaxis or severe hypersensitivity to any component of the chosen concentrate	YES / **NO**
Age Restriction:	☐	N/A

Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Primary and Secondary Prophylaxis Approval = 12 months, unless otherwise specified ☐ High Risk Prophylaxis Approval = until wound(s) healing appropriately ☐ ITI Approval = 6 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ANTIHEMOPHILIC FACTOR VIII (HUMAN) NON-MONOCLONAL ANTIBODY PURIFIED
Affected Medications: KOATE®-DVI
Effective Date: 01/01/2014
Last Review Date: 11/14/2012
Part D: No Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part B. ☐ Von Willebrand's Disease ☐ Acquired Hemophilia A.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Von Willebrand's Disease – High Risk Prophylaxis** ☐ For minor and major non-elective surgical Procedures ☐ DDAVP must have been deemed inadequate or inappropriate for prophylactic use, reason(s) must be documented **Hemophilia A – Primary Prophylaxis** ☐ Factor VIII levels <1% of normal (age 2+) **Hemophilia A – Secondary Prophylaxis** ☐ History of intracranial hemorrhage Factor ☐ Levels <1% and one or more joint bleeds ☐ Children under age 2 with Severe Hemophilia A (Factor VIII < 1% normal) who have had one or more joint bleeds, and for whom the benefits of prophylaxis outweigh the risk of central venous line use (if applicable) **Hemophilia A – High Risk Prophylaxis** ☐ For minor and major non-elective surgical Procedures **Immune Tolerance Induction (ITI)** ☐ Inhibitor titer <10 Bethesda Units before start of ITI therapy	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	**Primary and Secondary Prophylaxis:** ☐ All trough level monitoring must be recorded in chart notes **ITI** ☐ may continue until inhibitor levels approach zero (<0.6 BU/mL) and factor levels show normal recovery (>66%) and/or FVIII half-life is normal (>6h)	**YES** / NO
Exclusion Criteria:	**Exclusions for ITI** ☐ Adults who have failed an adequate course of ITI treatment in the past (at least 3 consecutive months of ITI terminated due to documented failure) ☐ Adults who have had measurable inhibitor levels for 5+ years and who have never undergone ITI treatment ☐ History of anaphylaxis or severe hypersensitivity to any component of the chosen concentrate	YES / **NO**

Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Primary and Secondary Prophylaxis Approval = 12 months, unless otherwise specified ☐ High Risk Prophylaxis Approval = until wound(s) healing appropriately ☐ ITI Approval = 6 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ANTIHEMOPHILIC FACTOR VIII/VWF COMPLEX
Affected Medications: ALPHANATE®, HUMATE-P
Effective Date: 01/01/2014
Last Review Date: 11/14/2012
Part D: No Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part B. ☐ Acquired Von Willebrand's Disease	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Von Willebrand's Disease – High Risk Prophylaxis** ☐ For minor and major non-elective surgical Procedures ☐ DDAVP must have been deemed inadequate or inappropriate for prophylactic use, reason(s) must be documented **Hemophilia A – Primary Prophylaxis** ☐ Factor VIII levels <1% of normal (age 2+) **Hemophilia A – Secondary Prophylaxis** ☐ History of intracranial hemorrhage Factor ☐ Levels <1% and one or more joint bleeds ☐ Children under age 2 with Severe Hemophilia A (Factor VIII < 1% normal) who have had one or more joint bleeds, and for whom the benefits of prophylaxis outweigh the risk of central venous line use (if applicable) **Hemophilia A – High Risk Prophylaxis** ☐ For minor and major non-elective surgical Procedures	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	**Primary and Secondary Prophylaxis:** ☐ All trough level monitoring must be recorded in chart notes ☐ Monitor for signs and symptoms of thrombosis	**YES** / NO
Exclusion Criteria:	☐ History of anaphylaxis or severe hypersensitivity to any component of the chosen concentrate ☐ Acute thrombosis, embolism or symptoms of DIC	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Primary and Secondary Prophylaxis Approval = 12 months, unless otherwise specified ☐ High Risk Prophylaxis Approval = until wound(s) healing appropriately	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ANTIHEMOPHILIC FACTOR VIII/VWF COMPLEX
Affected Medications: WILATE®
Effective Date: 01/01/2014
Last Review Date: 11/14/2012
Part D: No Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part B. ☐ Acquired Von Willebrand's Disease	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**High Risk Prophylaxis** ☐ For minor and major non-elective surgical Procedures ☐ DDAVP must have been deemed inadequate or inappropriate for prophylactic use, reason(s) must be documented	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Monitor for signs and symptoms of thrombosis	**YES** / NO
Exclusion Criteria:	☐ History of anaphylaxis or severe hypersensitivity to any component of the chosen concentrate ☐ Acute thrombosis, embolism or symptoms of DIC	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Primary and Secondary Prophylaxis Approval = 12 months, unless otherwise specified ☐ High Risk Prophylaxis Approval = until wound(s) healing appropriately	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ANTIHEMOPHILIC FACTOR IX CONCENTRATES
Affected Medications: BENEFIX®, ALPHANINE® SD, MONONINE®, RIXUBIS
Effective Date: 01/01/2014
Last Review Date: 09/26/2013
Part D: No Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part B.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Hemophilia B – Primary Prophylaxis** ☐ Factor IX levels <1% of normal (age 2+) **Hemophilia B – Secondary Prophylaxis** ☐ History of intracranial hemorrhage Factor ☐ Levels <1% and one or more joint bleeds ☐ Children under age 2 with Severe Hemophilia A (Factor VIII < 1% normal) who have had one or more joint bleeds, and for whom the benefits of prophylaxis outweigh the risk of central venous line use (if applicable) **Hemophilia B - High Risk Prophylaxis** ☐ For minor and major non-elective surgical procedures **Hemophilia B - Immune Tolerance Induction (ITI)** ☐ Evidence that the potential benefits of treating with ITI (taking into consideration low chance of success) outweighs the risks of nephritic syndrome and allergic reaction to Factor IX ☐ Must document inhibitor titer level	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	**Primary and Secondary Prophylaxis:** ☐ All trough level monitoring must be recorded in chart notes **ITI** ☐ May continue until inhibitor levels approach zero (<0.6 BU/mL) ☐ Monitor for signs and symptoms of thrombosis	**YES** / NO
Exclusion Criteria:	☐ History of anaphylaxis, or severe hypersensitivity to any component of the chosen concentrate ☐ Acute thrombosis, embolism or symptoms of DIC **Exclusions for ITI** ☐ Adults who have failed an adequate course of ITI treatment in the past (at least 3 consecutive months of ITI terminated due to documented failure or severe reaction) ☐ Adults who have had measurable inhibitor levels for 5+ years and who have never undergone ITI treatment	YES / **NO**

Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Primary and Secondary Prophylaxis Approval = 12 months, unless otherwise specified ☐ High Risk Prophylaxis Approval = until wound(s) healing appropriately ☐ ITI Approval: 6 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ANTIHEMOPHILIC FACTOR VIIa CONCENTRATE
Affected Medications: NOVOSEVEN® RT ®
Effective Date: 01/01/2014
Last Review Date: 11/14/2012
Part D: No Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part B. ☐ Acquired Von Willebrand syndrome	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Hemophilia A or B with inhibitors – Secondary Prophylaxis** ☐ Documentation of inhibitors AND one or more of the following criteria: ☐ History of intracranial hemorrhage ☐ Over age 2 with Severe Hemophilia A or B (Factor VIII or IX levels <1% of normal) and a history of one or more joint bleeds with risk of developing/progressing arthropathy ☐ Children under age 2 with Severe Hemophilia A or B, who have had one or more joint bleeds, and for whom the benefits of prophylaxis outweigh the risk of central venous line use (if applicable) **All Indications: High Risk Prophylaxis** ☐ For minor and major non-elective surgical procedures	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	**Secondary Prophylaxis:** ☐ All trough level monitoring must be recorded in chart notes ☐ Monitor for signs and symptoms of thrombosis	**YES** / NO
Exclusion Criteria:	☐ History of anaphylaxis, or severe hypersensitivity to any component of the chosen concentrate ☐ Acute thrombosis, embolism or symptoms of DIC	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Primary and Secondary Prophylaxis Approval = 12 months, unless otherwise specified ☐ High Risk Prophylaxis Approval = until wound(s) healing appropriately	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ANTI-INHIBITOR COAGULANT COMPLEX (HUMAN)
Affected Medications: FEIBA® NF
Effective Date: 01/01/2014
Last Review Date: 11/14/2012
Part D: No Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part B. ☐ Acquired Hemophilia A	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Must document inhibitor titer level for all indications **Hemophilia A or B with Inhibitors - High Risk Prophylaxis** ☐ For minor and major non-elective surgical ☐ Procedures **Acquired Hemophilia A – High Risk Prophylaxis** ☐ For minor and major non-elective surgical procedures ☐ Must have documentation of inhibitor titers of 5 BU or greater	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Monitor for signs and symptoms of thrombosis	**YES** / NO
Exclusion Criteria:	☐ Absence of inhibitors/antibodies to Factor VIII or Factor IX ☐ Normal coagulation mechanisms ☐ History of anaphylaxis, or severe hypersensitivity to any component of the chosen concentrate ☐ Acute thrombosis, embolism or symptoms of DIC	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ High Risk Prophylaxis Approval = until wound(s) healing appropriately	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ARCALYST
Affected Medications: ARCALYST (Rilonacept)
Effective Date: 01/01/2014
Last Review Date: 7/18/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Patient has a diagnosis of cryopyrin-associated periodic syndromes (CAPS), including familial cold auto-inflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS).	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Active or chronic infection, concurrent therapy with other biologics.	YES / **NO**
Age Restriction:	☐ 12 years of age and older	**YES** / NO
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ARZERRA
Affected Medications: ARZERRA (ofatumumab)
Effective Date: 07/01/2014
Last Review Date: 06/11/2014
Part D: No Part B: Yes (J9302)

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Previous therapies tried/failed ☐ Hepatitis B screening ☐ Karnofsky Performance Status OR ECOG performance status	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Untreated CLL: 300 mg initial dose, followed by up to 12 28-day cycles of 1,000 mg ☐ Refractory CLL: 300 mg initial dose, followed by 11 28-day cycles of 2,000 mg ☐ Continuation of therapy requires documentation of response to therapy	**YES** / NO
Exclusion Criteria:	☐ Hepatitis B (current or historical, unless being managed in consultation with GI, ID, or hepatologist) ☐ Live vaccination within 4 weeks of treatment ☐ Re-induction with Arzerra (max approval is 12 cycles) ☐ Karnofsky performance score less than 50% ☐ ECOG performance status 3 or higher	YES / **NO**
Age Restriction:	☐ 18 years and older	**YES** / NO
Prescriber Restrictions:	☐ Oncologist	**YES** / NO
Coverage Duration:	☐ Approval = 6 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ASPARAGINASE, PERASPARAGASE
Affected Medications: ERWINAZE (Aparaginase Erwinia Chrysanthemi), ONCASPAR (Pegaspargase)
Effective Date: 04/01/2014
Last Review Date: 3/12/2014
Part D: Yes Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ For use of Erwinaze (Aparaginase Erwinia Chrysanthemi): documentation of failure or contraindication to use of Oncaspar (Pegaspargase) must be provided.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐	N/A
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
AUBAGIO
Affected Medications: AUBAGIO (Teriflunomide)
Effective Date: 06/01/2013
Last Review Date: 4/10/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Use in Multiple Sclerosis (MS), patient has a relapsing form of MS. ☐ Baseline transaminase and bilirubin levels documented.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ For use in MS, patient has a relapsing form of MS and patient has tried interferon beta-1a intramuscular (Avonex), interferon beta-1a subcutaneous (Rebif), interferon beta-1b (Betaseron or Extavia), or glatiramer acetate (Copaxone). ☐ Exceptions to having tried an interferon beta-1a or -1b product (Avonex, Betaseron, Extavia, or Rebif) or glatiramer acetate (Copaxone) can be made if the patient is unable to administer injections due to dexterity issues or visual impairment. ☐ Patients who have tried natalizumab (Tysabri) for MS and have a relapsing form of MS will receive authorization, they are not required to try an interferon beta product or glatiramer acetate. ☐ Liver function tests will be monitored at least monthly for 6 months once treatment is initiated. ☐ Female patients should have a negative pregnancy test prior to therapy.	**YES** / NO
Exclusion Criteria:	☐ Patients with known liver disease should not begin treatment with teriflunomide. ☐ Concurrent use of Avonex, Betaseron, Extavia, Rebif, Copaxone, Tysabri, or fingolimod (Gilenya).	YES / **NO**
Age Restriction:	☐ Adults	**YES** / NO
Prescriber Restrictions:	☐ Prescribed by a neurologist or an MS specialist.	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
AVONEX
Affected Medications: AVONEX (interferon beta-1a)
Effective Date: 01/01/2014
Last Review Date: 7/18/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Has relapsing form of MS (eg. relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR ☐ first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS (i.e., multifocal white matter disease).	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Approve for patients already started on Avonex. ☐ For patients not currently on Avonex, approve if the patient has previously tried Betaseron, Copaxone, or Rebif.	**YES** / NO
Exclusion Criteria:	☐ Concurrent use of any of the following medications: interferon-beta therapy (Betaseron, Extavia, or Rebif), Copaxone, mitoxantrone, Tysabri, or fingolimod (Gilenya).	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Prescribed by or after consultation with a neurologist or an MS specialist.	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
PART B VERSUS PART D (B vs D)

Affected Medications: ABELCET, ABRAXANE, ACETYLCYST, ACYCLOVIR SOL, ADRIAMYCIN, ALBUTEROL, ALIMTA, ALKERAN, AMBISOME, AMIFOSTINE, AMINOSYN, AMPHOTERICIN, ARRANON , ARZERRA, ASTRAMORPH, ATGAM®, AVASTIN, AZASAN®, AZATHIOPRINE, BICNU, BLEOMYCIN, BROVANA, BUDESONIDE, BUSULFEX, CALCIJEX®, CALCITRIOL, CAMPATH, CAMPTOSAR, CARBOPLATIN, CARNITOR®, CELLCEPT®, CERUBIDINE, CESAMET®, CISPLATIN, CLADRIBINE, CLINIMIX, CLINISOL, CLOLAR, COLISTIMETH, COSMEGEN, CROMOLYN, CUBICIN®, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE, CYTOVENE, DACARBAZINE, DACOGEN, DAUNORUBICIN, DECAVAC, DEPO-PROVERA, DEXRAZOXANE, DOCETAXEL, DOXIL , DOXORUBICIN, DRONABINOL, DUONEB, DURAMORPH, ELITEK, ELLENCE, ELOXATIN, ELSPAR, EMEND®, ENGERIX-B, EPIRUBICIN, ERBITUX, ETOPOPHOS, ETOPOSIDE, FASLODEX, FIRMAGON, FLUDARABINE, FLUOROURACIL, GANCICLOVIR, GEMCITABINE , GEMZAR, GENGRAF, GRANISETRON HCL, GRANISOL , HALAVEN, HECTOROL®, HEPARIN SODIUM, HEPATAMINE, HEPATASOL, HERCEPTIN, HUMULIN R INJ U-500, HYCAMTIN, HYDROMORPHONE INJ, IDAMYCIN, IDARUBICIN, IFEX, IFOSFAMIDE, IMURAN®, INTRALIPID, INTRON-A, IPRATROPIUM, IRINOTECAN, ISTODAX, IXEMPRA KIT, KEPIVANCE, LEUCOVORIN, LEVALBUTEROL NEB, LEVOCARNITINE, LIPOSYN, MELPHALAN, MESNA, MESNEX, METHOTREXATE, MIACALCIN®, MITOXANTRONE HCL, MUSTARGEN, MYCOPHENOLATE MOFETIL, MYFORTIC®, NEBUPENT, NEORAL®, NEPHRAMINE, NIPENT, NULOJIX, ONDANSETRON HCL, ONDANSETRON ODT, ONTAK, OXALIPLATIN, PACLITAXEL, PAMIDRONATE DISODIUM, PENTOSTATIN, PERFOROMIST, PREMASOL, PROCALAMINE, PROGRAF®, PROLEUKIN, PROSOL, PULMICORT, PULMOZYME®, RAPAMUNE®, RECOMBIVAX HB, SANDIMMUNE®, SIMULECT®, TACROLIMUS, TAXOTERE, TET/DIP TOX INJ, THIOTEPA, THYMOGLOBULIN®, TOBI®, TOPOSAR, TOPOTECAN, TORISEL, TPN, TRAVASOL, TREANDA, TREXALL®, TRISENOX, TROPHAMINE, TWINRIX, UVADEX, VANCOMYCIN HCL, VECTIBIX, VELCADE, VIDAZA, VINBLASTINE, VINCASAR, VINCRISTINE, VINORELBINE, ZANOSAR, ZEMPLAR®, ZINECARD, ZORTRESS®

Effective Date: 01/01/2014
Last Review Date: 06/12/2013
Part D: Yes Part B: Yes

Covered Uses:	☐ This drug may be covered under Medicare Part B or D depending upon the circumstances. ☐ Information may need to be submitted describing the use and setting of the drug to make the determination.	**CONFIRMATION*** **YES** / NO
Required Medical Information:		N/A
Appropriate Treatment Regimen & Other Criteria:	☐ For ESRD agents, ☐ Deny as Part D, If Prescriber receive a monthly capitation payment to manage ESRD patients' care **AND** the drug prescribed is ESRD-related. ☐ Approve as Part D and direct reviewer to issue a 70-ESRD OVERRIDE, If the Prescriber does NOT receive a monthly capitation payment to manage ESRD patients' care **and/or** the drug prescribed is NOT ESRD-related. ☐ if the pharmacy determines that the prescription for a drug that may be ESRD-related was written by any of the following: dentist; chiropractor; gynecologist; ophthalmologist; podiatrist; or hospital emergency room prescriber, then the plan should accept	**YES** / NO

	this information from the pharmacy to establish that the prescriber does not receive a monthly capitation payment for managing the ESRD patient's care and provide an override to the ESRD PA edit.	
Exclusion Criteria:	☐	N/A
Age Restriction:	☐	N/A
Prescriber Restrictions:		N/A
Coverage Duration:	☐	N/A
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
BETASERON
Affected Medications: BETASERON (interferon beta-1b)
Effective Date: 01/01/2014
Last Review Date: 7/18/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Relapsing form of MS (eg. relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) **OR** ☐ first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS (i.e., multifocal white matter disease).	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Concurrent use of any of the following medications: interferon-beta therapy (Extavia, or Rebif), Copaxone, mitoxantrone, Tysabri, or fingolimod (Gilenya).	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Prescribed by or after consultation with a neurologist or an MS specialist.	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
BONIVA INJECTION
Affected Medications: BONIVA INJECTION (ibandronate injection)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Treatment of osteoporosis in women (non PMO). ☐ Hypercalcemia of malignancy. ☐ Prevention of postmenopausal osteoporosis. ☐ Treatment of bone metastases in patients with solid tumor (eg, breast cancer, prostate cancer). ☐ Osteoporosis disorder related to organ transplantation.	**CONFIRMATION*** **YES** / NO
Required Medical Information:		N/A
Appropriate Treatment Regimen & Other Criteria:	All **osteoporosis** uses (treatment or prevention), approve if patient has tried one oral bisphosphonate-containing product **AND** ☐ they had an inadequate response (determined by prescribing physician) or intolerability to oral bisphosphonate **OR** ☐ patient cannot take an oral bisphosphonate-containing product due to ☐ inability to swallow ☐ unable to remain in an upright position for designated period of time following oral bisphosphonate administration ☐ patient has pre-existing GI medical condition in which IV therapy is preferred over oral therapy, **OR** ☐ patient has a chronic, complex medication regimen in which oral bisphosphonate may compromise therapy (as determined by prescribing physician) ☐ **OR** patient is currently receiving ibandronate injection for a covered use. ☐ Part B versus Part D determination will be made at time of prior authorization review per CMS guidance to establish if the drug prescribed is to be used for an end-stage renal disease (ESRD)-related condition.	**YES** / NO
Exclusion Criteria:	☐ Use in the management of multiple myeloma patients ☐ patients with osteolytic lesions of multiple myeloma ☐ treatment of osteopenia or the prevention of bone loss in cancer	YES / **NO**

	patients ☐ Paget's disease of bone ☐ osteogenesis imperfecta, or prevention or treatment of glucocorticoid-induced osteoporosis (GIO) ☐ Coverage is not recommended for circumstances not listed in the Covered Uses.	
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
BOTOX
Affected Medications: BOTOX (onabotulinumtoxinA)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Plus Achalasia. ☐ Anal Fissure. ☐ Benign Prostatic Hyerplasia (BPH). ☐ Chronic facial pain/pain associated with TMJ dysfunction. ☐ Chronic low back pain. ☐ Headache (migraine, chronic tension HA, whiplash, chronic daily HA). ☐ Palmar/plantar and facial hyperhidrosis. ☐ Myofascial pain. ☐ Salivary hypersecretion. ☐ Spasticity (eg, due to cerebral palsy, stroke, brain injury, spinal cord injury, MS, hemifacial spasm). ☐ Essential tremor. ☐ Dystonia other than cervical (eg, focal dystonias, tardive dystonia, anismus). ☐ Bladder/voiding/urethral dysfunction. ☐ Frey's syndrome (gustatory sweating). ☐ Ophthalmic disorders (eg, esotropia, exotropia, nystagmus, facial nerve paresis). ☐ Speech/voice disorders (eg, dysphonias). ☐ Tourette's syndrome. ☐ Additional indications will be evaluated by a pharmacist and/or a physician on a case-by-case basis.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Chronic Migraine Prophylaxis,** ☐ initial treatment: patient experiences at least 15 headaches per month, and patient had an inadequate response to at least 8 weeks of oral migraine preventative therapy. ☐ continuation of treatment (after 1 injection cycle): 50% reduction in headache frequency since starting therapy. **Primary Axillary Hyperhidrosis**, ☐ patient has tried conventional treatments (such as topical aluminum chloride solution or iontophoresis) without adequate relief.	**YES** / NO

	Urinary incontinence associated with a neurologic condition (eg, spinal cord injury, multiple sclerosis): ☐ patient had an inadequate response to or is intolerant of an anticholinergic medication.	
Appropriate Treatment Regimen & Other Criteria:	☐ Patient has been educated about potential spread of toxin effects (eg, breathing and swallowing difficulties)	**YES** / NO
Exclusion Criteria:	☐ Use in the management of cosmetic uses (eg, facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platsymal bands, rejuvenation of the peri-orbital region), ☐ allergic rhinitis ☐ gait freezing in Parkinsons disease ☐ vaginismus ☐ interstitial cystitis ☐ Crocodile tears syndrome	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Chronic migraine, initial: 12 wks; subsequent: 12 months ☐ All other indications: approval = 12 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
BUPRENORPHINE/NALOXONE FILM
Affected Medications: SUBOXONE FILM (BUPRENORPHINE/NALOXONE)
Effective Date: 01/01/2014
Last Review Date: 9/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐	N/A
Appropriate Treatment Regimen & Other Criteria:	**Opioid Dependence:** ☐ pt must be enrolled in a program of supportive care ☐ no dependence on alcohol or benzodiazepines ☐ free from significant untreated psychiatric comorbidities. ☐ Quantity of Suboxone must be ≤ 102 tablets per 34 days.	**YES** / NO
Exclusion Criteria:	☐ Use in the management of pain in non-opioid dependent patients.	YES / **NO**
Age Restriction:	Opioid Dependence: ☐ Pt ≥ 16 years	**YES** / NO
Prescriber Restrictions:	☐ Prescriber must be certified to prescribe Suboxone per DATA 2000 requirements.	**YES** / NO
Coverage Duration:	☐ Initial Approval = 3 months. ☐ Subsequent Approvals = 6 months.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
CAPRELSA
Affected Medications: CAPRELSA® (vandetanib)
Effective Date: 01/01/2014
Last Review Date: 7/18/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Symptomatic or progressive medullary thyroid cancer with unresectable locally advanced or metastatic disease.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Hypocalcemia, hypokalemia, or hypomagnesemia must be corrected prior to Caprelsa administration. ☐ ECG should be obtained to monitor the QT at baseline, then 2 to 4 weeks after starting treatment or dose reduction/interruption, then 8 to 12 weeks after starting treatment or dose reduction/interruption, then every 3 months thereafter. ☐ ECG must be monitored more frequently if patient is receiving any drugs known to prolong the QT interval (e.g., anti-arrhythmic drugs, chloroquine, clarithromycin, dolasetron, granisetron, haloperidol, methadone, moxifloxacin, pimozide.)	**YES** / NO
Exclusion Criteria:	☐ Long QT syndrome.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless noted otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
CHANTIX
Affected Medications: CHANTIX (varenicline)
Effective Date: 01/01/2014
Last Review Date: 7/18/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ If the patient is currently taking Chantix, the patient's treatment, including the use of Chantix, has resulted in smoking cessation. ☐ Criteria only apply after a 90 day supply of Chantix has been utilized within the preceeding 12 months.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Patient will be observed for neuropsychiatric symptoms (e.g., changes in behavior, hostility, agitation, depressed mood, and suicide related events, including ideation, behavior, and attempted suicide) while taking Chantix.	N/A
Exclusion Criteria:	☐	N/A
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Initial approval = 12 weeks ☐ Subsequental approval = 12 weeks additional , max of 6 months per 12 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
CIMZIA
Affected Medications: CIMZIA (certolizumab)
Effective Date: 01/01/2014
Last Review Date: 9/23/2012
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ FDA approved indication must be documented in the member's chart notes within the most recent 6 months. ☐ Documentation of complete and current treatment course required. ☐ For treatment of RA: Laboratory test must confirm diagnosis of Rheumatoid Arthritis: Anti-Cyclic Citrullinated Peptide Antibody(anti-CCP) OR Rheumatoid Factor (RF). ☐ For Negative latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to request. **OR** ☐ For positive latent TB, patient must have completed or is receiving treatment for LTBI. ☐ For those at risk for Hepatitis B (HBV) infection, HBV has been ruled out or treatment has been initiated.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	**Adult Rheumatoid Arthritis (RA)** ☐ Patient has failed at least 12 weeks of therapy of **at least 2 DMARDs** (hydroxychloroquine, leflunomide, methotrexate, minocycline, sulfasalazine) **AND** ☐ Patient has failed at least 12 weeks of therapy of **another biologic agent** [abatacept (Orencia), rituximab(Rituxin), tocilizumab(Actemra), adalimumab (Humira), entanercept(Enbrel), infliximab(Remicade), certolizumab(Cimzia), golimumab(Simponi)]. **Adult Crohn's Disease (CD)** Induce remission: ☐ Approve if patient has tried corticosteroids or ☐ if corticosteroids are contraindicated or ☐ if patient is currently on corticosteroids. Maintain remission: ☐ Approve if patient has received 3 doses of certolizumab pegol to induce response/remission or has had 12 weeks of therapy with certolizumab pegol **AND** ☐ the patient has responded to therapy **OR**	**YES** / NO

	☐ if the patient has not received certolizumab pegol for induction of remission then authorize if patient has tried azathioprine, 6-mercaptopurine, or MTX or if patient has tried infliximab or adalimumab.	
Exclusion Criteria:	☐ Active infection (including TB) ☐ Concurrent use of: abatacept (Orencia), rituximab(Rituxin), tocilizumab(Actemra), adalimumab (Humira), entanercept(Enbrel), infliximab(Remicade), certolizumab(Cimzia), golimumab(Simponi) ☐ Use for the management of plaque psoriasis.	YES / **NO**
Age Restriction:	☐ ≥ 18 years old	**YES** / NO
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Initial RA, approval = 12 months ☐ Initial CD, approval = 3 months ☐ Subsequental approval = 12 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
C1 INHIBITOR
Affected Medications: BERINERT, CINRYZE
Effective Date: 10/01/2009
Last Review Date: 06/10/2009
Part D: No Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Hereditary Angiodema	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ FDA approved Indication must be documented in the member's chart notes within the most recent 6 months. ☐ Documentation of complete & current treatment course required. ☐ Number of HAE attacks per month must be >= 2. ☐ Laboratory confirmation of diagnosis: **(the following levels must be documented)** ☐ C4 antigenic level:_____ ☐ C1-inhibitor antigenic level: _____ ☐ C1-inhibitior functional level:_____. ☐ Enrollment in Cinryze Solutions Support program suggested: (877) 945-1000	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ **Initial approval** requires documented failure, intolerance, or clinical rationale for avoidance to the following: Androgens: danazol, stanozolol, oxandrolone, oxymetholone, tibolone, or methyltestosterone. ☐ **Subsequent approval** requires documentation of treatment success.	**YES** / NO
Exclusion Criteria:	☐ Coverage is not recommended for circumstances not listed under Covered Uses.	YES / **NO**
Age Restriction:		N/A
Prescriber Restrictions:	☐ Must be prescribed by, or in consultation with, an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders.	**YES** / NO
Coverage Duration:	☐ Initial approvals = 3 months. ☐ Subsequent approvals = 12 months.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
COMBINATION BETA2-AGONIST/CORTICOSTEROID INHALERS
Affected Medications: ADVAIR
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ COPD.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ For **Asthma,** documentation of current level of control per NIH guidelines (Well Controlled, Not Well Controlled, Poorly Controlled). ☐ For **COPD**, documentation of GOLD Staging (Stage I - IV) and PFT results.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ **For Asthma**, failed: ☐ inhaled corticosteroid monotherapy **OR** ☐ ≥ 2 other common treatments (cromolyn, leukotriene receptor antagonist, nedocromil, theophylline) **OR** ☐ poorly controlled asthma necessitating urgent treatment with combination product. ☐ Patients with well controlled asthma for 3 months or longer, should step-down to ICS monotherapy or other common treatments per NIH guidelines. ☐ **For COPD**, failed: ☐ Long Acting Beta Agonist monotherapy **OR** ☐ anticholingeric bronchodilator (Spiriva, Atrovent, Combivent) **OR** ☐ poorly controlled COPD necessitating urgent treatment with combination product.	**YES** / NO
Exclusion Criteria:	☐ Treatment of symptoms associated with a current rhinovirus infection/cough associated with a current episode of the common cold. ☐ Treatment of chronic cough due to GERD, NAEB, bronchiolitis, bronchiectasis, ACE-Inhibitor induced cough, whooping cough, pertussis, psychogenic cough, habit cough, tic cough. ☐ Treatment of symptoms due to an acute respiratory infection (eg, bronchitis, sinusitis, pneumonia). ☐ Coverage is not recommended for circumstances not listed in the Covered Uses.	YES / **NO**
Age	☐	N/A

Restriction:		
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Initial approval: 6 months. ☐ Subsequent approval: 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
COPAXONE
Affected Medications: COPAXONE (glatiramer)
Effective Date: 01/01/2014
Last Review Date: 7/18/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Relapsing-remitting MS **OR** ☐ first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS (i.e., multifocal white matter disease).	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Concurrent use of any of the following medications: interferon-beta therapy (Avonex, Betaseron, Extavia, or Rebif) or mitoxantrone.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Prescribed by or after consultation with a neurologist or an MS specialist.	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
CYRAMZA
Affected Medications: CYRAMZA (ramucirumab)
Effective Date: 07/01/2014
Last Review Date: 06/11/2013
Part D: No Part B: Yes (J9999)

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Documentation of disease progression after fluoropyrimide or platinum-containing chemotherapy ☐ Disease progression on ≥ 2 of the following: Irinotecan, Paclitaxel, Docetaxel ☐ Karnofsky Performance Status OR ECOG performance status.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ 8 mg/kg every two weeks ☐ Re-approval: recent scan (within 3 months) demonstrating that patient is responding to therapy	**YES** / NO
Exclusion Criteria:	☐ Uncontrolled hypertension ☐ Karnofsky performance score less than 50% ☐ ECOG performance status 3 or higher	YES / **NO**
Age Restriction:	☐ 18 years and older	**YES** / NO
Prescriber Restrictions:	☐ Oncologist	N/A
Coverage Duration:	☐ Approval = 3 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
DIGOXIN
Affected Medications: LANOXIN 0.25mg (digoxin 0.25mg)
Effective Date: 01/01/2014
Last Review Date: 05/22/2013
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Serum digoxin level within 12 months (or 14 -21 days after dose increase or initiation)	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Serum digoxin level 0.5 to 1.0 ng/ml (or clinical justification for higher serum target) AND diagnosis of heart failure or atrial fibrillation.	**YES** / NO
Exclusion Criteria:	☐ Significant sinus or atrioventricular block (unless on permanent pacemaker)	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
EMSAM
Affected Medications: EMSAM (selegiline transdermal system)
Effective Date: 01/01/2014
Last Review Date: 7/18/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Clinical diagnosis of major depressive disorder **AND** ☐ Patient not responsive to ≥ **two** (2) of the following antidepressants with documented trials of clinically sufficient doses and duration of six weeks each or longer: ☐ selective serotonin reuptake inhibitors (SSRI), ☐ serotonin/norepinephrine reuptake inhibitors (SNRI), ☐ bupropion, ☐ mirtazapine, or ☐ tricyclic/tetracyclic antidepressants. **OR** ☐ Clinical diagnosis of major depressive disorder for those patients who are unable to take any oral preparations (including commercially available liquid antidepressants). ☐ For requests over 6 mg/24 hours, patient must agree to adhere to a tyramine restrictive diet.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Pheochromocytoma ☐ Concurrent use of the following medications: dextromethorphan or St. John's Wort.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Psychiatrist or receiving input from a psychiatry practice	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ENBREL
Affected Medications: ENBREL (etanercept)
Effective Date: 01/01/2014
Last Review Date: 7/18/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Plus Acute or chronic graft versus host disease (GVHD).	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ FDA approved indication must be documented in the member's chart notes within the most recent 6 months. ☐ Documentation of complete and current treatment course required. ☐ For treatment of RA: Laboratory test must confirm diagnosis of Rheumatoid Arthritis: Anti-Cyclic Citrullinated Peptide Antibody(anti-CCP) OR Rheumatoid Factor (RF). ☐ For Negative latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to Enbrel request. **OR** ☐ For Positive latent TB, patient must have completed or receiving treatment for LTBI. ☐ For those at risk for Hepatitis B (HBV) infection, HBV has been ruled out or treatment has been initiated.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	**Rheumatoid Arthritis (RA), Juvenile Idiopathic Arthritis (JIA)** ☐ pt tried ≥ 2 oral DMARDs for ≥ 12wks (hydroxychloroquine, leflunomide, sulfasalazine, minocycline, methotrexate) **OR** ☐ pt has failed at least 12 weeks of therapy of another biologic agent [abatacept (Orencia), rituximab(Rituxin), tocilizumab(Actemra), adalimumab (Humira), entanercept(Enbrel), infliximab(Remicade), certolizumab(Cimzia), golimumab(Simponi)] **Psoriatic Arthritis (PsA)** ☐ pt tried ≥ 1 oral DMARD for ≥ 12wks (hydroxychloroquine, leflunomide, sulfasalazine, minocycline, methotrexate) **Plaque psoriasis (PP)** ☐ pt has tried ≥ 1 systemic therapy (methotrexate, cyclosporine, isotretinoin) **OR** phototherapy (UVB, PUVA)	**YES** / NO

	GVHD ☐ Approve if managed by a transplant center **AND** has tried or currently is receiving one conventional GVHD treatment (high-dose SC, CSA, tacrolimus, etc.)	
Exclusion Criteria:	☐ Active infection (including TB). ☐ Concurrent use with abatacept (Orencia), rituximab(Rituxin), tocilizumab(Actemra), adalimumab (Humira), entanercept(Enbrel), infliximab(Remicade), certolizumab(Cimzia), golimumab(Simponi). ☐ Intra-articular injection of etanercept. ☐ Use in the management of alopecia areata, alopecia totalis, alopecia universalis, asthma, Crohn's disease, dermatomyositits/polymyositis, inclusion body myositis, Graves ophthalmopathy, hepatitis C, alcoholic hepatitis, idiopathic pulmonary fibrosis, immune-mediated cochleovestibular disorders, immune thrombocytopenic purpura, myelodysplastic syndrome, prevention of peri-prosthetic osteolysis, primary sclerosing cholangitis, recurrent spontaneous pregnancy loss, ocular sarcoidosis, pulmonary sarcoidosis, sciatica, Sjogren's syndrome, Takayasu's arteritis, Wegener's granulomatosis, cancer anorexia/weight loss syndrome, new-onset diabetes mellitus type 1, keloids, and Alzheimer's disease. ☐ Positive test for tuberculosis, active HZV, HCV or HBV.	YES / **NO**
Age Restriction:	☐ RA, PsA, PP, AS: Adults.	**YES** / NO
Prescriber Restrictions:	☐ PP: in consultation with a dermatologist.	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ENTERAL NUTRITION
Affected Medications: ENTERAL NUTRITION
Effective Date: 08/01/2011
Last Review Date: 06/8/2011
Part D: No Part B: Yes

Covered Uses:	All FDA approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Nutritional Deficiency identified by one of the following: ☐ Total protein < 5.6g/dl or albumin < 3.4g/dl, **OR** ☐ Recent assessment by MD / RD indicating caloric/protein intake is not obtainable through regular, liquefied or purified foods. ☐ In the absence of Nutritional Deficiency, prolonged history of malnutrition (ie. Years) and both of the following: ☐ Dx or Sx of cachexia **AND** ☐ Residence in home, nursing facility or chronic home care ☐ In the absence of Nutritional Deficiency, unplanned weight loss of ≥ 10% and ONE of the following criteria: ☐ Severe trauma resulting in increased metabolic need (e.g., severe burn, major bone fracture), **OR** ☐ Malabsorption difficulty (e.g., Crohn's disease, short-gut syndrome, bowel resection, fistula, gastric bypass, cystic fibrosis, renal dialysis, dysphagia, achalasia), **OR** ☐ Diagnosis that requires additional calories (cancer, AIDS, pulmonary insufficiency, ☐ Children < 6yrs require the following: ☐ Documentation of 'failure to thrive', **AND** ☐ Nutritional Deficiency (defined above), **OR** ☐ Oral Aversion	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Registered Dietician assessment in the past 3 months indicates sufficient caloric/protein intake is not obtainable through regular, liquefied or pureed foods (i.e., liquefied/pureed foods have been tried and failed)	**YES** / NO
Exclusion Criteria:	☐ Able to obtain formula type or qty required through other programs (i.e. WIC)	YES / **NO**
Age Restriction:	☐ See 'Required Medical Information'	**YES** / NO
Prescriber Restrictions:		N/A
Coverage Duration:	☐ Authorization = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ERIVEDGE
Affected Medications: ERIVEDGE (vismodegib)
Effective Date: 01/01/2014
Last Review Date: 7/18/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐	N/A
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐	N/A
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ESTROGENS
Affected Medications: ACTIVELLA, ALORA, CENESTIN, CLIMARA, CLIMARA PRO PATCH, COMBIPATCH, DIVIGEL, ELESTRIN PATCH, ENJUVIA, ESTRACE TAB, ESTRADIOL TAB, ESTRADIOL PATCH, ESTRODIOL-NORETHINDRONE TAB, ESTROPIPATE TAB, EVAMIST SOL, JINTELI TAB, MENEST TAB, MONOSTAR PATCH, MINIVELLE PATCH, PREFEST TAB, PREMARIN, PREMPRO, VIVELLE-DOT
Effective Date: 01/01/2014
Last Review Date: 05/22/2013
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Patient has been educated about increased risks of DVT, pulmonary embolism (PE), stroke and myocardial infarction (MI) in postmenopausal women. ☐ Patient has been educated about cancer risk and increased risk of developing probable dementia while on systemic hormone replacement therapy. ☐ A yearly evaluation of need is completed discussing need for hormone replacement therapy.	**YES** / NO
Exclusion Criteria:	☐	N/A
Age Restriction:	☐ > 65 years of age	**YES** / NO
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
EXJADE
Affected Medications: Exjade (deferasirox)
Effective Date: 01/01/2014
Last Review Date: 7/18/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Diagnosis of transfusion-dependent anemia with chronic iron overload due to blood transfusions (transfusional hemosiderosis). ☐ Pretreatment serum ferritin level within the last 60 days of at least 1000 mcg/L Baseline and then monthly, or more frequently as indicated, monitoring of serum ferritin, serum creatinine/creatinine clearance, serum transaminases, bilirubin, and urinalysis (urine protein). ☐ On renewal, for patients with serum ferritin below 500 mcg/L, temporary interruption of Exjade therapy should be considered. ☐ For patients with persistent or severe increases in creatinine or liver function tests, the prescriber will consider dose modification or interruption of treatment. ☐ Diagnosis of chronic iron overload in patients 10 years and older with nontransfusion-dependent thalassemia syndromes and with a liver iron concentration (LIC) of at least 5 mg of iron per gram of liver dry weight (mg Fe/g dw) and a serum ferritin greater than 300 mcg/L on at least 2 measurements 1 month apart.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Exjade should not be used with Desferal (deferoxamine).	**YES** / NO
Exclusion Criteria:	☐ CrCl < 40 mL/min. ☐ Severe hepatic impairment. ☐ Platelet count <50,000/mcL. ☐ Patient with poor performance status and high-risk myelodysplastic syndrome (MDS) or advanced malignancies.	YES / **NO**
Age Restriction:	☐ ≥ 2 years of age	**YES** / NO
Prescriber Restrictions:	☐ Hematologist	**YES** / NO

Coverage Duration:	☐ Authorization will be for 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
EXTAVIA
Affected Medications: Extavia (interferon beta-1b)
Effective Date: 01/01/2014
Last Review Date: 7/18/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Relapsing form of MS (eg. relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR ☐ first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS (i.e., multifocal white matter disease).	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ For patients requesting Extavia, approve if the patient has previously tried Betaseron, Copaxone, or Rebif.	**YES** / NO
Exclusion Criteria:	☐ Concurrent use of any of the following medications: interferon-beta therapy (Betaseron, or Rebif), Copaxone, mitoxantrone, Tysabri, or fingolimod (Gilenya).	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Prescribed by or after consultation with a neurologist or an MS specialist.	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
EYLEA
Affected Medications: EYLEA® (aflibercept)
Effective Date: 01/12/2012
Last Review Date: 01/11/2012
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA approved indications not otherwise excluded by from Part D..	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Initial approval requires documented reasoning for the avoidance of the following: ○ Intravitreal Avastin (bevacizumab) ☐ *If an exception is warranted, please call 541-330-4999 or submit medical records documenting the justification.*	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Subsequent approval requires documentation of treatment success.	**YES** / NO
Exclusion Criteria:	☐ Evidence of a current ocular or periocular infection	YES / **NO**
Age Restriction:		N/A
Prescriber Restrictions:	☐ Ophthalmologist	**YES** / NO
Coverage Duration:	☐ Approval = 6 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
FERRIPROX
Affected Medications: Ferriprox (Deferiprone)
Effective Date: 01/01/2014
Last Review Date: 7/18/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐	N/A
Appropriate Treatment Regimen & Other Criteria:	☐	N/A
Exclusion Criteria:	☐ Evidence of a current ocular or periocular infection	YES / **NO**
Age Restriction:		N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
FORTEO
Affected Medications: FORTEO (teriparatide)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ For osteoporosis, documentation of T Score ≤ to -2.5 or FRAX Score indicating Major fracture risk ≥ 20% or HIP Fracture ≥ 3%.	N/A
Appropriate Treatment Regimen & Other Criteria:	**For osteoporosis** ☐ approve if the patient has tried an oral **OR** ☐ intravenous bisphosphonate (eg, alendronate, risedronate, ibandronate, zoledronic acid [Reclast]), **OR** ☐ if the patient has severe renal impairment (eg, creatinine clearance less than 30 mL/min) **OR** ☐ chronic kidney disease, **OR** ☐ if the patient has multiple vertebral fractures in the setting of vertebral T-scores less than -3.5 ☐ Documentation of calcium and Vitamin D treatment required. ☐ Therapy will be discontinued after a lifetime total of 24 months of treatment.	**YES** / NO
Exclusion Criteria:	☐ Paget's disease of bone, unexplained elevations of alkaline phosphatase, open epiphyses (ie, pediatric or young adult patient), prior radiation therapy involving the skeleton, history of a skeletal malignancy, bone metastases, pre-existing hypercalcemia, metabolic bone disease other than osteoporosis, concurrent bisphosphonate use, prevention of osteoporosis (women and men).	YES / **NO**
Age Restriction:	☐ Forteo should not be used in pediatric patients or young adults with open epiphyses	**YES** / NO
Prescriber Restrictions:	☐	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
GAZYVA
Affected Medications: GAZYVA (obinutuzumab)
Effective Date: 01/01/2014
Last Review Date: 12/11/2013
Part D: No Part B: Yes (J9999)

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Diagnosis of Chronic Lymphocytic Leukemia ☐ Documentation of of Negative Hepatitis screening (HBsAG and anti-HBc measurements)	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Combination with chlorambucil	**YES** / NO
Exclusion Criteria:	☐	N/A
Age Restriction:	☐ Age > 18 years	**YES** / NO
Prescriber Restrictions:	☐ Oncologist	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
GILENYA
Affected Medications: GILENYA (fingolimod)
Effective Date: 01/01/2014
Last Review Date: 9/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ For use in Multiple Sclerosis (MS), patient has a relapsing form of MS.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ For use in MS, patient has a relapsing form of MS and patient has tried interferon beta-1a intramuscular (Avonex), interferon beta-1a subcutaneous (Rebif), interferon beta-1b (Betaseron or Extavia), or glatiramer acetate (Copaxone). ☐ Exceptions to having tried an interferon beta-1a or -1b product (Avonex, Betaseron, Extavia, or Rebif) or glatiramer acetate (Copaxone) can be made if the patient is unable to administer injections due to dexterity issues or visual impairment. ☐ Patients who have tried natalizumab (Tysabri) for MS and have a relapsing form of MS will receive authorization, they are not required to try an interferon beta product or glatiramer acetate.	**YES** / NO
Exclusion Criteria:	☐ Concurrent use of Avonex, Betaseron, Extavia, Rebif, Copaxone or Tysabri.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Prescribed by a neurologist or an MS specialist.	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
GILFOTRIF
Affected Medications: GILOTRIF (Afatanib)
Effective Date: 03/01/2014
Last Review Date: 9/23/2013
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Diagnosis of metastatic non-small cell lung cancer with known active epidermal growth factor receptor exon 19 deletion or exon 21 (L858R) substitution mutations.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐	N/A
Exclusion Criteria:	☐ Previous treatment of non-small cell lung cancer with alternative therapies	YES / **NO**
Age Restriction:	☐ Age >18 years	**YES** / NO
Prescriber Restrictions:	☐ Prescribed by an Oncologist	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
GLEEVEC
Affected Medications: GLEEVEC (imatinib)
Effective Date: 01/01/2014
Last Review Date: 9/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All medically-accepted indications not otherwise excluded from Part D. ☐ Patients already started on Gleevec.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Diagnosis for which Gleevec is being used. ☐ For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. ☐ New patients with CML and ALL which is Ph-positive may receive authorization for Gleevec.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ For CML, new patient must have Ph-positive CML for approval of Gleevec. ☐ For ALL, new patient must have Ph-positive ALL for approval of Gleevec.	**YES** / NO
Exclusion Criteria:	☐ New patients with chronic myeloid leukemia (CML) whose Ph status is unknown. ☐ New patients with acute lymphoblastic leukemia (ALL) whose Ph status is unknown.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
GLUCAGON-LIKE PEPTIDE-1 AGONISTS
Affected Medications: BYETTA, BYDUREON
Effective Date: 01/01/2014
Last Review Date: 7/18/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ The patient is diagnosed as having type-2 diabetes with an HbA1c level greater than 7. ☐ The patient has a creatinine clearance of greater than 30mL/minute or normal kidney function. ☐ The patient demonstrated an inadequate treatment response, intolerance or contraindication to metformin AND a sulfonylurea OR a TZD. ☐ If the patient has received previous Byetta therapy for at least 3 months, the patient demonstrated an expected reduction in HbA1c since starting Byetta therapy.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ History of pancreatitis.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
GONADOTROPIN
Affected Medications: CHORIONIC GONADOTROPIN, PREGNYL
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Preoperative use in male infants/toddlers with hypospadias and chordee **OR** with total epispadias and bladder exstrophy.	**CONFIRMATION*** **YES** / NO
Required Medical Information:		N/A
Appropriate Treatment Regimen & Other Criteria:	☐ Hypogonadotropic hypogonadism in males. ☐ Preoperative use for hypospadias and chordee OR total epispadias and bladder exstrophy in male infants or toddlers.	**YES** / NO
Exclusion Criteria:	☐ Use in the management of infertility (diagnosis or treatment) in males or females, obesity, prevention of recurrent or habitual miscarriage, or treatment or prevention of breast cancer.	YES / **NO**
Age Restriction:	☐ Prepubertal cryptorchidism, child or adolescent. ☐ Hypospadias or epispadias, infant or toddler.	**YES** / NO
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless noted otherwise.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
GRANIX
Affected Medications: GRANIX ® (tbo-filgrastim)
Effective Date: 07/01/2014
Last Review Date: 12/11/2013
Part D: No Part B: Yes (J1446)

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Prophylaxis of febrile neutropenia (FN) or other dose-limiting neutropenic events**: ☐ patient has a non-myeloid cancer and is currently receiving or will be receiving myelosuppressive anti-cancer drugs, **AND** ☐ meets one of the following: ☐ patient has experienced FN or a dose-limiting neutropenic event with a previous cycle of chemotherapy, **OR** ☐ patient is at high risk (greater than 20%) or intermediate risk (10-20%) for developing FN based on chemotherapy regimen and patient's risk factors, **OR** ☐ patient is at low risk (< 10%) for developing FN based on chemotherapy regimen and patient's risk factors **AND** chemotherapy is intended to be curative or adjuvant **AND** patient is at significant risk for serious medical consequences of FN.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐	N/A
Exclusion Criteria:	☐ E. coli protein hypersensitivity. ☐ Use of Granix within 24 hours preceding or following chemotherapy or radiotherapy.	YES / **NO**
Age Restriction:	☐ 18 years and older	**YES** / NO
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 6 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
GROWTH HORMONE
Affected Medications: GENOTROPIN®, HUMATROPE®, NORDITROPIN FLEXPRO®, NORDITROPIN NORDIFLEX®, NUTROPIN AQ®, NUTROPIN®, OMNITROPE®, SAIZEN®
Effective Date: 01/01/2014
Last Review Date: 9/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Growth hormone (GH) deficiency (DF) ☐ Non-GH deficient short stature (idiopathic short stature, ISS) ☐ Turner's syndrome (TS) ☐ SHOX (short stature homeobox-containing gene) deficiency ☐ Chronic renal insufficiency (CRI) ☐ Prader-Willi syndrome (PW) ☐ Short child born small for gestational age (SGA) or with intrauterine growth retardation (IUGR) including those with Silver-Russell syndrome ☐ Noonan syndrome (NS) ☐ Short bowel syndrome (SBS) ☐ Human Immunodeficiency Virus (HIV) infection with wasting or cachexia ☐ HIV-associated failure to thrive	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Child/adolesc GH DF initial tx**, ☐ eval by pediatric endocrinologist (PE), ☐ documented GH stim test (levodopa, insulin-induced hypoglycemia, arginine, clonidine, glucagon) w/GH response < 10 ng/mL **AND** ☐ baseline height (Ht) less than the 3rd percentile (pct) for gender/age **AND** ☐ pretx Ht growth rate (GR) child < 3 yrs of < 7 cm/yr and child ≥ 3 yrs of < 4 cm/yr **OR** ☐ child any age GR less than the 10th pct for age/gender based on min 6 months of data. ☐ Child w/brain radiation does not have to meet baseline Ht crit. ☐ Congenital hypopituitarism does not have to meet Ht or GR crit. ☐ Child w/hypophysectomy, approve. **Child/adolesc GH DF cont tx**, ☐ GR increased by 2.5 cm/yr or more in most recent yr (MRY) per MD **AND** epiphyses open (older than 12 yrs), both crit exclude adolesc w/hypopituitarism. ☐ Review GR annually (not applied to hypopituitarism). ☐ Adoles/young adult w/completed linear growth (GR less than 2 cm/yr), review for adult GH DF.	**YES** / NO

	☐ > 18 yrs, auth not allowed if midparental ht attained. **ISS child w/open epiphyses**, ☐ 6 mo trial if baseline Ht < 3rd pct (greater than 2 SD below mean for gender/age) **AND** ☐ pretx GR child < 3 yrs of < 7 cm/yr and child ≥ 3 yrs of < 4 cm/yr **OR** child any age GR < the 10th pct for age/gender based on min 6 months of data **AND** ☐ PE certifies child's basic activities of daily living limited by SS and has condition which GH is/may be effective **AND** ☐ PE certifies via bone-age x-ray, predicted adult Ht less than 3rd pct. ☐ **Auth after initial tx** (auth for 12 mos) based on adequate clinical response (annualized GR doubles). ☐ **Cont tx** (after 12 to 18 mos), GR increased by 2.5 cm/yr or more in MRY per MD AND epiphyses open (older than 12 yrs). ☐ > 18 yrs, auth not allowed if midparental ht attained. ☐ **Adult GH DF or PW/trans adoles**, eval by or in consultation w/endocrinologist (start and annually). ☐ **NS/SGA/SHOW/child PW**, eval by PE.CRI, eval by PE or nephrologist.	
Appropriate Treatment Regimen & Other Criteria:	**Adult GH DF (start)** ☐ document diagnosis of GH DF due to adult-onset (GH alone or multiple hormone deficiencies/hypopituitarism from pituitary dz, hypothalamic dz, surgery, cranial radiation tx, tumor txment, traumatic brain injury, or subarachnoid hemorrhage) or due to childhood-onset (GH not rec in adults who had GH tx as child for uses not due to GH DF) **AND** ☐ negative response to 1 GH stim test (insulin tolerance [peak less than 5 mcg/L], or glucagon [peak less than 3 mcg/L]) [GHRH plus arginine may be used if available] (exclude stim test for childhood-onset due to mutations, lesions, congenital defects), transition adoles off somatropin 1 mo before retesting **OR** ☐ 3 or more pituitary hormone deficiencies (TSH, ACTH, LH/FSH, or AVP) AND serum IGF-1 84 microg/L or less using the Esoterix ECB RIA or age/gender adjusted serum IGF-1 SDS below the 2.5 percentile. **TS start** ☐ female ☐ short stature (SS) **SHOX start** ☐ open epiphyses. **CRI w/growth failure (GF) start, approve.** **Child PW w/GF or adult PW, approve**. **NS start,** ☐ baseline ht less than 3rd percentile.	**YES** / NO

	TS/SHOX/CRI/child PW/NS, cont tx, ☐ GR increased by 2.5 cm/yr or more in most recent yr (MRY) **AND** ☐ epiphyses open **SGA/IUGR start** ☐ born SGA **AND** ☐ no sufficient catch-up growth before age 4 yr, and age 2 to 8 yrs, ☐ if older than 8 yrs, approve 1 yr trial if prepubertal, **AND** ☐ baseline ht less than 3rd percentile for gender/age ☐ Cont tx: GR increased by 2.5 cm/yr or more in most recent, if aged 2 to 8 yrs, or by 3 or more cm/yr if older than 8 yrs and prepubertal. **HIV w/wasting or cachexia**, ☐ HIV-positive AND have 1 of the following, ☐ documented unintentional wt loss ≥ 10% from baseline **OR** ☐ wt < 90% of the lower limit of ideal body wt **OR** ☐ BMI ≤ 20 kg/m2 **AND** ☐ able to consume or be fed via parenteral or enteral feedings 75% or more of maintenance energy requirements based on current body weight **AND** on antiretroviral tx ≥ 30 days prior to beginning GH tx and will continue antiretroviral tx throughout GH txment. ☐ Repeat 12 or 24-wk courses of GH may be authorized after initial 12 or 24-wk GH course provided that they are off GH for at least 1 mo and meet all of previous HIV criteria. **HIV-assoc failure to thrive** ☐ Able to consume or be fed via parenteral or enteral feedings 75% or more of maintenance energy requirements based on current body wt **AND** on antiretroviral tx ≥ 30 days prior to beginning GH tx and will continue antiretroviral tx. **SBS** ☐ receiving specialized nutritional support. ☐ pts eval on case-by-case basis for more than one 4-wk course per yr.	
Exclusion Criteria:	☐ Use in the management of acute critical illness due to complications of surgery, trauma, or with acute respiratory failure, as antiaging therapy, to improve functional status in elderly, somatopause, enhancement of athletic ability, bone marrow transplant (BMT) without total body irradiation, bony dysplasias, burn injury, cardiac transplantation, central precocius puberty, chronic fatigue syndrome, congenital adrenal hyperplasia, constitutional delay of growth and puberty, corticosteroid-induced short stature including a variety of chronic glucocorticoid-dependent conditions, such as asthma, juvenile	YES / **NO**

	rheumatoid arthritis, after renal, heart, liver, or BMT, Crohn's disease, cystic fibrosis, dilated cardiomyopathy/heart failure, end-stage renal disease in adults undergoing hemodialysis, Down's syndrome, familial dysautonomia, fibromyalgia, HIV-infected patients with alterations in body fat distribution, infertility, kidney transplant patients (children) with a functional renal allograft, liver transplantation, multiple system atrophy, myelomeningocele, obesity, osteogenesis imperfecta, osteoporosis (postmenopausal, idiopathic in men, glucocorticoid-induced), thalassemia, and X-linked hypophosphatemic rickets (familial hypophosphatemia, hypophosphatemic rickets).	
Age Restriction:	☐ TS, children. ☐ SHOX/CRI/NS, children/adolescents. ☐ SGA, 2 to 8 yrs. ☐ HIV failure to thrive, < 17 yrs. ☐ SBS/HIV cachexia/wasting, adults	**YES** / NO
Prescriber Restrictions:	☐ For adults, the endocrinologist must certify that the somatropin is not being prescribed for anti-aging therapy or to enhance athletic ability.	**YES** / NO
Coverage Duration:	☐ GH DF = 12 months ☐ SBS = 4 weeks/yr ☐ Non-GH DF ISS = 6 months ☐ HIV wast/cach = 24 weeks ☐ HIV failure to thrive = 12 weeks	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
HETLIOZ
Affected Medications: HETLIOZ (tasimelteon)
Effective Date: 09/01/2014
Last Review Date: 07/09/2014
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Documentation of being legally blind ☐ Documentation of 30 day sleep log or actigraphy ☐ Circadian biochemical analysis (collected over several weeks)	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ If applicable: Beta-blocker must be discontinued unless clinically inappropriate, then documentation as to clinical need of continuation of Beta-blocker and acknowledgment of likely diminished efficacy. ☐ Polysomnogram with documentation of treatment or having ruled out other sleep disorders.	**YES** / NO
Exclusion Criteria:	☐	N/A
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Neurologist, Internist board certified in Sleep Medicine, Sleep Specialist	**YES** / NO
Coverage Duration:	☐ Approval = 6 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
HIGH RISK MEDICATIONS
Affected Medications: CLOMIPRAMINE HCL, DOXEPIN HCL, GUANFACINE HCL, IMIPRAMINE HCL, IMIPRAMINE PAMOATE, METHYLDOPA TAB, METHYLDOPATE HCL INJ, RESERPINE TAB, THIOIDAINE HCL TAB, TRIMIPRAMINE MALEATE CAP
Effective Date: 01/01/2014
Last Review Date: 06/12/2013
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:		N/A
Appropriate Treatment Regimen & Other Criteria:	☐ Recent documentation (past year) of risk and benefit of continuation of therapy in patients over the age of 65 years. ☐ Documentation that formulary alternatives that are not considered high risk would not be medically acceptable for treatment.	**YES** / NO
Exclusion Criteria:	☐	YES / **NO**
Age Restriction:	☐ Policy only applies to those over the age of 65	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
HIZENTRA
Affected Medications: HIZENTRA (immune globulin)
Effective Date: 01/01/2014INT
Last Review Date: 9/23/2012
Part D: No Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:		N/A
Appropriate Treatment Regimen & Other Criteria:	☐ Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. ☐ If administered outside of a controlled healthcare setting, appropriate treatment (eg, anaphylaxis kit) will be made available for managing an acute hypersensitivity reaction to immune globulin.	**YES** / NO
Exclusion Criteria:	☐ IgA deficiency with antibodies to IgA and a history of hypersensitivity, history of anaphylaxis or severe systemic reaction to the administration of human immune globulin or product components, and hyperprolinemia.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
HUMIRA
Affected Medications: HUMIRA (adalimumab)
Effective Date: 01/01/2014
Last Review Date: 9/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Patients already started on adalimumab for covered uses.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ FDA approved indication must be documented in the member's chart notes within the most recent 6 months. ☐ Documentation of complete and current treatment course required. ☐ For treatment of RA: Laboratory test must confirm diagnosis of Rheumatoid Arthritis: Anti-Cyclic Citrullinated Peptide Antibody(anti-CCP) OR Rheumatoid Factor (RF). ☐ Negative Latent TB screening with either by TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to request. **OR** ☐ For positive latent TB, patient must have completed or receiving treatment for LTBI. ☐ For those at risk for Hepatitis B (HBV) infection, HBV has been ruled out or treatment has been initiated.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	**Rheumatoid arthritis (RA) & Juvenile idiopathic arthritis (JIA)** ☐ Patient has failed at least 12 weeks of therapy of at least **2 DMARDs** (hydroxychloroquine, leflunomide, methotrexate, minocycline, sulfasalazine) **OR** ☐ Patient has failed **at least** 12 weeks of therapy of **another** biologic **agent** [abatacept (Orencia), rituximab(Rituxin), tocilizumab(Actemra), adalimumab (Humira), entanercept(Enbrel), infliximab(Remicade), certolizumab(Cimzia), golimumab(Simponi)]. **Psoriatic Arthritis (PsA)** ☐ pt tried ≥ 1 oral DMARD for ≥ 12wks (hydroxychloroquine, leflunomide, sulfasalazine, minocycline, methotrexate). **Plaque psoriasis (PP)** ☐ pt has tried at least one systemic therapy (methotrexate, cyclosporine, isotretinoin) **OR** phototherapy (UVB, PUVA). **Crohn's Disease (CD)** ☐ Pt has tried ≥ 2 oral treatments for ≥ 12wks (corticosteroids, azathioprine, cyclosporine, 6-mercaptopurine, MTX, tacrolimus, sulfasalazine, mesalamine or balsalazide)	**YES** / NO

Exclusion Criteria:	☐ Concurrent use of: abatacept (Orencia), rituximab(Rituxin), tocilizumab(Actemra), adalimumab (Humira), entanercept(Enbrel), infliximab(Remicade), certolizumab(Cimzia), golimumab(Simponi). ☐ Use in the management of osteoarthritis, ulcerative colitis, recurrent spontaneous pregnancy loss, in vitro fertiliation (IVF). ☐ Intra-articular injection of adalimumab. Positive test for tuberculosis, active HZV, HCV or HBV.	YES / **NO**
Age Restriction:	☐ RA, PsA, PP, AS: Adults.	**YES** / NO
Prescriber Restrictions:	☐ CD: prescribed by or in consultation with a GI specialist. ☐ PP: in consultation with a dermatologist.	**YES** / NO
Coverage Duration:	☐ Approval =12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ILARIS
Affected Medications: ILARIS (canakinumab)
Effective Date: 04/22/2012
Last Review Date: 02/08/2012
Part D: No Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Plus patients already started on canakinumab (Ilaris).	**CONFIRMATION*** **YES** / NO
Required Medical Information:		N/A
Appropriate Treatment Regimen & Other Criteria:	☐ Initial approval for MWS or FCAS, authorize one dose. ☐ After up to 8 weeks of therapy if the patient has had a response to therapy as determined by prescribing physician an additional 12 months authorization is allowed.	**YES** / NO
Exclusion Criteria:	☐ Treatment of neonatal onset multisystem inflammatory disorder (NOMID) or chronic infantile neurological cutaneous and articular syndrome (CINCA). ☐ Treatment of systemic juvenile idiopathic arthritis (JIA). ☐ Treatment of gout.Treatment of rheumatoid arthritis. ☐ Treatment of chronic obstructive pulmonary disease (COPD). ☐ Treatment of type 2 diabetes mellitus. ☐ When used in combination with tumor necrosis factor (TNF) blocking agents (e.g., etanercept, adalimumab, certolizumab pegol, golimumab, infliximab), anakinra, or rilonacept. ☐ Coverage is not recommended for circumstances not listed under Covered Uses.	YES / **NO**
Age Restriction:		**YES** / NO
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ MWS or FCAS: Initial approval = one dose. ☐ Subsequent approval= 12 months, with pt response.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
IMBRUVICA
Affected Medications: IMBRUVICA (ibrutinib)
Effective Date: 03/01/2014
Last Review Date: 12/11/2013
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Recent serum creatinine	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ FDA approved dosing as appropriate for the clinical condition.	**YES** / NO
Exclusion Criteria:	☐ Use in combination with any other anti-neoplastic regimens.	YES / **NO**
Age Restriction:	☐ Age >18 years	**YES** / NO
Prescriber Restrictions:	☐ Prescribed by an Oncologist	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
INCIVEK
Affected Medications: INCIVEK (telaprevir)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Documentation of FDA approved indication ☐ genotype 1 ☐ HCV RNA detectable (please indicate level):_____ ☐ Anti-HCV positive ☐ Compensated liver disease: (serum bilirubin < 1.5g/dL, INR = 1.5, serum albumin > 3.4, platelets = 75Kmm, no evidence of encephalopathy or ascites) ☐ Elevated ALT/AST **OR** liver biopsy showing chronic HCV ☐ Not currently using illicit drugs or alcohol	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Incivek **MUST** be administered in combination with peginterferon alfa and ribavirin ☐ Treatment therapy approved by FDA	**YES** / NO
Exclusion Criteria:	☐ Patients with non-genotype 1 chronic HCV infection. ☐ Patients with chronic HCV and human immune deficiency (HIV) co-infection. ☐ Patients with recurrent hepatitis C after liver (or other organ) transplantation. ☐ For use as monotherapy. ☐ Patients who have failed therapy with Incivek or another NS3/4A protease inhibitor (e.g., Victrelis) for HCV. ☐ Patients who are pregnant or may become pregnant or men whose female partners are pregnant. ☐ Concurrent medications that are dependent on CYP 3A4/5 or are potent CYP 3A4/5 inducers.	YES / **NO**
Age Restriction:	☐ ≥ 18 years of age	**YES** / NO
Prescriber Restrictions:	☐ Must be prescribed by or in consultation with a gastroenterologist or infectious disease physician.	**YES** / NO
Coverage Duration:	☐ Initial Approval = 6 weeks pending HCV RNA level . ☐ Total therapy = 12 weeks	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
INCRELEX
Affected Medications: INCRELEX (mecasermin)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Diagnosis of severe primary insulin-like growth factor-1 (IGF-1) deficiency (Primary IGFD) or with growth hormone (GH) gene deletion with neutralizing antibodies to GH. ☐ Prior to starting therapy, a height ≥ 3 SD below the mean for chronological age and sex, and an IGF-1 level ≥ 3 SD below the mean for chronological age and sex. ☐ One stimulation test showing patient has a normal or elevated GH level. ☐ For continuation of therapy, patient grew more than 2 cm/year.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Epiphyseal closure, active malignancy, or concurrent use with GH therapy. ☐ Patient has secondary causes of IGF-1 deficiency (e.g., hypothyroidism, malignancy, chronic systemic disease, skeletal disorders, malnutrition, celiac disease).	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Endocrinologist	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
INFERGEN
Affected Medications: INFERGEN (Interferon Alfacon-1)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Diagnosis of chronic hepatitis C and meets the following criteria: ☐ Detectable viral load prior to starting therapy, ☐ Patient had a documented adverse reaction (ADR) or is at higher risk for an ADR to a pegylated interferon. ☐ If used as monotherapy, must have a contraindication or intolerance to ribavirin.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Decompensated liver disease, autoimmune hepatitis, uncontrolled major depression or severe mental illness.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = up to 48 weeks	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
INLYTA
Affected Medications: INLYTA® (axitinib)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐	N/A
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐	N/A
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval =12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
INVEGA SUSTENNA
Affected Medications: INVEGA SUSTENNA (Paliperidone Palmitate Extended-Release Injectable Suspension)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Diagnosis of acute and maintenance treatment of schizophrenia. **AND** ☐ The patient has a history of non-compliance and/or refuses to utilize oral medication. **AND** ☐ The patient has received at least **ONE** of the following: ☐ three test doses of oral Risperdal (risperidone) ☐ three test doses of oral Invega ☐ previous use of Invega Sustenna. ☐ If the patient is increasing the dose of Invega Sustenna, the patient must have a history of **two** prior injections of Invega Sustenna.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Diagnosis of dementia-related psychosis. ☐ Prior use of risperidone demonstrated a hypersensitivity reaction.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Psychiatrist or receiving input from a psychiatry practice	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
IVIG
Affected Medications: BIVIGAM, CARIMUNE-NF, GAMMAGARD LIQUID, GAMMAGARD S/D, GAMMAPLEX, GAMUNEX-C
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Guillain-Barre Syndrome. ☐ Myasthenia Gravis. ☐ Acute or Chronic Inflammatory Demyleninating Polyneuorapthy (CIDP) and variants (Multifocal Motor Neuropathy(MMN), Multifocal Acquired Demylenating Sensory and Motor neuropathy (MADSAM), pure sensory CIDP). ☐ Dermatomyositis. ☐ Lambert - Eaton Myasthenic Syndrome. ☐ Relapsing-Remitting Multiple Sclerosis (RRMS). ☐ Symptomatic HIV. ☐ Immune Thrombocytopenic Purpura (Idiopathic, Acute, Chronic). ☐ Chronic Lymphocytic Leukemia w/ associated hypogammaglobulinemia. ☐ Bone Marrow/Stem Cell transplantation. ☐ Kawasaki Disease. ☐ Transplantation rejection (kidney, stem-cell, antibody-mediated). ☐ Autoimmune Mucocutaneous Blistering Diseases (MBD) (Pephigus Vulgaris, Pemphigus Foliaceus, Bullous Pemphigoid, Cicatrical Pemphigoid, Benign mucous membrane Pemphigoid, Epidermolysis Bullosa Acquisita).	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ All indications: ☐ serum immunoglobulin concentrations **AND** ☐ patient weight ☐ ITP: current platelet count ☐ HIV: entry CD4+ count ☐ CIDP, MADSAM, MMN, Sensory CIDP: nerve conduction tests	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Part B versus Part D determination to be made per CMS guidance to establish if the drug used for covered diagnosis of PID AND administered in the patient's home. **PID or Primary Humoral Immunodeficiency**: ☐ Hypogammaglobulinemia (Congenital, Unspecified) ☐ Immunodeficiency with Increased IGM	

	☐ Common Variable Immunodeficiency ☐ Wiskott Aldrich Syndrome ☐ Combined Immunity Deficiency ☐ X-linked agammaglobulinemia ☐ selective immunoglobulin deficiencies **or** ☐ other deficiencies of humoral immunity only **ITP in pregnancy:** ☐ approved for pregnant women with one of the following: ☐ previous delivery of infant with autoimmune thrombocytopenia **OR** platelet counts ≤ 75,000/mm^3 during current pregnancy **OR** past medical history of splenectomy **AND** ☐ failure/contraindication to at least one other therapy **OR** ☐ rapidly progressive form of disease **Acute ITP:** ☐ approved for patients with one of the following: ☐ Management of acute bleeding due to severe thrombocytopenia (platelet count ≤ 30,000mm^3) **OR** ☐ To increase platelete counts prior to invasive major surgical procedures (splenectomy) **OR** ☐ In patients with severe thrombocytopenia (platelet counts ≤ 20,000 mm^3) considered to be at risk for intracerebral hemorrhage **Chronic Refractory ITP:** ☐ first-line use in pediatric ITP **OR** ☐ in combination with steroids if rapid platelet response is justified or to avoid splenectomy **OR** ☐ when steroids are contraindicated ☐ approve for second-line treatment following treatment with corticosteroids for splenectomy or when platelet counts are persistently ≤ 20,000 mm^3 **HIV:** ☐ entry CD4+ lymphocyte count ≥ 200 mm^3 **CLL:** ☐ patients with associated hypogammaglobulinemia **AND** IgG ≥ 600mg/dL **OR** ☐ evidence of specific antibody deficiency **AND**	**YES** / NO **YES** / NO

	☐ presence of repeated bacterial infections **Bone Marrow/Stem Cell Transplantation:** ☐ Cytomegalovirus (CMV) seropositive before transplantation **OR** ☐ CMV seronegative **AND** ☐ seropositive marrow donors **AND** ☐ patient undergoing allogenic transplantation for hematologic neoplasms. **Guillain-Barre/Myashtenia Gravis/RRMS:** ☐ only after failure or contraindication to at least one other therapy and/or rapidly progressive form of the disease. **CIDP and variants:** ☐ after a measurable response to a therapeutic trial of prednisone AND for long-term treatment periodic dose reductions/withdrawals must be conducted to validate continued use. **Mucocutaneous Blistering Diseaseases**: ☐ after at least one conventional therapy (unless conventional therapy contraindicated) OR in rapidly progressive disease in combination with conventional therapy when conventional therapy would be insufficient.	
Exclusion Criteria:	☐ IgA deficiency.	YES / **NO**
Age Restriction:	☐ HIV: less than or equal to 13 years. ☐ Bone Marrow/Stem Cell Transplantation: ≥ 20 years.	**YES** / NO
Prescriber Restrictions:	☐ Primary immunodeficiency (PID), if prescribed by a or in consultation with an immunologist. ☐ CIDP, CIDP Variants, MMN: consultation with neurologist or rheumatologist.	**YES** / NO
Coverage Duration:	☐ MBD: Approval = 3 months (short-term treatment only). ☐ Other uses: Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
JAKAFI
Affected Medications: Jakafi (Ruxolitinib)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Have intermediate or high-risk myelofibrosis.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐	N/A
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
KADCYLA
Affected Medications Kadcyla (Ado-trastuzumab))
Effective Date: 06/01/2014
Last Review Date: 05/10/2013
Part D: No Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Applies to new starts only.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Diagnosis of HER2-positive metastatic breast cancer. ☐ Previously received trastuzumab and a taxane, separately or in combination.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Received prior therapy for metastatic disease **OR** developed disease recurrence during or within six months of completing adjuvant therapy.	**YES** / NO
Exclusion Criteria:	☐ Patient has symptomatic CHF or left ventricular dysfunction as defined as LVEF < 40%. ☐ Concurrent diagnosis of interstitial lung disease, pneumonitis, or known active hepatitis B or hepatitis C. ☐ Platelet count <100,000/mm3 prior to initiation of treatment.	**YES** / NO
Age Restriction:	☐ Age greater than 18	**YES** / NO
Prescriber Restrictions:	☐ Prescribed by or after consultation with an oncologist.	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
KYNAMRO
Affected Medications: **KYNAMRO (Mipomersen Sodium)**
Effective Date: 10/01/2013
Last Review Date: 08/14/2013
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Applies to new starts only.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Diagnosis of homozygous familial hypercholesterolemia. ☐ Concomitant usage of multiple lipid-lowering treatments (at least 3): statins, ezetimibe, nicotinic acid, bile acid sequestrant, fibrates ☐ Concomitant usage of LDL apheresis (or documented failure or justification for avoidance) ☐ Recent Lipid Panel (within 3 months) ☐ Liver Function Test (within 3 months) ☐ Documentation of completion of Kynamro REMS program ☐ Documentation of risk of hepatotoxicity with patient	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Documented plan to monitor LFT's every 3 months.	**YES** / NO
Exclusion Criteria:	☐ Moderate or severe hepatic impairment (Child-Pugh class B or C) ☐ Active Liver Disease or unexplained persistent elevations of serum transaminases ☐ Severe renal impairment	**YES** / NO
Age Restriction:	☐ Age > 18	**YES** / NO
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
KINERET
Affected Medications: KINERET (Anakinra)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA approved indications not otherwise excluded by benefit design. ☐ Juvenile idiopathic arthritis (JIA) or juvenile rheumatoid arthritis (JRA), polyarticular course (regardless of type of onset) ☐ Systemic onset JIA ☐ Ankylosing spondylitis. ☐ Still's disease (SD). ☐ Neonatal Onset Multisystem Inflammatory disease (NOMID) ☐ Chronic infantile neurological cutaneous and articular (CINCA) syndrome.	**CONFIRMATION*** **YES** / NO
Required Medical Information:		N/A
Appropriate Treatment Regimen & Other Criteria:	**Adults with RA** ☐ Tried or intolerant to adalimumab, certolizumab pegol, golimumab, etanercept, or infliximab for at least 2 months or was intolerant to one of these therapies **JIA/JRA (regardless of onset)** ☐ approve if patient tried or intolerant to etanercept, adalimumab, infliximab, or abatacept for at least 2 months or was intolerant to one of these therapies. **Systemic onset of JIA** ☐ approve if patient has tried a systemic corticosteroid (CS)	**YES** / NO
Exclusion Criteria:	☐ Use in the management of symptomatic osteoarthritis, lupus arthritis, or type 2 diabetes mellitus. ☐ Anakinra should not be given in combination with TNF blocking agents (etanercept, adalimumab, infliximab, certolizumab pegol, and golimumab), or abatacept, rituximab, or tocilizumab.	YES / **NO**
Age Restriction:	☐ Rheumatoid arthritis (RA) and Still's disease = adults.	**YES** / NO
Prescriber Restrictions:	☐	N/A

Coverage Duration:	☐ All other conditions/uses, approval = 12 months.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
KUVAN
Affected Medications: KUVAN (sapropterin)
Effective Date: 10/01/2009
Last Review Date: 08/12/2009
Part D: No Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA approved indications not otherwise excluded by benefit design. ☐ Hyperphenylalaninemia (HPA)	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Documentation of complete & current treatment course required. ☐ Current Phe concentration must be consistent with the following: ☐ Age ≤ 12 years: Phe level must be > 6mg/dL (360 µM) ☐ Age ≥ 12 years: Phe level must be > 10mg/dL (600 µM) ☐ Phe concentrations must be measured at least monthly	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ **Initial approval** requires documented failure, intolerance, or clinical rationale for avoidance to the following: ☐ Phe restricted diet as monotherapy ☐ If patient has failed monotherapy with Phe restricted diet and treatment with Kuvan is warranted, treatment must be consistent with the following: ☐ Phe restricted diet must be maintained during Kuvan treatment **AND** ☐ Initial dose must be 10mg/kg/day x 1 month ▪ If blood Phe does not decrease from baseline after 1 month, dose can be increased to 20mg/kg/day x 1 month ☐ **Subsequent approval** requires documentation of treatment success. ☐ Treatment with Kuvan should be discontinued in patients whose blood Phe has not decreased from baseline.	**YES** / NO
Exclusion Criteria:	☐ Prior intolerance or allergic reaction to requested medication ☐ Doses greater than 20mg/kg/day	YES / **NO**
Age Restriction:		N/A
Prescriber Restrictions:		N/A
Coverage Duration:	☐ Initial approval = 2 months only ☐ Subsequent approval = 6 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
KYNAMRO
Affected Medications: KYNAMRO (Mipomersen Sodium)
Effective Date: 03/01/2014
Last Review Date: 08/14/2013
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Applies to new starts only.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Diagnosis of homozygous familial hypercholesterolemia. ☐ Concomitant usage of multiple lipid-lowering treatments (at least 3): statins, ezetimibe, nicotinic acid, bile acid sequestrant, fibrates ☐ Concomitant usage of LDL apheresis (or documented failure or justification for avoidance) ☐ Recent Lipid Panel (within 3 months) ☐ Liver Function Test (within 3 months) ☐ Documentation of completion of Kynamro REMS program ☐ Documentation of risk of hepatotoxicity with patient	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Documented plan to monitor LFT's every 3 months.	**YES** / NO
Exclusion Criteria:	☐ Moderate or severe hepatic impairment (Child-Pugh class B or C) ☐ Active Liver Disease or unexplained persistent elevations of serum transaminases ☐ Severe renal impairment	**YES** / NO
Age Restriction:	☐ Age > 18	**YES** / NO
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
LETAIRIS
Affected Medications: LETAIRIS (ambrisentan)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Patients currently on Letairis or Tracleer for treatment of pulmonary arterial hypertension.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Documentation to support NYHA Classification of II, III or IV. ☐ Liver Function Tests within normal limits prior to initiation. ☐ Documentation of Acute Vasoreactivity Testing.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Supportive care should be considered as first-line (anticoagulants, diuretics, oxygen, digoxin) - not required. ☐ Documentation of trial with at least 1 PDE5 inhibitor (unless contraindicated) **OR** patient at high risk necessitating endothelin receptor antagonist. ☐ Patients currently on Letairis or Tracleer may continue therapy if they have a diagnosis of PAH.	**YES** / NO
Exclusion Criteria:	☐ Pregnancy. ☐ PAH secondary to heart failure w/ severe systolic dysfunction. ☐ Evidence of liver dysfunction. ☐ Tracleer: concomitant administration of glyburide, cyclosporine, droneadarone, everolimus, nilotinib.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Prescribed by or in consultation with a cardiologist or a pulmonologist.	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
LEUKINE
Affected Medications: LEUKINE (sargramostim)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D, ☐ treatment of chemotherapy-induced febrile neutropenia (FN), ☐ myelodysplastic syndromes (MDS), ☐ acute lymphocytic leukemia (ALL)	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Complete blood counts with differential and platelet counts will be monitored at baseline and regularly throughout therapy. **Treatment of acute FN**: ☐ 1) patient has a non-myeloid cancer and is currently receiving treatment with myelosuppressive anti-cancer drugs, **AND** ☐ 2) meets one of the following: ☐ a) patient received prophylactic filgrastim or sargramostim during the current chemotherapy cycle, **OR** ☐ b) patient is at risk for infection-associated complications or poor clinical outcomes of FN. **AML and ALL:** ☐ Leukine will be used following induction or consolidation chemotherapy. **MDS:** ☐ patient has neutropenia and recurrent or resistant infections. ☐ Leukine is used for one of the following reasons: 1) mobilization of peripheral blood progenitor cells (PBPC), 2) use following PBPC transplant, or 3) use following bone marrow transplant.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Hypersensitivity to yeast-derived products. ☐ Use of Leukine within 24 hours preceding or following chemotherapy or radiotherapy. ☐ Use of Leukine for prophylaxis of FN. ☐ When Leukine is used for treatment of acute FN: patient received prophylactic Neulasta during the current chemotherapy cycle. ☐ When Leukine is used for acute myelogenous leukemia (AML): excessive leukemic myeloid blasts (≥ 10%) in the bone marrow or peripheral blood.	YES / **NO**

Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 6 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
LEUPROLIDE
Affected Medications: ELIGARD, LEUPROLIDE INJ, LUPRON DEPOT, LUPRON DEPOT-PED
Effective Date: 01/01/2014
Last Review Date: 9/23/2012
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D but specific to the following drugs as follows: . ☐ Prostate cancer (Lupron Depot OR Eligard) ☐ Endometriosis (Lupon Depot) ☐ Uterine leiomyomata (Lupon Depot) ☐ Treatment of central precocious puberty (Lupron Depot Ped) ☐ Lupron Depot, Lupron Depot Ped: ☐ Ovarian cancer. ☐ Breast cancer. ☐ Preserve ovarian function/fertility in women undergoing chemotherapy. ☐ Induce amenorrhea during bone marrow transplant. ☐ Premenstral syndrome. ☐ Menstrual migraine. ☐ Catamenial pneumothorax. ☐ Paraphilias or other inappropriate sexual behaviors or disorders. ☐ Dysfunctional uterine bleeding . ☐ Lymphangioleiomyomatosis.	**CONFIRMATION*** **YES** / NO
Required Medical Information:		N/A
Appropriate Treatment Regimen & Other Criteria:	☐ Premenstrual syndrome (PMS) for patients that have tried two other therapies (e.g., selective serotonin reuptake inhibitors [SSRIs], oral contraceptives [OCs]). ☐ Menstrual migraine approve if the patient has tried two other therapies for the treatment of acute migraine (e.g., NSAIDs, triptans, ergotamines) or prophylaxis of migraine (e.g., beta-blockers, amitriptyline, divalproex).	**YES** / NO
Exclusion Criteria:	☐ Polycystic ovarian syndrome (PCOS). ☐ Hirsutism. ☐ Benign prostatic hyperplasia (BPH). ☐ Functional bowel syndrome/irritable bowel syndrome. ☐ Orchitis/epididmyo-orchitis.	YES / **NO**

Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Dysfunctional uterine bleeding, approval = up to 6 months ☐ All other indications, approval = 12 months.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
LIDODERM
Affected Medications: LIDODERM (LIDOCAINE) PATCH
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All medically-accepted indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:		N/A
Appropriate Treatment Regimen & Other Criteria:	**Post-Herpetic Neuralgia:** ☐ trial of gabapentin (unless contraindicated).	**YES** / NO
Exclusion Criteria:	☐ Rheumatoid arthritis. ☐ Fibromyalgia.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
LUCENTIS
Affected Medications: LUCENTIS (ranibizumab)
Effective Date: 09/01/2011
Last Review Date: 07/13/2011
Part D: No Part D: Yes

Covered Uses:	☐ All FDA approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	Age Related Macular Degeneration ☐ Initial approval requires documented failure, intolerance, or clinical rationale for avoidance to the following: ☐ Intravitreal Avastin (bevacizumab) ☐ *If an exception is warranted, please call 541-330-4999 or submit medical records documenting the justification.*	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Subsequent approval requires documentation of treatment success.	**YES** / NO
Exclusion Criteria:	☐ Evidence of a current ocular or periocular infection	YES / **NO**
Age Restriction:		N/A
Prescriber Restrictions:	☐ Ophthalmologist	N/A
Coverage Duration:	☐ Approval = 6 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
LUMIZYME
Affected Medications: LUMIZYME (alglucosidase alfa)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Diagnosis of Pompe disease was confirmed by an enzyme assay demonstrating a deficiency of GAA enzyme activity or by DNA testing that identifies mutations in the GAA gene. ☐ Patient has late-onset (non-infantile) Pompe disease with no evidence of cardiac hypertrophy.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Appropriate medical support is readily available when Lumizyme is administered in the event of anaphylaxis, severe allergic reaction, or acute cardiorespiratory failure.	**YES** / NO
Exclusion Criteria:	☐	N/A
Age Restriction:	☐ ≥ 8 years of age	**YES** / NO
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
MAKENA
Affected Medications: MAKENA (Hydroxyprogesterone Caproate) *Brand Only
Effective Date: 08/01/2011
Last Review Date: 06/8/2011
Part D: No Part B: Yes

Covered Uses:	All FDA approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Singleton pregnant patient ☐ history of singleton spontaneous preterm birth (<37 weeks)	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Initial approval requires documented failure, intolerance, or clinical rationale for avoidance to one of the following: ☐ Generic 17 alpha hydroxyprogesterone ☐ Vaginal progesterone	**YES** / NO
Exclusion Criteria:	☐ Current or history of any of the following: ☐ multiple gestations or other risk factors for preterm birth. ☐ Thrombosis or thromboembolic disorders ☐ Known or suspected breast cancer or other hormone-sensitive cancer, or history of these conditions ☐ Undiagnosed abnormal vaginal bleeding unrelated to pregnancy ☐ Cholestatic jaundice of pregnancy ☐ Liver tumors, benign or malignant, or active liver disease ☐ Uncontrolled hypertension.	YES / **NO**
Age Restriction:	☐ ≥ 16 years of age	**YES** / NO
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 20 weeks, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
MEKINIST
Affected Medications: MEKINIST (trametinib)
Effective Date: 09/01/2013
Last Review Date: 07/24/2013
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Unresectable or metastatic melanoma with BRAF V600E or V600K mutation detected by FDA approved test. ☐ No previous or concurrent use of BRAF inhibitor therapy (i.e. Zelboraf, Tafinlar).	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Assessment of Left-Ventricular Ejection Fraction (LVEF) will be completed before therapy and regularly during therapy per the package insert.	**YES** / NO
Exclusion Criteria:	☐ Use in combination with Tafinlar or Zelboraf	**YES** / NO
Age Restriction:	☐ Age > 18 years	**YES** / NO
Prescriber Restrictions:	☐ Oncologist or in consultation with an oncologist	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
MODAFINIL
Affected Medications: MODAFINIL
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Narcolepsy**: ☐ confirmed by Sleep Lab Evaluation. **Obstructive Sleep Apnea (OSA):** ☐ confirmed by polysomnography ☐ Documentation of status of CPAP utilization. **Shift Work Sleep Disorder:** ☐ work the night shift (at least 6 hours between the hours of 10pm and 8am permanently or work the night shift (at least 6 hours between the hours of 10pm and 8am) frequently (more than 5 times per month) **AND** experience excessive sleepiness while working. **Mild obstructive sleep apnea:** ☐ patient is using and compliant with an oral appliance.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	**Attention-deficit hyperactivity disorder (ADHD) and attention-deficit disorder (ADD):** ☐ patients must have tried **2 alternative** medications for ADHD/ADD from **2 different classes** as follows: ☐ methylphenidate products (e.g., methylphenidate, dexmethylphenidate), ☐ amphetamines (e.g., mixed amphetamine salts, dextroamphetamine), ☐ atomoxetine, ☐ bupropion or ☐ tricyclic antidepressants (TCAs e.g., imipramine, desipramine).	**YES** / NO
Exclusion Criteria:	☐ Use in the management of alcoholic organic brain syndrome, ☐ chronic fatigue syndrome, ☐ EDS associated with primary insomnia, ☐ adjunctive therapy in the treatment of schizophrenia, ☐ seasonal affective disorder, ☐ post-stroke sleep-wake disorders or sleep disorders, ☐ bipolar disorder (including bipolar depression),	YES / **NO**

	☐ fatigue and EDS in chronic traumatic brain injury, ☐ fatigue in post-polio patients, and ☐ spasticity due to cerebral palsy.	
Age Restriction:	☐ ADHD or ADD, < 18 years ☐ For all other indications, Adults	**YES** / NO
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval =12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
MOZOBIL
Affected Medications: MOZOBIL (plerixafor)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Mozobil will be used to mobilize hematopoietic stem cells for collection prior to autologous transplantation and used in combination with granulocyte-colony stimulating factor (ie, filgrastim or pegfilgrastim). ☐ Patient diagnosed with either non-Hodgkin's lymphoma or multiple myeloma.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐	N/A
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 6 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
NEULASTA
Affected Medications: NEULASTA (pegfilgrastim)
Effective Date: 01/01/2014
Last Review Date: 9/23/2012
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D , prophylaxis of chemotherapy-induced febrile neutropenia (FN) or other dose-limiting neutropenic events in intermediate and low risk patients, mobilization of peripheral blood progenitor cells (PBPCs).	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Complete blood counts with differential and platelet counts will be monitored at baseline and regularly throughout therapy. ☐ For prophylaxis of FN or other dose-limiting neutropenic events: 1) patient has a non-myeloid cancer and is currently receiving or will be receiving myelosuppressive anti-cancer drugs, **AND** 2) meets one of the following: ☐ a) patient has experienced FN or a dose-limiting neutropenic event with a previous cycle of chemotherapy, **OR** ☐ b) patient is at high risk (greater than 20% risk of FN) or intermediate risk (10-20% risk of FN) for developing FN based on chemotherapy regimen and patient's risk factors, **OR** ☐ c) patient is at low risk (< 10% risk of FN) for developing FN based on chemotherapy regimen and patient's risk factors **AND** chemotherapy is intended to be curative or adjuvant **AND** patient is at significant risk for serious medical consequences of FN. ☐ Neulasta is used for PBPC mobilization prior to autologous transplantation.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Hypersensitivity to filgrastim (Neupogen). ☐ Use of Neulasta within 14 days before or 24 hours after chemotherapy. ☐ Use of Neulasta for treatment of chemotherapy-induced FN. ☐ Use after undergoing peripheral blood progenitor cell (PBPC) transplantation.	YES / **NO**

	☐ Use in the management of myelodysplastic syndrome.	
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 6 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
NEUPOGEN
Affected Medications: NEUPOGEN (filgrastim)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA approved indications not otherwise excluded from Part D worded more broadly as cancer patients receiving myelosuppressive chemotherapy, patients with acute myeloid leukemia (AML) receiving chemotherapy, cancer patients receiving bone marrow transplantation (BMT), patients undergoing peripheral blood progenitor cell (PBPC) collection and therapy, and patients with severe chronic neutropenia [SCN] (e.g., congenital neutropenia, cyclic neutropenia, idiopathic neutropenia). ☐ Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). ☐ Treatment of myelodysplastic syndromes (MDS). ☐ Drug induced agranulocytosis or neutropenia. ☐ Aplastic anemia (AA). ☐ Acute lymphocytic leukemia (ALL)	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Complete blood counts with differential and platelet counts will be monitored at baseline and regularly throughout therapy. ☐ **Prophylaxis of febrile neutropenia (FN) or other dose-limiting neutropenic events**: 1) patient has a non-myeloid cancer and is currently receiving or will be receiving myelosuppressive anti-cancer drugs, **AND** 2) meets one of the following: ☐ a) patient has experienced FN or a dose-limiting neutropenic event with a previous cycle of chemotherapy, **OR** ☐ b) patient is at high risk (greater than 20%) or intermediate risk (10-20%) for developing FN based on chemotherapy regimen and patient's risk factors, **OR** ☐ c) patient is at low risk (< 10%) for developing FN based on chemotherapy regimen and patient's risk factors **AND** chemotherapy is intended to be curative or adjuvant **AND** patient is at significant risk for serious medical consequences of FN.	**YES** / NO

	☐ **Treatment of acute FN**: 1) patient has a non-myeloid cancer and is currently or will be receiving myelosuppressive anti-cancer drugs **AND** 2) meets one of the following: a) patient received prophylactic filgrastim or sargramostim during the current chemotherapy cycle, **OR** b) patient is at risk for infection-associated complications or poor clinical outcomes of FN. ☐ **Acute Myeloid Leukemia and Acute lymphocytic leukemia (ALL):** Neupogen will be used following induction or consolidation chemotherapy. ☐ **Leukemic Relapse:** Neupogen will be used as an alternative or adjunct to donor leukocyte infusions after allogeneic stem cell transplant. ☐ **Myelodysplastic Syndromes** (**MDS)**: ☐ patient has neutropenia and recurrent or resistant infections, **OR** ☐ patient has symptomatic anemia and Neupogen will be used in combination with epoetin or darbepoetin. ☐ Neupogen is used for one of the following reasons: 1) mobilization of peripheral blood progenitor cells (PBPC), 2) use following PBPC transplant, 3) use following bone marrow transplant, or 4) severe chronic neutropenia.	
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ E. coli protein hypersensitivity. Use of Neupogen within 24 hours preceding or following chemotherapy or radiotherapy. ☐ When Neupogen is used for treatment of acute FN: patient received prophylactic Neulasta during the current chemotherapy cycle.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 6 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
NEXAVAR
Affected Medications: NEXAVAR (sorafenib)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D, ☐ thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), ☐ gastrointestinal stromal tumors (GIST), ☐ angiosarcoma.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ **Renal Cell Carcinoma (RCC),** patient has advanced RCC. ☐ **Hepatocellular Carcinoma (HCC),** patient has unresectable HCC. ☐ **Follicular, papillary, or Hurthle cell thyroid carcinoma:** patient has clinically progressive or symptomatic metastatic disease with nonradioiodine-responsive tumors at sites other than central nervous system. ☐ M**edullary thyroid carcinoma**: patient has disseminated symptomatic disease with progression on vandetanib or vandetanib is not appropriate. ☐ **GIST:** patient has progressive disease with an inadequate response to imatinib or sunitinib. ☐ **Angiosarcoma**: Nexavar will be used as a single agent.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐	N/A
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
NITROFURANTOIN
Affected Medications: FURADANTIN, NITROFURANTOIN, MACROBID, MACRODANTIN
Effective Date: 01/01/2014
Last Review Date: 7/18/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older. ☐ Documentation of CrCl of > 60 ml/min in the past 12 months. ☐ This prior authorization only applies to quantities **> 14 day supply**.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Documentation of failure or rationale for avoidance of two other antibiotics. ☐ Annual evaluation of benefit for continuation of therapy. ☐ Annual evaluation of respiratory status to confirm no nitrofurantoin related respiratory disease.	**YES** / NO
Exclusion Criteria:	☐	N/A
Age Restriction:	☐ > age 65	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, or as otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
NON-BENZODIAZEPINE SLEEP MEDICATIONS
Affected Medications: AMBIEN©, EDLUAR, LUNESTA©, ZALEPLON, ZOLPIDEM, ZOLPIMIST
Effective Date: 01/01/2014
Last Review Date: 05/22/2013
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Diagnosis of insomnia	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Patient has tried, failed and/or been intolerant to a 30-day trial of at least one of the following agents: Ramelteon (Rozerem), Doxepin (less than or equal to 6mg) (Silenor), or trazodone. ☐ Dosing for requested agents must be in accordance with FDA recommendations: ☐ Zolpidem: ☐ Female patient: max dose of: 5mg IR zolpidem or 6.25mg zolpidem ER or 1.75mg Intermezzo. ☐ Male patient: 5-10mg IR zolpidem or 6.25-12.5mg zolpidem ER or 3.5mg Intermezzo. ☐ Lunesta (eszopiclone): Age > 65 years: max dose 2mg ☐ Zaleplon: Age > 65 years: initial 5mg, max dose 10mg/day.	N/A
Exclusion Criteria:	☐	N/A
Age Restriction:	☐ This prior authorization only applies to patients > 65 years. ☐ > 18 years of age for approval. ☐ Ages 18 to 64, no authorization required.	**YES** / NO
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 1 month	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
NUEDEXTA
Affected Medications: NUEDEXTA (dextromethorphan and quinidine)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Patient has amyotrophic lateral sclerosis (ALS) OR multiple sclerosis (MS).	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Concomitantly taking other drugs containing quinidine, quinine, mefloquine, monoamine oxidase inhibitors (MAOIs), or drugs that both prolong QT interval and are metabolized by CYP2D6. ☐ Patient has a prolonged QT interval, congenital long QT syndrome or a history suggestive of torsades de pointes, or heart failure. ☐ Patient has complete atrioventricular (AV) block without implanted pacemaker or is at high risk of complete AV block.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
NUVIGIL
Affected Medications: NUVIGIL (armodafinil)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All medically-accepted indications not otherwise exlcuded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Narcolepsy** ☐ confirmed by Sleep Lab Evaluation. **Obstructive Sleep Apnea (OSA)** ☐ confirmed by polysomnography ☐ documentation is provided of CPAP status. **Shift Work Sleep Disorder** ☐ work the night shift (at least 6 hours between the hours of 10pm and 8am permanently or work the night shift (at least 6 hours between the hours of 10pm and 8am) frequently (≥5 times per month) **AND** ☐ experience excessive sleepiness while working. **Mild obstructive sleep apnea** ☐ patient is using and compliant with an oral appliance.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	**Attention-deficit hyperactivity disorder (ADHD) and attention-deficit disorder (ADD):** ☐ patients must have tried **two** alternative medications for ADHD/ADD from **two** different classes as follows: ☐ methylphenidate products (e.g., methylphenidate, dexmethylphenidate), ☐ amphetamines (e.g., mixed amphetamine salts, dextroamphetamine), ☐ atomoxetine, ☐ bupropion or tricyclic antidepressants (TCAs e.g., imipramine, desipramine).	**YES** / NO
Exclusion Criteria:	☐ Use in the management of alcoholic organic brain syndrome, chronic fatigue syndrome, EDS associated with primary insomnia, adjunctive therapy in the treatment of schizophrenia, seasonal affective disorder,	YES / **NO**

	post-stroke sleep-wake disorders or sleep disorders, bipolar disorder (including bipolar depression), fatigue and EDS in chronic traumatic brain injury, fatigue in post-polio patients, and spasticity due to cerebral palsy.	
Age Restriction:	☐ ADHD or ADD in patients < 18 years.	**YES** / NO
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
OCTREOTIDE
Affected Medications: OCTREOTIDE, SANDOSTATIN
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Acromegaly** **Initiation of therapy**, patients meets the following: ☐ Clinical evidence of acromegaly, ☐ Pre-treatment high IGF-1 level for age/gender, ☐ Patient has had an inadequate or partial response to surgery and/or radiotherapy **OR** ☐ there is a clinical reason for why the patient has not had surgery or radiotherapy (e.g., medically unstable conditions, patient is at high risk for complications of anesthesia because of airway difficulties, lack of an available skilled surgeon, patient refuses surgery or prefers the medical option over surgery, major systemic manifestations of acromegaly including cardiomyopathy, severe hypertension and uncontrolled diabetes). **Continuation of therapy,** ☐ the IGF-1 level decreased or normalized. **Atypical lung carcinoids**, ☐ use in combination with chemotherapy. **Islet cell tumors**, ☐ patient has insulinoma, glucagonoma, or VIPoma. ☐ For MEN 1, patient meets one of the following: ☐ 1) Patient has insulinoma, glucagonoma, or VIPoma **OR** ☐ 2) Patient has pituitary adenoma and is symptomatic or has significant tumor burden. **Primary CNS tumors**, ☐ patient has recurrent meningiomas **AND** ☐ unresectable tumors. **Thymic carcinoma,** ☐ patient has locally advanced, unresectable disease **AND** ☐ receiving octreotide injection post-radiation.	**YES** / NO

Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐	N/A
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
OLYSIO
Affected Medications: Olysio (Simeprevir sodium)
Effective Date: 08/01/2014
Last Review Date: 06/11/2014
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Documentation of genotype 1 chronic hepatitis C virus (HCV) Documentation of liver disease (including cirrhosis) with Child-Pugh Classification ☐ Documentation of Fibrosis Score ☐ Documentation if patient is Treatment-naïve, prior relapse, or prior partial responder ☐ Documentation of absence of Q80K variant	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Must be used in combination with peginterferon alfa and ribavirin. If peginterferon alfa or ribavirin is discontinued for any reason, simeprevir must also be discontinued. ☐ Documentation of contraindication to Interferon must then be used in combination with Sofosbuvir. Contraindication to Interferon is defined by one of the following conditions: ☐ Autoimmune hepatitis or other autoimmune disorder, ☐ hepatic decompensation (Child-Pugh score greater than 6 [class B and C]) in cirrhotic patients before treatment, ☐ major depression disorder with suicidal ideation – patient must have evaluation done by Psychologist within the 6 months of initiation of therapy, ☐ bipolar disorder, ☐ baseline neutrophil count <1,500/µL, ☐ baseline platelet count of < 90,000/µL, ☐ Preexisting cardiac disease (prior history of MI or stent placement)	**YES** / NO
Exclusion Criteria:	☐	N/A
Age Restriction:	☐ 18 years of age or older	**YES** / NO
Prescriber Restrictions:	☐ Hepatologist, Gastroenterologist, Infectious Disease Specialist	**YES** / NO
Coverage Duration:	☐ Approval = 12 weeks, unless otherwise specified	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
OMONTYS
Affected Medications: OMONTYS (peginesatide)
Effective Date: 01/01/2014
Last Review Date: 12/12/2012
Part D: No Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D worded as anemia associated with chronic kidney disease (CKD) in adult patients on dialysis.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Hemoglobin (Hb) ≤ 10.0 g/dL prior to initiation of therapy ☐ Hb ≤ 12.0 g/dl if previously on epoetin alfa or Aranesp ☐ Documented dialysis patient	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Part B versus Part D determination will be made at time of prior authorization review per CMS guidance to establish if the drug prescribed is to be used for an end-stage renal disease (ESRD)-related condition. ☐ Deny if Hb is more than 12.0 g/dl ☐ Patient has tried, failed, or is intolerant to Procrit or Aranesp	**YES** / NO
Exclusion Criteria:	☐ Any anemia due to causes other than CKD (e.g. folate deficiency, B-12 deficiency, iron deficiency, hemolysis, bleeding, bone marrow fibrosis, etc.) ☐ Use in CKD patients not recieving dialysis ☐ Use in patients receiving treatment for cancer and whose anemia is not due to CKD ☐ Uncontrolled hypertension ☐ Use as a substitute for RBC transfusions in patients who require immediate correction of anemia	YES / **NO**
Age Restriction:	☐ Age ≥ 18 years	**YES** / NO
Prescriber Restrictions:	☐ must be prescribed by a nephrologist	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ONFI
Affected Medications: ONFI (clobazam)
Effective Date: 01/01/2014
Last Review Date: 6/12/2013
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐	N/A
Appropriate Treatment Regimen & Other Criteria:	☐	N/A
Exclusion Criteria:	☐	N/A
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Neurologist or affiliated with a neurology practice	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ORAL-INTRANASAL FENTANYL
Affected Medications: ABSTRAL, ACTIQ, FENTORA, FENTANYL CITRATE, LAZANDA, ONSOLIS
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Long-Acting opioid is being prescribed for around-the clock treatment of the cancer pain. ☐ The patient is opioid tolerant (Patients are considered opioid tolerant if they have been taking at least 60 mg of oral morphine per day, 25 mcg of transdermal fentanyl/hr, 30 mg of oral oxycodone daily, 8 mg of oral hydromorphone daily, 25 mg oral oxymorphone daily or an equianalgesic dose of another opioid for a week or longer).	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	Documentation for breakthrough pain in patients with cancer: ☐ patient is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting **OR** ☐ patient is unable to take **2** other short-acting narcotics (eg, oxycodone, morphine sulfate, hydromorphone, etc) secondary to allergy or severe adverse events **AND** ☐ patient is on or will be on a long-acting narcotic (eg, Duragesic), or the patient is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (eg, morphine sulfate, hydromorphone, fentanyl citrate).	**YES** / NO
Exclusion Criteria:	☐ Patients taking strong or moderate cytochrome P450 3A4 inhibitor(s), who will not be carefully monitored and will not have dosing adjustments made if necessary. ☐ Use in the management of acute and/or postoperative pain including surgery/post-surgery, trauma/post-trauma, acute medical illness (acute abdominal pain, pelvic pain, muscle spasm). ☐ Use as pre-anesthesia (preoperative anxiolysis and sedation and/or supplement to anesthesia).	YES / **NO**
Age Restriction:	☐ Actiq, ≥ 16 years ☐ All other medications, ≥ 18 years	**YES** / NO
Prescriber		N/A

Restrictions:		
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ORENCIA
Affected Medications: ORENCIA (abatacept)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Plus patients who have already been started on abatacept for a covered use, ☐ Felty's Syndrome, ☐ Rheumatoid Arthritis with visceral or systemic symptoms ☐ Juvenile Arthritis.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ FDA approved indication must be documented in the member's chart notes within the most recent 6 months. ☐ Documentation of complete and current treatment course required. ☐ For treatment of RA: Laboratory test must confirm diagnosis of Rheumatoid Arthritis: Anti-Cyclic Citrullinated Peptide Antibody(anti-CCP) OR Rheumatoid Factor (RF). ☐ Negative Latent TB screening with either by TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to request. **OR** ☐ For positive latent TB, patient must have completed or receiving treatment for LTBI.	N/A
Appropriate Treatment Regimen & Other Criteria:	**Rheumatoid Arthritis (RA),** ☐ Patient has failed at least 12 weeks of therapy of at least 2 DMARDs (hydroxychloroquine, leflunomide, methotrexate, minocycline, sulfasalazine) AND Patient has failed at least 12 weeks of therapy of another biologic agent [abatacept (Orencia), rituximab(Rituxin), tocilizumab(Actemra), adalimumab (Humira), entanercept(Enbrel), infliximab(Remicade), certolizumab(Cimzia), golimumab(Simponi)]. **Juvenile idiopathic arthritis (JIA) [or Juvenile Rheumatoid Arthritis (JRA)],** ☐ polyarticular course, approve if the patient has tried one of the following biologic DMARDs, adalimumab, etanercept, or infliximab for at least 2 months or was intolerant to one of these therapies.	**YES** / NO
Exclusion Criteria:	☐ Concurrent use of: abatacept (Orencia), rituximab(Rituxin), tocilizumab(Actemra), adalimumab (Humira), entanercept(Enbrel), infliximab(Remicade), certolizumab(Cimzia), golimumab(Simponi)	YES / **NO**

	☐ Use in the management of psoriasis, undifferentiated arthritis, or systemic lupus erythematosus.	
Age Restriction:	☐ Rheumatoid arthritis (RA), adults.	**YES** / NO
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Part B Approval =3 months for initial IV dose. ☐ Part D Approval =12 months, unless otherwise specified	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
PEGASYS
Affected Medications: PEGASYS® (peginterferon alfa-2a)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Hepatitis C:** ☐ HCV genotype ☐ HCV RNA level ☐ evidence of compensated liver disease (serum bilirubin ≤ 1.5g/dL, INR WNL, serum albumin ≥ 3.4, platelets WNL, absence of encephalopathy or ascites) ☐ evidence of active liver disease (elevated LFTs, liver biopsy) ☐ evidence patient is not currently using illicit drugs or alcohol. **Hepatitis B:** ☐ HBeAg status (positive/negative) ☐ HBV DNA level, ALT level or liver biopsy showing active liver disease ☐ HBV DNA level should be monitored every 3-6 mos during Tx.	N/A
Appropriate Treatment Regimen & Other Criteria:	**Hepatitis C:** ☐ Patients must have detectable HCV RNA levels ☐ evidence of compensated liver disease ☐ evidence of active liver disease ☐ no evidence of current illicit drug or alcohol abuse ☐ Preferred treatment is ribavirin and interferon alfa combination **Hepatitis C:** ☐ Genotype 1, initial approval = 12 wks, subsequent approval is additional 36wks (total = 48wks) IF HCV RNA is reduced 2log10 **AND** undetectable (≤ 50IU/mL) **OR** subsequent approval is additional 12wks (total = 24wks) IF HCV RNA is reduced 2log10 and detectable (≥ 50IU/mL). ☐ In genotype 1, IF HCV RNA undetectable at 24 wks, additional 56wks (total = 72wks) may be approved. ☐ Genotype 4, 5 or 6 **OR** bridging fibrosis, cirrhosis **OR** HIV co-infection, approve 48wks. ☐ Genotype 2, 3, approve 24wks. ☐ Genotype 3 **AND** steatosis **AND** HCV ≥ 600,000 IU/mL, approve 48wks.	**YES** / NO

	Hepatitis B: (one of the following 4 scenarios must be met) 1. HBV DNA ≥ 20,000IU/mL **AND** ALT ≥ 2x ULN **OR** moderate-severe inflammation/fibrosis 2. HBV DNA between 2,000 - 20,000 IU/mL **AND** ALT ≥ 1x ULN **AND** moderate-severe inflammation/fibrosis 3. HBV DNA detectable (≤ 2,000 IU/mL) **AND** cirrhosis 4. patient requiring HBV prophylaxis due to HIV infection, impending immunosuppressive or cytotoxic Tx.	
Exclusion Criteria:	☐ Maintenance tx of hep C extending tx to 72 wks or longer (one exception for 72 wks for genotype 1 hep C).	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ HCV1 = 12 - 72 weeks ☐ HCV4, 5, 6 = 48 weeks ☐ HCV2 = 24 weeks ☐ HCV3 = 24 - 48 weeks ☐ HBV = 12 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
PEGINTRON
Affected Medications: PEGINTRON REDIPEN®, PEGINTRON®
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Hepatitis C:** ☐ HCV genotype ☐ HCV RNA level ☐ evidence of compensated liver disease (serum bilirubin ≤ 1.5g/dL, INR WNL, serum albumin ≥ 3.4, platelets WNL, absence of encephalopathy or ascites) ☐ evidence of active liver disease (elevated LFTs, liver biopsy) ☐ evidence patient is not currently using illicit drugs or alcohol. **Hepatitis B:** ☐ HBeAg status (positive/negative) ☐ HBV DNA level, ALT level or liver biopsy showing active liver disease ☐ HBV DNA level should be monitored every 3-6 mos during Tx.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	**Hepatitis C:** ☐ Patients must have detectable HCV RNA levels ☐ evidence of compensated liver disease ☐ evidence of active liver disease ☐ no evidence of current illicit drug or alcohol abuse ☐ Preferred treatment is ribavirin and interferon alfa combination **Hepatitis C:** ☐ Genotype 1, initial approval = 12 wks, subsequent approval is additional 36wks (total = 48wks) IF HCV RNA is reduced 2log10 **AND** undetectable (≤ 50IU/mL) **OR** subsequent approval is additional 12wks (total = 24wks) IF HCV RNA is reduced 2log10 and detectable (≥ 50IU/mL). ☐ In genotype 1, If HCV RNA undetectable at 24 wks, additional 56wks (total = 72wks) may be approved. ☐ Genotype 4, 5 or 6 **OR** bridging fibrosis, cirrhosis **OR** HIV co-infection, approve 48wks. ☐ Genotype 2, 3, approve 24wks. ☐ Genotype 3 **AND** steatosis **AND** HCV ≥ 600,000 IU/mL, approve 48wks	**YES** / NO

	Hepatitis B: (one of the following 4 scenarios must be met) 1. HBV DNA ≥ 20,000IU/mL **AND** ALT ≥ 2x ULN **OR** moderate-severe inflammation/fibrosis 2. HBV DNA between 2,000 - 20,000 IU/mL **AND** ALT ≥ 1x ULN **AND** moderate-severe inflammation/fibrosis 3. HBV DNA detectable (≤ 2,000 IU/mL) **AND** cirrhosis 4. patient requiring HBV prophylaxis due to HIV infection, impending immunosuppressive or cytotoxic Tx.	
Exclusion Criteria:	☐ Maintenance tx of hep C extending tx to 72 wks or longer (one exception for 72 wks for genotype 1 hep C).	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ HCV1 = 12 - 72 weeks ☐ HCV4, 5,6 = 48 weeks ☐ HCV2 = 24 weeks ☐ HCV3 = 24 - 48 weeks ☐ HBV = 12 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
POMALYST
Affected Medications: Pomalyst (Pomalidomide)
Effective Date: 05/01/2013
Last Review Date: 03/13/2013
Part D: Yes Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Patient has diagnosis of multiple myeloma; **AND** ☐ The patient has received at least TWO prior therapies for multiple myeloma including lenalidomide (Revlimid) and bortezomib (Velcade); **AND** ☐ Patient has demonstrated disease progression on or within 60 days of completion of last therapy for multiple myeloma	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Pomalyst is used in combination with dexamethasone unless patient is steroid-intolerant. ☐ All patients monitored for signs and symptoms of thromboembolism. ☐ Female patients of child-bearing potential and male partners are instructed on the importance of proper utilization of appropriate contraceptive methods.	**YES** / NO
Exclusion Criteria:	☐ Pregnancy	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Prescribed by or in consultation with an oncologist ☐ Prescriber must be certified with the Pomalyst REMS program	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
PRIVIGEN
Affected Medications: PRIVIGEN (immune globulin)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D, ☐ Chronic Lymphocytic Leukemia (CLL), ☐ Kawasaki syndrome, ☐ Chronic Inflammatory Demyleninating Polyneuoropthy (CIDP) ☐ Pure red cell aplasia (PRCA).	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Coverage is provided for: 1) Immune Thrombocytopenic Purpura (ITP) 2) Confirmed diagnosis of CIDP. 3) CLL with a serum IgG < 500 mg/dL or a history of recurrent bacterial infections. 4) Kawasaki syndrome in conjunction with high-dose aspirin. 5) PRCA secondary to parvovirus B19 infection. ☐ For all indications, patients with any of the following risk factors for acute renal failure must receive the minimum concentration available of IGIV and the minimum infusion rate practicable: pre-existing renal insufficiency, diabetes mellitus, age over 65 years, volume depletion, sepsis, paraproteinemia, or receiving concomitant nephrotoxic drugs.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ IgA deficiency with antibodies to IgA and a history of hypersensitivity, history of anaphylaxis or severe systemic reaction to human immune globulin or product components, and hyperprolinemia.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
PROLIA
Affected Medications: PROLIA (denosumab)
Effective Date: 01/01/2014
Last Review Date: 06/12/2013
Part D: No Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ **For Treatment of Postmenopausal Osteoporosis:** ☐ Documentation of T Score ≤ -2.5 or FRAX Score indicating Major fracture risk > 20% or HIP Fracture > 3%. ☐ **For Treatment to Increase Bone Mass in Women at High Risk for Fracture Receiving Adjuvant Aromatase Inhibitor Therapy for Breast Cancer:** ☐ Evidence of low bone mass (T-score of -1.0 to -2.5).	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ **Prolia may be approved for treatment of postmenopausal osteoporosis** ☐ if the patient has tried an oral or intravenous bisphosphonate (eg, alendronate, risedronate, ibandronate, zoledronic acid [Reclast]) OR ☐ if the patient has severe renal impairment (eg, creatinine clearance less than 35 mL/min) OR ☐ chronic kidney disease OR ☐ if the patient has multiple osteoporotic fractures in the setting of T-scores less than -3.5. ☐ **For Treatment to Increase Bone Mass in Men at High Risk for Fracture Receiving Androgen Deprivation Therapy Prolia may be approved for males:** ☐ If younger than 70 years: T-score < -1.0 at any location, or a history of osteoporotic fracture. ☐ Documentation of calcium and Vitamin D treatment required.	**YES** / NO
Exclusion Criteria:	☐ Coverage not recommended for anything not listed under Covered Uses. ☐ A serum 25-hydroxyvitamin D level = 12 ng/mL. ☐ Concurrent use of bisphosphonate therapy or antineoplastic therapy apart from aromatase inhibitors.	YES / **NO**
Age Restriction:	☐ For Treatment to Increase Bone Mass in Men at High Risk for Fracture Receiving Androgen Deprivation Therapy: ☐ Age > 70 years if normal bone mineral density or no history of fracture. ☐ > 18 years for all other indications.	**YES** / NO

Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
PROMACTA
Affected Medications: PROMACTA (eltrombopag)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Thrombocytopenia due to hepatitis C virus (HCV)-related cirrhosis.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Cause of thrombocytopenia.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ For treatment of thrombocytopenia due to HCV-related cirrhosis ☐ approve to allow for initiation of antiviral therapy	**YES** / NO
Exclusion Criteria:	☐ Use in the management of thrombocytopenia in myelodysplastic syndrome (MDS).	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	**Treatment of thrombocytopenia due to**: ☐ chronic immune (idiopathic) thrombocytopenic purpura (ITP) ☐ approve if prescribed or consultation by hematologist ☐ HCV-related cirrhosis ☐ approve if prescribed or consultation by gastroenterologist or a physician who specializes in infectious disease	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
PROVENGE
Drug Name: PROVENGE (sipuleucel-T)
Effective Date: 07/29/2010
Last Review Date: 09/08/2010
Part D: No Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Prostate Cancer (dx: 185 only)	**CONFIRMATION*** **YES** / NO

Required documentation:	☐ Documentation of complete & current treatment course required.
	☐ Evidence of metastases to soft tissue or bone
	☐ Testosterone levels
	  ☐ < 50 ug
	  ☐ Below lowest level of normal
	☐ Evidence of disease progression
	  ☐ Two sequential rising PSA levels obtained 2-3 wks apart
	  ☐ Other: _____
		YES / NO

Appropriate Treatment Regimen:	☐ FDA prescribing guidelines: ☐ Up to three infusions, generally two weeks apart	**YES** / NO
Exclusion Criteria:	☐ Prior intolerance or allergic reaction to requested medication ☐ Concomitant use of other chemotherapy or immunosuppressive therapy	YES / **NO**
Age Restriction:		N/A
Provider Restriction:		N/A
Approval Duration:	☐ Approvals = 3 infusions or 2 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
RANEXA
Affected Medications: RANEXA (ranolazine extended-release tablets)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Patient has tried, failed and/or been intolerant (continues to have angina symptoms that limits daily activities) to a 30-day trial of the following: ☐ nitrate PLUS a beta blocker **or** ☐ calcium channel blocker. **OR** ☐ Patient has received prior treatment with Ranexa, the patient experienced a decrease in angina frequency since initiating treatment.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Patients with clinically significant hepatic impairment ☐ Patient is receiving a strong CYP3A inhibitor that prolongs the QT interval.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Cardiologist or affiliated with a cardiology practice	**YES** / NO
Coverage Duration:	☐ Intial approval = 3 months ☐ Renewal approval = Plan Year	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
REBIF
Affected Medications: REBIF (interferon beta-1a)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:		N/A
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Concurrent use of Avonex, Betaseron, Extavia, Copaxone, Tysabri, or fingolimod (Gilenya).	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Prescribed by or after consultation with a neurologist or an MS specialist.	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
RELISTOR
Affected Medications: RELISTOR (methylnaltrexone bromide)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Treatment of opioid-induced constipation in a patient with advanced illness who is receiving palliative care. **AND** ☐ Patient demonstrated an inadequate treatment response or intolerance to a drug regimen of polyethylene glycol 3350 (PEG 3350) **OR** ☐ Patient has a documented contraindication to polyethylene glycol 3350 (PEG 3350).	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Known or suspected mechanical gastrointestinal obstruction.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 6 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
REMICADE
Affected Medications: REMICADE (infliximab)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Patients already started on infliximab for covered uses. ☐ Juvenile Idiopathic Arthritis (JIA) ☐ Behcet's disease (BD) ☐ Uveitis (UV) ☐ Pyoderma gangrenosum (PG) ☐ Hidradenitis suppurativa (HS) ☐ Graft-versus-host disease (GVHD) ☐ Celiac Sprue ☐ Wegener Granulomatosis	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ FDA approved indication must be documented in the member's chart notes within the most recent 6 months. ☐ Documentation of complete and current treatment course required. ☐ For treatment of RA: Laboratory test must confirm diagnosis of Rheumatoid Arthritis: Anti-Cyclic Citrullinated Peptide Antibody(anti-CCP) OR Rheumatoid Factor (RF). ☐ Negative Latent TB screening with either by TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to request. **OR** ☐ For positive latent TB, patient must have completed or receiving treatment for LTBI.	N/A
Appropriate Treatment Regimen & Other Criteria:	☐ **RA/JIA:** ☐ pt tried at least 1 oral DMARDs (hydroxychloroquine, leflunomide, sulfasalazine, minocycline, methotrexate) **AND** ☐ at least 1 biologic DMARD (such as adalimumab, etanercept) ☐ **Psoriatic Arthritis (PsA):** ☐ pt tried at least 1 oral DMARD (hydroxychloroquine, leflunomide, sulfasalazine, minocycline, methotrexate) **AND** ☐ at least 1 biologic DMARD (such as adalimumab, etanercept) ☐ **Ankylosing Spondylitis (AS):** ☐ pt tried at least 1 oral treatment (corticosteroids, hydroxychloroquine, leflunomide, sulfasalazine, minocycline, methotrexate) **AND** ☐ at least 1 biologic DMARD (such as adalimumab, etanercept).	**YES** / NO

	☐ **Plaque psoriasis (PP):** ☐ pt has tried at least 1 oral systemic therapy (methotrexate, cyclosporine, isotretinoin) **OR** ☐ phototherapy (UVB, PUVA) **AND** ☐ at least one biologic DMARD (such as adalimumab, etanercept) ☐ **Crohn's Disease (CD):** ☐ Pt has tried at least 1 oral treatments for at least 12 weeks (corticosteroids, azathioprine, cyclosporine, 6-mercaptopurine, MTX, tacrolimus, sulfasalazine, mesalamine or balsalazide) **AND** ☐ at least 1 biologic DMARD (such as adalimumab), unless indicated for pediatric Crohn's ☐ **Ulcerative colitis (UC):** ☐ Pt has tried at least 2 oral treatments for at least 12 weeks (corticosteroids, azathioprine, cyclosporine, 6-mercaptopurine, MTX, tacrolimus, sulfasalazine, mesalamine or balsalazide) ☐ **Behcet's Disease (BD):** ☐ Pt has not responded to 1 conventional tx (eg, systemic CS, immunosuppressant (eg, AZA, MTX, mycophenolate mofetil (MM), CSA, tacrolimus, chlorambucil, cyclophosphamide (CPM), or interferon alfa), etanercept or adalimumab ☐ **Uveitis (UV):** ☐ pt has tried periocular/intraocular CS, systemic CS, immunosuppressant (eg, MTX, MM, CSA, AZA, CPM), etanercept, adalimumab ☐ **Pyoderma Gangrenosum (PG):** ☐ pt has tried 1 systemic tx (eg, systemic CS, immunosuppressant (eg, AZA, 6MP, CSA, CPM, chlorambucil), etanercept or adalimumab) for 2 months, or 2-month trial of intralesional CS or CSA for localized PG ☐ **Hidradenitis Supperativa (HS):** ☐ pt has tried 1 tx (eg, intralesional/oral CS, topical or systemic antibiotic, isotretinoin) ☐ **Graft Versus Host Disease (GVHD):** ☐ pt has tried 1 tx (eg, high-dose CS, antithymocyte globulin, CSA, thalidomide, tacrolimus, MM, etc.) or receiving IFB concurrently.	
Exclusion Criteria:	☐ Concurrent use of: abatacept (Orencia), rituximab(Rituxin), tocilizumab(Actemra), adalimumab (Humira), entanercept(Enbrel), infliximab(Remicade), certolizumab(Cimzia), golimumab(Simponi). ☐ Positive test for tuberculosis, active HZV, HCV or HBV.	YES / **NO**

Age Restriction:	☐ RA, PP, PsA, AS: Adults.	**YES** / NO
Prescriber Restrictions:	☐ CD, UC: in consultation with a GI specialist. ☐ PP: in consultation with a dermatologist.	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
REMODULIN
Affected Medications: REMODULIN (treprostinil sodium)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Patients currently on Remodulin for covered uses.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	Pulmonary arterial hypertension (PAH) ☐ patients not currently on Remodulin must have a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment ☐ patients currently on Remodulin may continue therapy if they have a diagnosis of PAH, acute vasoreactivity testing should be done	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ PAH: for initiation of therapy pt must have mean pulmonary artery pressure at least 25mm Hg at rest **OR** ☐ at least 30 mm Hg with exertion **AND** ☐ pt must have tried conservative treatment (calcium channel blockers, Adcirca, Revatio, Letairis, Tracleer) unless contraindicated or patient's severity warrants initial treatment with Remodulin.	**YES** / NO
Exclusion Criteria:	☐ Coverage is not recommended for circumstances not listed in the Covered Uses.	YES / **NO**
Age Restriction:	☐ PAH: Adults	**YES** / NO
Prescriber Restrictions:	☐ PAH: In consultation with a cardiologist or a pulmonologist.	**YES** / NO
Coverage Duration:	☐ Approval = 12 months.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
REVATIO
Affected Medications: REVATIO (sildenafil)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Infants with pulmonary arterial hypertension (PAH).	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ NYHA Functional Class II or III symptoms. ☐ PAH (WHO Group 1) was confirmed by right heart catheterization **OR** ☐ by Doppler echocardiography for infants with any of the following conditions: 1) post cardiac surgery, 2) chronic heart disease, 3) chronic lung disease associated with prematurity, 4) congenital diaphragmatic hernias. ☐ For new starts only: patient has had an inadequate response or intolerance to Adcirca (tadalafil). ☐ For Revatio injection: patient was previously receiving Revatio tablets but is now temporarily unable to take oral medications.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Patient requires nitrate therapy on a regular or intermittent basis.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Revatio tablets = 12 months ☐ Revatio injection = 3 months OR unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
REVLIMID
Affected Medications: REVLIMID (lenalidomide)
Effective Date: 01/01/2014
Last Review Date: 08/14/2013
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D, ☐ chronic lymphocytic leukemia (CLL), ☐ myelodysplastic syndromes (MDS) without the deletion 5q, ☐ progressive solitary plasmacytoma or smoldering myeloma that has progressed to active/symptomatic ☐ systemic light chain amyloidosis, and ☐ the following subtypes of non-Hodgkin's lymphomas (NHL): ☐ AIDS-related diffuse large B-cell lymphoma (DLBCL), ☐ AIDS-related lymphoma associated with Castleman's disease, ☐ AIDS-related primary effusion lymphoma, ☐ DLBCL, ☐ follicular lymphoma (FL), ☐ gastric mucosa associated lymphoid tissue (MALT) lymphoma, ☐ mantle cell lymphoma (MCL), ☐ nodal marginal zone lymphoma, ☐ nongastric MALT lymphoma, primary cutaneous B-cell lymphoma (PCBCL), and ☐ splenic marginal zone lymphoma.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Active/symptomatic myeloma or progressive solitary plasmacytoma**, ☐ Revlimid is warranted in any of the following settings: ☐ a) Revlimid is used as primary induction therapy in combination with dexamethasone or both melphalan and prednisone, ☐ b) Revlimid is used as maintenance monotherapy for patients responding to primary induction therapy or for patients with stable or responsive disease following stem cell transplant, ☐ c) Revlimid is used as salvage or palliative therapy. **Low or intermediate-1 risk MDS,** ☐ Revlimid is warranted in any of the following settings: ☐ a) In those with a 5q deletion, patients have transfusion-dependent anemia (i.e., greater than 2 units of red blood cells in the previous 8 weeks) or symptomatic anemia, ☐ b) In those without a 5q deletion and symptomatic anemia, patients have pretreatment serum erythropoietin level greater	**YES** / NO

	than 500 mU/mL or both a pretreatment serum erythropoietin level less than or equal to 500 mU/mL and have failed a trial of epoetin or darbepoetin. **NHL,** ☐ Revlimid is warranted in any of the following settings: ☐ Revlimid is used in relapsed or refractory disease in patients with CLL, ☐ Revlimid is used as monotherapy or in combination with rituximab for relapsed, refractory, or progressive disease in the following subtypes of NHL: ☐ AIDS-related DLBCL, ☐ AIDS-related lymphoma associated with Castleman's disease, ☐ AIDS-related primary effusion lymphoma, ☐ DLBCL, ☐ FL, ☐ gastric MALT lymphoma, ☐ MCL, ☐ nodal marginal zone lymphoma, ☐ nongastric MALT lymphoma, ☐ PCBCL, ☐ splenic marginal zone lymphoma. **Systemic light chain amyloidosis,** ☐ Revlimid is used in combination with dexamethasone as primary therapy. **MCL** ☐ disease has relapsed or progressed after two prior therapies, one of which included bortezomib. ☐ Female patients of child-bearing potential, pregnancy is excluded by two negative serum or urine pregnancy tests. ☐ Complete blood counts are regularly evaluated for hematological toxicity.	
Appropriate Treatment Regimen & Other Criteria:	☐ All patients are monitored for signs and symptoms of thromboembolism. ☐ Female patients of child-bearing potential and male patients are instructed on the importance and proper utilization of appropriate contraceptive methods.	**YES** / NO
Exclusion Criteria:	☐ Pregnancy.	YES / **NO**
Age Restriction:	☐	N/A

Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval =12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
RISPERDAL CONSTA
Affected Medications: RISPERDAL CONSTA (risperidone)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ The patient has a history of non-compliance and/or refuses to utilize oral medications. ☐ The patient must have a history of 3 test doses of oral Risperdal (risperidone). ☐ If the patient is increasing the dose of Risperdal Consta the patient has a history of two prior injections of Risperdal Consta.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Dementia-related psychosis.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Psychiatrist or receiving input from psychiatry practice	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
RITUXAN
Affected Medications: RITUXAN (rituximab)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Covered Uses:	☐ All FDA-approved/ medically-accepted indications not otherwise excluded from Part D. ☐ Patients already started on Rituxan for rheumatoid arthritis (RA).	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ FDA approved indication must be documented in the member's chart notes within the most recent 6 months. ☐ Documentation of complete and current treatment course required. ☐ For treatment of RA: Laboratory test must confirm diagnosis of Rheumatoid Arthritis: Anti-Cyclic Citrullinated Peptide Antibody(anti-CCP) OR Rheumatoid Factor (RF). ☐ Negative Latent TB screening with either by TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to request. **OR** ☐ For positive latent TB, patient must have completed or receiving treatment for LTBI.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	**Adult with RA** Initial course: ☐ Patient has failed at least 12 weeks of therapy of at least 2 DMARDs (hydroxychloroquine, leflunomide, methotrexate, minocycline, sulfasalazine) **AND** ☐ Patient has failed at least 12 weeks of therapy of another biologic agent [abatacept (Orencia), rituximab(Rituxin), tocilizumab(Actemra), adalimumab (Humira), entanercept(Enbrel), infliximab(Remicade), certolizumab(Cimzia), golimumab(Simponi)] Repeat course: ☐ approve if 16 weeks or more after the first dose of the previous rituximab regimen and the patient has responded (eg, less joint pain, morning stiffness, or fatigue, or improved mobility, or decreased soft tissue swelling in joints or tendon sheaths) as determined by the prescribing physician.	**YES** / NO
Exclusion Criteria:	☐ Concurrent use of: abatacept (Orencia), rituximab(Rituxin), tocilizumab(Actemra), adalimumab (Humira), entanercept(Enbrel), infliximab(Remicade), certolizumab(Cimzia), golimumab(Simponi).	YES / **NO**
Age Restriction:	☐ RA, adults.	**YES** / NO

Prescriber Restrictions:	☐ Adult with RA (initial and repeat courses). Prescribed by a rheumatologist or in consultation with a rheumatologist. ☐ Non-RA indications, if prescribed by or in consultation with an oncologist, hematologist, neurologist, multiple sclerosis (MS) specialist, rheumatologist, dermatologist, or immunologist, or who are being managed by a transplant center.	**YES** / NO
Coverage Duration:	☐ RA: Approval =2 doses. ☐ 16 wks or more after, approve 2 more doses if response per doctor. ☐ Other indications = 12 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
SAMSCA
Affected Medications: SAMSCA (Tolvaptan Tablets)
Effective Date: 01/01/2014
Last Review Date: 9/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D ☐ Patients already started on tolvaptan for the treatment of hyponatremia.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Serum sodium < 125 mEq/L at baseline or less marked hyponatremia, defined as serum sodium < 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion).	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ For the treatment of clinically significant hypervolemic and euvolemic hyponatremia with serum sodium < 125 mEq/L at baseline or less marked hyponatremia, defined as < 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion).	**YES** / NO
Exclusion Criteria:	☐ Patients requiring intervention to raise serum sodium urgently to prevent or to treat serious neurological symptoms.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
SANDOSTATIN LAR
Affected Medications: SANDOSTATIN LAR DEPOT
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D, ☐ atypical lung carcinoids, ☐ islet cell tumors, ☐ multiple endocrine neoplasia type 1 (MEN 1).	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Acromegaly therapy** ☐ Initiation of therapy, patient meets the following: 1) Clinical evidence of acromegaly, 2) Pre-treatment high IGF-1 level for age/gender, 3) Patient has had an inadequate or partial response to surgery and/or radiotherapy **OR** ☐ there is a clinical reason for why the patient has not had surgery or radiotherapy (e.g., medically unstable conditions, patient is at high risk for complications of anesthesia because of airway difficulties, lack of an available skilled surgeon, patient refuses surgery or prefers the medical option over surgery, major systemic manifestations of acromegaly including cardiomyopathy, severe hypertension and uncontrolled diabetes). ☐ Continuation of therapy, the IGF-1 level decreased or normalized. **Atypical lung carcinoids**, use in combination with chemotherapy. **Islet cell tumors**, patient has insulinoma, glucagonoma, or VIPoma. M**ultiple endocrine neoplasia type 1 (MEN 1)** patient meets one of the following: 1) Patient has insulinoma, glucagonoma, or VIPoma **OR** 2) Patient has pituitary adenoma and is symptomatic or has significant tumor burden. ☐ Patient received at least 2 weeks of initial treatment with Sandostatin Injection (not the Depot formulation) and treatment with Sandostatin Injection was effective and tolerable.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐	N/A
Age Restriction:		N/A

Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
SEROSTIM
Affected Medications: SEROSTIM (somatropin)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Patient has a diagnosis of cachexia or wasting syndrome associated with HIV infection. ☐ Serostim is used in combination with antiretroviral therapy. ☐ Alternative causes of wasting (eg, inadequate nutrition intake, malabsorption, opportunistic infections, hypogonadism) have been ruled out or treated appropriately. ☐ Prior to somatropin, patient had a suboptimal response to at least 1 other therapy for wasting or cachexia (eg, megestrol or dronabinol) unless contraindicated or not tolerated. ☐ For continuation of therapy: Patients treated with Serostim for 12 or more weeks have demonstrated a response to therapy (ie, body mass index has improved or stabilized).	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Acute critical illness, active malignancy	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval =12 weeks	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
SIGNIFOR
Affected Medications: SIGNIFOR (pasireotide diaspartate)
Effective Date: 03/01/2014
Last Review Date: 09/23/2013
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ HbA_1C (within 3 months) ☐ Liver function tests (within 3 months) ☐ Ultrasound of gallbladder (within 3 months) ☐ EKG (within 3 months)	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Provide documentation of failure or inability to receive curative surgery ☐ Provide documentation of failure or inability to receive ketoconazole or metyrapone	**YES** / NO
Exclusion Criteria:	☐ Poorly controlled diabetes mellitus (HbA_1C >8%) ☐ Severe hepatic impairment (Child Pugh C)	YES / **NO**
Age Restriction:	☐ Age > 18 years.	**YES** / NO
Prescriber Restrictions:	☐ Endocrinologist or in collaboration with an endocrinology practice	**YES** / NO
Coverage Duration:	☐ Approval = 6 months unless otherwise stated	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
SIMPONI
Affected Medications: SIMPONI (golimumab)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA approved indications not otherwise excluded from Part D. ☐ Patients already started on golimumab for a covered use.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ FDA approved indication must be documented in the member's chart notes within the most recent 6 months. ☐ Documentation of complete and current treatment course required. ☐ For treatment of RA: Laboratory test must confirm diagnosis of Rheumatoid Arthritis: Anti-Cyclic Citrullinated Peptide Antibody(anti-CCP) OR Rheumatoid Factor (RF). ☐ Negative Latent TB screening with either by TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to request. **OR** ☐ For positive latent TB, patient must have completed or receiving treatment for LTBI.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	**Rheumatoid Arthritis (RA):** ☐ Patient has failed at least 12 weeks of therapy of at least **2 DMARDs** (hydroxychloroquine, leflunomide, methotrexate, minocycline, sulfasalazine) AND ☐ Patient has failed at least 12 weeks of therapy of **another biologic** agent [abatacept (Orencia), rituximab(Rituxin), tocilizumab(Actemra), adalimumab (Humira), entanercept(Enbrel), infliximab(Remicade), certolizumab(Cimzia), golimumab(Simponi)] **Psoriatic Arthritis (PsA):** ☐ pt tried at least 1 oral DMARD (hydroxychloroquine, leflunomide, sulfasalazine, minocycline, methotrexate) **AND** ☐ at least 1 biologic DMARD (such as adalimumab, etanercept) **Ankylosing Spondylitis (AS):** ☐ pt tried at least 1 oral treatment (corticosteroids, hydroxychloroquine, leflunomide, sulfasalazine, minocycline, methotrexate) **AND** ☐ at least 1 biologic DMARD (such as adalimumab, etanercept)	**YES** / NO
Exclusion Criteria:	☐ Concurrent use of abatacept (Orencia), rituximab(Rituxin), tocilizumab(Actemra), adalimumab (Humira), entanercept(Enbrel), infliximab(Remicade), certolizumab(Cimzia), golimumab(Simponi). ☐ Management of plaque psoriasis without psoriatic arthritis.	YES / **NO**

Age Restriction:	☐ Rheumatoid arthritis (RA), adults.	**YES** / NO
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
SIRTURO
Affected Medications: SIRTURO (bedaquiline fumarate)
Effective Date: 03/01/2014
Last Review Date: 09/23/2013
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Pulmonary multi-drug resistant tuberculosis (MDR-TB).	**CONFIRMATION*** **YES** / NO
Required Medical Information:	Patient has failed, is resistant, or is allergic to quad therapy of any combination of the following: ☐ Isoniazid ☐ Rifampin ☐ Ethambutol ☐ Pyrazinamide ☐ Fluoroquinolone ☐ Capreomycin, Kanamycin,Amikacin, Streptomycin ☐ Ethionamide/Prothinamide ☐ Cycloserine/Terizidone ☐ Aminosalicylic acid (acdic salt)	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Documentation of being administered by directly observed therapy (DOT) ☐ Baseline ECG ☐ BMP (including K, Ca, Mg – documentation of correction if needed) ☐ LFTs	**YES** / NO
Exclusion Criteria:	☐ drug-sensitive TB (DS-TB) ☐ latent infection due to *Mycobacterium tuberculosis* ☐ extrapulmonary TB (e.g., central nervous system).	YES / **NO**
Age Restriction:	☐ Age > 18 years.	**YES** / NO
Prescriber Restrictions:	☐ Endocrinologist or in collaboration with an endocrinology practice	**YES** / NO
Coverage Duration:	☐ Approval = 24 weeks unless otherwise stated	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
SOLARAZE
Affected Medications: SOLARAZE (diclofenac sodium)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:		N/A
Appropriate Treatment Regimen & Other Criteria:	**Bowen's disease**, ☐ approve Solaraze after a trial of at least **one** other therapy used for the management of Bowen's disease (eg, topical 5-fluorouracil [5-FU], imiquimod, cryotherapy, photodynamic therapy, curettage, excision, laser, or radiotherapy). **DSAP**, ☐ approve Solaraze after a trial of at least **two** other therapies used for the management of DSAP (eg, topical 5-FU, imiquimod, topical corticosteroid, topical vitamin D3 analogues, topical or oral retinoid, cryotherapy, photodynamic therapy, and laser).	**YES** / NO
Exclusion Criteria:	☐ Use in the treatment of cosmetic conditions (e.g., liver spots, wrinkles, alopecia areata). ☐ Use for the treatment of osteoarthritis.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
SOLIRIS
Affected Medications: SOLIRIS (eculizumab)
Effective Date: 04/01/2010
Last Review Date: 02/10/2010
Part D: No Part B: Yes

Covered Uses:	☐ All FDA approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Documentation of complete & current treatment course required. ☐ Confirmed diagnosis using: ☐ Flow Cytometric Immunophenotyping ☐ ≥ 4 blood transfusions required in previous 12 months ☐ Administration of quadravalent, conjugated meningococcal vaccination ≥ 2wks prior to Tx must be documented ☐ Documentation of initial LDH level: _____ ☐ Documentation of initial Hb level: _____ ☐ Soliris OneSource can be reached at 1-888-765-4747	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Subsequent approval requires documentation of treatment success. ☐ LDH, ☐ Hb, ☐ blood transfusion hx, ☐ infusion records ☐ current chart notes required	**YES** / NO
Exclusion Criteria:	☐ Prior intolerance or allergic reaction to requested medication. ☐ Current meningitis infection or lack of meningococcal vaccination ☐ Other serious infections	YES / **NO**
Age Restriction:		N/A
Prescriber Restrictions:	☐ Hematologist or oncologist	**YES** / NO
Coverage Duration:	☐ Initial Approval = 3 months ☐ Subsequent approval = 6 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
SOMATULINE DEPOT
Affected Medications: SOMATULINE DEPOT (lanreotide)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Patient meets the following criteria for initiation of therapy: 1) Clinical evidence of acromegaly, 2) Pre-treatment high IGF-1 level for age/gender, and 3) Patient has had an inadequate or partial response to surgery and/or radiotherapy **OR** ☐ There is a clinical reason for why the patient has not had surgery or radiotherapy (e.g., medically unstable conditions, patient is at high risk for complications of anesthesia because of airway difficulties, lack of an available skilled surgeon, patient refuses surgery or prefers the medical option over surgery, major systemic manifestations of acromegaly including cardiomyopathy, severe hypertension and uncontrolled diabetes). ☐ For continuation of therapy, the IGF-1 level decreased or normalized.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐	N/A
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise noted.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
SOMAVERT
Affected Medications: SOMAVERT (pegvisomant)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Patient meets the following criteria for initiation of therapy: 1) Clinical evidence of acromegaly, 2) Pre-treatment high IGF-1 level for age/gender, 3) Patient has had an inadequate or partial response to octreotide or lanreotide **OR** patient is intolerant to or has a contraindication to octreotide or lanreotide, and 4) Patient has had an inadequate or partial response to surgery and/or radiotherapy **OR** there is a clinical reason for why the patient has not had surgery or radiotherapy (e.g., medically unstable conditions, patient is at high risk for complications of anesthesia because of airway difficulties, lack of an available skilled surgeon, patient refuses surgery or prefers the medical option over surgery, major systemic manifestations of acromegaly including cardiomyopathy, severe hypertension and uncontrolled diabetes). ☐ For continuation of therapy, the IGF-1 level decreased or normalized.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐	N/A
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise noted.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
SORIATANE
Affected Medications: SORIATANE (Acitretin)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D ☐ Prevention of non-melanoma skin cancers in high risk individuals	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ If the patient is female and able to bear children (e.g., no hysterectomy, not reached menopause, has achieved menses). **AND** ☐ The patient is unresponsive to other therapies for the covered diagnoses **OR** the other therapies for the treatment of the covered diagnoses are contraindicated due to the clinical condition of the patient. **AND** ☐ Pregnancy has been excluded as confirmed by 2 negative urine or serum pregnancy tests with a sensitivity of at least 25 mIU/mL. **AND** ☐ the patient has chosen to use any of the following methods of contraception: one primary form (e.g., tubal ligation, partner's vasectomy, intrauterine devices, birth control pills, injectable/implantable/insertable/topical hormonal birth control products) plus one secondary form (e.g., diaphragms, latex condoms, cervical caps) used in combination with a spermicide OR absolute abstinence. **AND** ☐ The patient has agreed to use her chosen form of contraception for at least 1 month before initiation of Soriatane therapy, during Soriatane therapy, and for at least 3 years after discontinuation of therapy. **AND** ☐ The patient has been advised that ethanol must not be ingested by female patients during Soriatane treatment and for 2 months following therapy. **AND** ☐ The patient will have a negative pregnancy test on a monthly basis.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Female patient or guardian signed a Patient Agreement/Informed Consent.	**YES** / NO
Exclusion Criteria:	☐ Severely impaired liver function. ☐ Severely impaired kidney function. ☐ Chronic abnormally elevated blood lipid values. ☐ Currently taking methotrexate or tetracycline.	YES / **NO**
Age Restriction:	☐	N/A

Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise noted.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
SOVALDI
Affected Medications: SOVALDI (Sofosbuvir)
Effective Date: 08/01/2014
Last Review Date: 06/11/2014
Part D: Yes Part B: No

Covered Uses:	☐ All FDA approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Documented genotype chronic hepatitis C virus (HCV) OR hepatocellular carcinoma meeting Milan criteria (awaiting liver transplantation) **AND** ☐ Documentation of liver disease (including cirrhosis) with Child-Pugh Classification ☐ Fibrosis Staging ☐ Documentation if patient is Treatment-naïve, prior relapse, or prior partial responder ☐ Creatinine Clearance: calculated by Serum Creatinine, Age, Weight	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	**Genotype 1, 3, 4** ☐ Sovaldi 12 weeks AND ☐ Must be used in combination with peginterferon alfa and ribavirin. ☐ If peginterferon alfa or ribavirin is permanently discontinued then Sovaldi must also be discontinued. **Genotype 1** ☐ Documentation of contraindication to Interferon. ☐ Sovaldi 12 weeks AND ☐ Must be used in combination with: Simeprevir **Genotype 2** ☐ Sovaldi 12 weeks AND ☐ Must be used in combination with ribavirin **Genotype 3** (non-preferred regimen see LONESTAR-2) ☐ Must have documentation of contraindication to Interferon. ☐ Sovaldi 24 weeks AND ☐ Must be used in combination with ribavirin Contraindication to Interferon is defined by one of the following conditions: ☐ Autoimmune hepatitis or other autoimmune disorder, ☐ hepatic decompensation (Child-Pugh score greater than 6 [class B and C]) in cirrhotic patients before treatment, ☐ major depression disorder with suicidal ideation – patient must have evaluation done by Psychologist within the 6 months of initiation of therapy,	**YES** / NO

	☐ bipolar disorder, ☐ baseline neutrophil count <1,500/µL, ☐ baseline platelet count of < 90,000/µL, ☐ Preexisting cardiac disease (prior history of MI or stent placement) Patients with Hepatocellular Carcinoma Awaiting Liver Transplantation ☐ Sovaldi (maximum 48 weeks) AND ☐ Must be used in combination with ribavirin	
Exclusion Criteria:	☐ eGFR <30mL/min or requiring hemodialysis ☐ Concomitant use of: carbamazepine, phenytoin, phenobarbital, oxcarbazepine, tipranavir or ritonavir	YES / **NO**
Age Restriction:	☐ 18 years of age or older	**YES** / NO
Prescriber Restrictions:	☐ Hepatologist, Gastroenterologist, ID Specialist	**YES** / NO
Coverage Duration:	☐ Approval = 12 weeks (maximum of 24 weeks) ☐ Awaiting Liver Transplant: until date of transplant up to 48 weeks	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
SPRYCEL
Affected Medications: SPRYCEL (dasatinib)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All medically-accepted indications not otherwise excluded from Part D. ☐ Patients already started on Sprycel.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Diagnosis for which Sprycel is being used. ☐ For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. ☐ New patients with CML and ALL which is Ph-positive may receive authorization for Sprycel.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	Chronic myeloid leukemia (CML) ☐ new patient must have Ph-positive CML for approval of Sprycel. Acute lymphoblastic leukemia (ALL) ☐ new patient must have Ph-positive ALL for approval of Sprycel.	**YES** / NO
Exclusion Criteria:	☐ New patients with chronic myeloid leukemia (CML) which is Philadelphia chromosome (Ph)-negative. ☐ New patients with CML whose Ph status is unknown. ☐ New patients with acute lymphoblastic leukemia (ALL) which is Ph-negative. ☐ New patients with ALL whose Ph status is unknown.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise noted.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
STELARA
Affected Medications: STELARA (ustekinumab)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Patients already started on ustekimumab for a covered use.	**CONFIRMATION*** **YES** / NO
Required Medical Information:		N/A
Appropriate Treatment Regimen & Other Criteria:	☐ Plaque psoriasis in adults. ☐ Patient has a minimum body surface area (BSA) of 5% or more and has tried a systemic therapy **OR** phototherapy for 3 months with one of the following: MTX, cyclosporine, acitretin (Soriatane), UVB or PUVA phototherapy, **AND** has tried adalimumab, etanercept, or infliximab for plaque psoriasis. ☐ Exceptions allowed for patients with less than 5% BSA if they have plaque psoriasis of palms, soles, head and neck, nails, intertriginous areas or genitalia **OR** ☐ if they've had an inadequate response to a 3-month trial of systemic therapy with one of the following: MTX, cyclosporine, or acritretin, **AND** ☐ has tried a TNF antagonist (adalimumab, etanercept, infliximab), **AND** ☐ has significant disability or impairment in physical or mental functioning according to the treating physician. ☐ Rarely, a pt may have contraindications to nearly all of these other therapies and exceptions can be evaluated by a pharmacist and/or physician on a case-by-case basis.	**YES** / NO
Exclusion Criteria:	☐ Ustekinumab should not be given in combination with a tumor necrosis factor (TNF) antagonist (eg, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), with anakinra, or with alefacept. Use in the management of psoriatic arthritis without plaque psoriasis. ☐ Use in the management of Crohn's disease, or multiple sclerosis.	YES / **NO**
Age Restriction:	☐ Adults	**YES** / NO

Prescriber Restrictions:	☐ Prescribed by or in consultation with a dermatologist.	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise noted.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
SUTENT
Affected Medications: SUTENT (sunitinib malate)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D, ☐ thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), ☐ lung neuroendocrine tumors, ☐ angiosarcoma, ☐ solitary fibrous tumor, ☐ hemangiopericytoma.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ **RCC**, patient has advanced RCC. ☐ **GIST**: patient had disease progression on imatinib or was intolerant to imatinib. ☐ **PNET**s: patient has well differentiated tumors and progressive unresectable locally advanced or metastatic disease. ☐ **LNETs**: tumors are low or intermediate grade (typical or atypical carcinoid) and patient has unresectable or advanced disease (stage IIIb-IV). ☐ **Follicular, papillary, or Hurthle cell thyroid carcinoma**: patient has clinically progressive or symptomatic metastatic disease with nonradioiodine-responsive tumors at sites other than central nervous system. ☐ **Medullary thyroid carcinoma**: patient has disseminated symptomatic disease with progression on vandetanib or vandetanib is not appropriate. ☐ **Angiosarcoma, solitary fibrous tumor, or hemangiopericytoma**: Sutent will be used as a single agent.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Patient will be monitored for signs and symptoms of CHF. ☐ Liver function test monitoring at initiation of therapy and throughout treatment. ☐ Sutent therapy will be interrupted for serious hepatic adverse events and discontinued if serious hepatic adverse events do not resolve.	**YES** / NO
Exclusion Criteria:	☐ Clinical manifestations of congestive heart failure (CHF).	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise noted.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
SYLATRON
Affected Medications: SYLATRON (peginterferon alfa-2b)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D, ☐ Chronic myelogenous leukemia (CML)	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Melanoma**: ☐ must have microscopic or gross nodal involvement and had a surgical resection of the tumor including complete lymphadenectomy. **CML:** ☐ patient unable to tolerate a tyrosine kinase inhibitor (eg, imatinib, dasatinib, or nilotinib) or post-transplant patient without remission or with relapse.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Patients will be monitored and evaluated for signs and symptoms of depression and other psychiatric symptoms throughout treatment. ☐ For melanoma, Sylatron must be requested within 84 days (12 weeks) of the surgical resection.	**YES** / NO
Exclusion Criteria:	☐ Autoimmune hepatitis. ☐ Decompensated hepatic disease. ☐ Uncontrolled major depression or severe mental illness.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise noted.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
SYLVANT
Affected Medications: SYLVANT (siltuximab)
Effective Date: 09/01/2014
Last Review Date: 07/09/2014
Part D: Yes Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ The diagnosis was confirmed by biopsy of lymph gland ☐ HIV and human herpes virus-I (HHV-8) negative ☐ Hematology laboratory tests prior to each dose for the first 12 months and every 3 dosing cycles thereafter	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Before first treatment: ANC greater than or equal to 1.0 $x10^9$ /L, Platelet count greater than or equal to 75 $x10^9$ /L, Hemoglobin less than 17 g/dL ☐ Retreatment: ANC greater than or equal to 1.0 $x10^9$ /L, Platelet count greater than or equal to 50 $x10^9$ /L, Hemoglobin less than 17 g/dL	**YES** / NO
Exclusion Criteria:	☐	N/A
Age Restriction:	☐ 18 years and older	**YES** / NO
Prescriber Restrictions:	☐ Oncologist	**YES** / NO
Coverage Duration:	☐ Approval = 3 months, unless otherwise noted.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
SYMLIN
Affected Medications: SYMLINPEN (pramlintide acetate)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D ☐ patient has type 1 or 2 diabetes mellitus.	**CONFIRMATION*** **YES** / NO
Required Medical Information:		N/A
Appropriate Treatment Regimen & Other Criteria:	☐ If patient received Symlin in previous 3 months, patient demonstrated an expected reduction in HbA1c since starting Symlin therapy. **OR** ☐ The patient has inadequate glycemic control (HbA1c > 7%). **AND** ☐ Patient is currently receiving optimal mealtime insulin therapy.	**YES** / NO
Exclusion Criteria:	☐ Severe hypoglycemia that required assistance during the past 6 months. ☐ Gastroparesis. ☐ Patient requires drug therapy to stimulate gastrointestinal motility. ☐ Hypoglycemia unawareness (i.e., inability to detect and act upon the signs or symptoms of hypoglycemia). ☐ HbA1c level greater than 9 percent. ☐ Weight loss treatment.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise noted.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
SYNRIBO
Affected Medications: Synribo (Omacetaxine)
Effective Date: 05/01/2013
Last Review Date: 03/13/2013
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ All Resistance, intolerance, or contraindication to two or more tyrosine kinase inhibitors (TKIs) must be documented. ☐ Examples of prior TKI therapies for CML include imatinib, dasatinib, nilotinib, bosutinib, and ponatinib.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐	N/A
Exclusion Criteria:	☐ Concurrent use of anticoagulants, aspirin, or NSAIDs when the platelet count is <50,000/mm^3 (risk bleeding). ☐ Poorly controlled diabetes mellitus. ☐ Avoid until good glycemic control has been established. ☐ Patients with NYHA class III or IV heart disease, active ischemia, or other uncontrolled cardiac conditions.	YES / **NO**
Age Restriction:	☐ Age > 18 years.	**YES** / NO
Prescriber Restrictions:	☐ Prescribed by or after consultation with an oncologist.	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise noted.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
TAFINLAR
Affected Medications: TAFINLAR (dabrafenib mesylate)
Effective Date: 09/01/2013
Last Review Date: 07/26/2013
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Unresectable or metastatic melanoma with BRAF V600E mutation detected by FDA approved test	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐	N/A
Exclusion Criteria:	☐ Combination with Mekinist or Zelboraf	YES / **NO**
Age Restriction:	☐ Age > 18 years	**YES** / NO
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise noted.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
TARCEVA
Affected Medications: TARCEVA (erlotinib)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Non-small cell lung cancer (NSCLC)** ☐ locally advanced or metastatic. ☐ First line treatment of NSCLC, patient has a known active epidermal growth factor receptor (EGFR) mutation or amplification of the EGFR gene. ☐ Second or third line treatment of NSCLC, Tarceva is used as monotherapy. ☐ Maintenance treatment of NSCLC, the following criteria are met: 1) patient responded to or remains stable after four cycles of platinum-based chemotherapy, AND 2) Tarceva is being used as monotherapy. **Pancreatic cancer**, the following criteria are met: 1) pancreatic cancer is locally advanced, unresectable or metastatic, AND 2) Tarceva is used as first line treatment, AND 3) Tarceva is used in combination with gemcitabine.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐	N/A
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise noted.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
TARGRETIN
Affected Medications: TARGRETIN (Bexarotene)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D, ☐ Mycosis fungoides, ☐ Sezary Syndrome (Capsules only), ☐ Adult T-cell leukemia/lymphoma (Gel only), and ☐ Primary cutaneous B-cell lymphoma (Gel only)	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Targretin Capsule**: ☐ Patient must meet one of following criteria: received prior systemic therapy for CTCL OR advanced-stage MF (stage IIB, III or IV) or SS **OR** ☐ early-stage MF (stage IA, IB or IIA) with folliculotropic/large cell transformation **OR** ☐ early-stage MF (stage IA, IB or IIA) refractory to skin directed therapy. **Targretin Gel:** ☐ Patient must meet one of following criteria for CTCL: early-stage MF (stage IA, IB, or IIA) **OR** ☐ stage IIB or III MF in combination with systemic therapy.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Patient has been instructed on the importance and proper utilization of appropriate contraceptive methods.	**YES** / NO
Exclusion Criteria:	☐ Pregnancy.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise noted.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
TASIGNA
Affected Medications: TASIGNA (nilotinib)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All medically-accepted indications not otherwise excluded from Part D. ☐ Patients already started on Tasigna.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Diagnosis for which Tasigna is being used. ☐ For indication of CML, the Philadelphia chromosome (Ph) status of the leukemia must be reported. ☐ New patients with CML which is Ph-positive may receive authorization for Tasigna.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ For CML, new patient must have Ph-positive CML for approval of Tasigna.	**YES** / NO
Exclusion Criteria:	☐ New patients with chronic myeloid leukemia (CML) which is Philadelphia chromosome (Ph)-negative. ☐ New patients with CML whose Ph status is unknown.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months.	N/A
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
TAZORAC
Affected Medications: TAZORAC (tazarotene)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Psoriasis of fingernails or toenails. ☐ Oral lichen planus. ☐ Congenital ichthyoses (X-linked recessive ichthyosis, non-erythrodermic autosomal recessive lamellar ichthyosis, autosomal dominant ichthyosis vulgaris). ☐ Basal cell carcinoma. ☐ Mycosis fungoides lesions/cutaneous T-cell lymphomas. ☐ Keratosis pilaris (atrophicans). ☐ Treatment of other non-cosmetic conditions (eg, actinic keratoses, skin neoplasms, warts, dermatitis/eczema, folliculitis, acne rosacea, cystic acne, comedonal acne).	**CONFIRMATION*** **YES** / NO
Required Medical Information:		N/A
Appropriate Treatment Regimen & Other Criteria:	☐ Acne vulgaris after a trial with at least 1 other topical retinoid product (eg, tretinoin cream/gel/solution/microgel, adapalene). ☐ For the treatment of other non-cosmetic conditions (eg, actinic keratoses, skin neoplasms, warts, dermatitis/eczema, folliculitis, acne rosacea, cystic acne, comedonal acne) exceptions can be made if the patient has tried at least 1 other therapy.	**YES** / NO
Exclusion Criteria:	☐ Cosmetic skin conditions (eg, alopecia, hyperpigmentation, liver spots, melasma/cholasma, seborrheic keratosis, stretch marks, scarring, wrinkles, premature aging, photo-aged or photo-damaged skin, mottled hyper- and hypopigmentation, benign facial lentigines, roughness, telangiectasia, skin laxity, keratinocytic atypia, melanocytic atypia, dermal elastosis). ☐ Coverage not recommended for anything not listed under Covered Uses.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
TECFIDERA
Affected Medications: Tecfidera (dimethyl fumarate)
Effective Date: 08/01/2013
Last Review Date: 05/22/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Diagnosis of a relapsing form of multiple sclerosis. ☐ CBC (within 6 months) before initiating treatment, then annually and as clinically indicated	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Initial dose of 120mg BID 7 days, then increasing to 240mg BID thereafter For use in MS ☐ Patient has failed interferon beta-1a or -1b (Avonex, Rebif, Betaseron or Extavia), or glatiramer acetate (Copaxone). ☐ Exceptions to having tried an interferon beta-1a or -1b product (Avonex, Rebif, Betaseron or Extavia), or glatiramer acetate (Copaxone) can be made if the patient is unable to administer injections due to dexterity issues, visual impairment, depression or mood disorders. ☐ Patients who have tried natalizumab (Tysabri) for MS and have a relapsing form of MS will receive authorization, they are not required to try an interferon beta product or glatiramer acetate.	**YES** / NO
Exclusion Criteria:	☐ Concurrent use of Avonex, Betaseron, Extavia, Rebif, Copaxone, Tysabri or Gilenya	YES / **NO**
Age Restriction:	☐ Age > 18 years	**YES** / NO
Prescriber Restrictions:	☐ Prescribed by or after consultation with a neurologist or an MS specialist.	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise noted.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
THALOMID
Affected Medications: THALOMID (thalidomide)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D, ☐ Myelofibrosis with myeloid metaplasia, ☐ Progressive solitary plasmacytoma or smoldering myeloma that has progressed to active/symptomatic myeloma, ☐ Systemic light chain amyloidosis, ☐ Waldenstrom's macroglobulinemia.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Erythema nodosum leprosum (ENL),** ☐ Thalomid is used for maintenance therapy or as part of a combination regimen in a patient with moderate to severe neuritis for acute therapy. **Active/symptomatic myeloma or progressive solitary plasmacytoma,** ☐ Thalomid is warranted in any of the following settings: a) Thalomid is used in combination with dexamethasone or both melphalan and prednisone as primary induction therapy, b) Thalomid is used as maintenance monotherapy for patients responding to primary induction therapy or for patients with stable or responsive disease following stem cell transplant, c) Thalomid is used as salvage or palliative therapy. ☐ Use for treatment of myelofibrosis with myeloid metaplasia. **Systemic light chain amyloidosis,** ☐ Thalomid is used as primary treatment in combination with dexamethasone. **Waldenstrom's macroglobulinemia**, ☐ Thalomid is used as monotherapy or in combination with rituximab. ☐ In females of childbearing potential, pregnancy is excluded as confirmed by a negative serum or urine pregnancy test.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ All patients are monitored for signs and symptoms of thromboembolism. ☐ Female patients of child-bearing potential and male patients are instructed on the importance and proper utilization of appropriate contraceptive methods for Thalomid use.	**YES** / NO
Exclusion Criteria:	☐ Pregnancy.	YES / **NO**
Age Restriction:	☐	N/A

Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
TOBI PODHALER
Affected Medications: TOBI PODHALER ® (tobramycin inhalation powder), TOBI / tobramycin nebulized solution when used as a Part B medication
Effective Date: 03/01/2014
Last Review Date: 12/11/2013
Part D: Yes (TOBI Podhaler only) Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from part D. ☐ When tobramycin (TOBI) nebulized solution is used as a part D medication, this policy does not apply.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Diagnosis of Cystic Fibrosis, phenotyping not required	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Use of TOBI Podhaler requires documentation of failure of nebulized tobramycin or clinical rationale for avoidance ☐ Use is limited to 28 day on / 28 day off usage ☐ Not limited to treatment of *Pseudomonas aeruginosa* but limited to treatment of Cystic Fibrosis	**YES** / NO
Exclusion Criteria:	☐	N/A
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise noted.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
TOPAMAX/ZONEGRAN
Affected Medications: TOPAMAX (Brand name), TOPAMAX SPRINKLE (Brand name), ZONEGRAN, ZONISAMIDE
Effective Date: 01/01/2014
Last Review Date: 06/12/2013
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:		N/A
Appropriate Treatment Regimen & Other Criteria:	☐ For migraine prevention: pt tried at least 2 other medications commonly used to prevent migraines (beta blockers, depakote, TCAs) unless contraindicated.	**YES** / NO
Exclusion Criteria:	☐ Weight loss treatment except if patient is being treated for seizures, bipolar disorder, migraine prevention, bulimia nervosa, binge-eating disorder, etc with topiramate or zonisamide (exceptions are not recommended for patients with seizures, bipolar disorder, migraine headache, bulimia nervosa, binge-eating disorder, etc who are using topiramate or zonisamide only for weight loss OR for patients who are using topiramate or zonisamide to prevent weight gain or produce weight loss caused by other medications such as antipsychotics [eg, clozapine, olanzapine, quetiapine, risperidone, thioridazine] or antidepressants). ☐ Smoking cessation therapy (exceptions are not recommended for patients with psychiatric conditions who are using topiramate or zonisamide only for smoking cessation OR patients who have successfully stopped smoking and are using topiramate or zonisamide to prevent relapse).	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
TOPICAL RETINOID PRODUCTS
Affected Medications: ADAPALENE, ATRALIN, AVITA, DIFFERIN, EPIDUO, RETIN-A, RETIN-A MICRO, TRETINOIN, TRETIN-X, VELTIN, ZIANA
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ For topical tretinoin products (examples include Atralin, Avita, Retin-A, Retin-A Micro, Tretin-X, and generic topical tretinoin), ☐ Actinic keratosis/treatment of precancerous skin lesions. ☐ Ichthyosis. ☐ Warts. ☐ Keloids. ☐ Lichen planus. ☐ Oral leukoplakia. ☐ Darier's disease (keratosis follicularis). ☐ Treatment of other non-cosmetic conditions therapy (eg, basal cell carcinoma [skin cancer], confluent and reticulated papillomatosis.	**CONFIRMATION*** **YES** / NO
Required Medical Information:		N/A
Appropriate Treatment Regimen & Other Criteria:	**Topical tretinoin products** (examples include Atralin, Avita, Retin-A, Retin-A Micro, Tretin-X, and generic topical tretinoin), ☐ approval for the treatment of other non-cosmetic conditions (eg, dermatitis/eczema, folliculitis, milia, keratosis pilaris, sebaceous hyperplasia/cyst, basal cell carcinoma [skin cancer], confluent and reticulated papillomatosis) can be made if the patient has tried at least 1 other therapy. **Topical adapalene products** (examples include Differin gel, Differin cream, etc. and generic adapalene products), ☐ approval for the treatment of other non-cosmetic conditions (eg, dermatitis/eczema, folliculitis, milia, keratosis pilaris, sebaceous hyperplasia/cyst, basal cell carcinoma [skin cancer], confluent and reticulated papillomatosis, Darier's disease, molluscum contagiosum) can be made if the patient has tried at least 1 other therapy. ☐ Coverage of the combination clindamycin plus tretinoin product (Ziana) and the combination adapalene plus benzoyl peroxide product (Epiduo) is recommended for acne vulgaris ONLY and all other indications are not recommended.	**YES** / NO

Exclusion Criteria:	☐ Use in the treatment of cosmetic conditions (e.g., liver spots, stretch marks, scarring, solar elastosis, premature aging, treatment of photo-aged or photo-damaged skin, solar lentigines, skin roughness, mottled hyperpigmentation, age spots, wrinkles, geographic tongue, hyperpigmentation caused by folliculitis, acne, or eczema, melasma/cholasma, alopecia androgenetic, alopecia areata, seborrheic keratosis).	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise noted.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
TRACLEER
Affected Medications: TRACLEER (Bosentan)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Patients currently on Letairis or Tracleer for treatment of pulmonary arterial hypertension.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Documentation to support NYHA Classification of II, III or IV. ☐ Liver Function Tests within normal limits prior to initiation. ☐ Documentation of Acute Vasoreactivity Testing.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Supportive care should be considered as first-line (anticoagulants, diuretics, oxygen, digoxin) - not required. ☐ Documentation of trial with at least 1 PDE5 inhibitor (unless contraindicated) **OR** patient at high risk necessitating endothelin receptor antagonist. ☐ Patients currently on Letairis or Tracleer may continue therapy if they have a diagnosis of PAH.	**YES** / NO
Exclusion Criteria:	☐ Pregnancy. ☐ PAH secondary to heart failure w/ severe systolic dysfunction. ☐ Evidence of liver dysfunction. ☐ Tracleer: concomitant administration of glyburide, cyclosporine, droneadarone, everolimus, nilotinib.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Prescribed by or in consultation with a cardiologist or a pulmonologist.	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
TRELSTAR
Affected Medications: TRELSTAR (triptorelin)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Prostate cancer**, must meet **one** of the following: ☐ Locally advanced, recurrent or metastatic disease (including palliative treatment) **OR** ☐ Use as neoadjuvant/concurrent/adjuvant ADT in combination with radiation therapy for clinically localized disease with intermediate or high risk of recurrence, **OR** ☐ Use as neoadjuvant therapy in conjunction with brachytherapy in patients with a large prostate to shrink the prostate to an acceptable size for brachytherapy.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Use as neoadjuvant ADT for radical prostatectomy.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
TYSABRI
Affected Medications: TYSABRI (natalizumab)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Adults with Multiple Sclerosis (MS). ☐ Patient has a relapsing form of MS. ☐ Adults with Crohn's disease (CD). ☐ Patient has moderately to severely active CD with evidence of inflammation (eg, elevated C-reactive protein).	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	**Adults with Multiple Sclerosis (MS)** ☐ Patient has a relapsing form of MS and has had an inadequate response to, or is unable to tolerate, therapy with at least **two** of the following MS medications: interferon beta-1a (Avonex, Rebif), interferon beta-1b (Betaseron, Extavia), glatiramer acetate (Copaxone), or fingolimod (Gilenya). ☐ Exceptions to having tried an interferon beta-1a or -1b product (Avonex, Betaseron, Extavia, or Rebif) can be made if the patient has depression or a mood disorder. ☐ In these cases, the patient should try glatiramer acetate (Copaxone) or fingolimod (Gilenya), but is not required to try an interferon beta-1a or -1b. **Adults with Crohn's disease (CD)**. ☐ Patient has moderately to severely active CD with evidence of inflammation (eg, elevated C-reactive protein) and has had an inadequate response to treatment with corticosteroids (systemic), azathioprine, 6-mercaptopurine, or methotrexate, and patient has tried two TNF antagonists for CD for at least 2 months each, adalimumab, certolizumab pegol, or infliximab, and had an inadequate response or was intolerant to the TNF antagonists. ☐ Exception to the CD criteria of treatment with corticosteroids (systemic) are allowed if steroids are contraindicated or not desired, then azathioprine, 6-mercaptopurine, or methotrexate must be tried if they are not contraindicated.	**YES** / NO

Exclusion Criteria:	☐ Concurrent use of another immunomodulator (eg, Rebif, Betaseron, Extavia, Copaxone or Avonex) or fingolimod (Gilenya) in multiple sclerosis (MS) patients. ☐ Use in MS patients with chronic progressive MS. ☐ Concurrent use with immunosuppressants (eg, 6-mercaptopurine, azathioprine, cyclosporine, methotrexate) or tumor necrosis factor (TNF) alfa inhibitors (eg, infliximab, adalimumab, certolizumab pegol) in Crohn's disease (CD) patients. ☐ Ulcerative colitis is a not covered indication.	YES / **NO**
Age Restriction:	☐ Adults	**YES** / NO
Prescriber Restrictions:	☐ MS. Prescribed by a neurologist or an MS specialist registered with the TOUCH prescribing program. ☐ CD. Prescribed by a physician registered with the TOUCH program.	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
VARIZIG
Affected Medications: VARIZIG (varicella zoster immune globulin (human) IM injection)
Effective Date: 09/01/2013
Last Review Date: 08/14/2013
Part D: No Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ For postexposure prophylaxis of varicella in high-risk individuals	**CONFIRMATION*** **YES** / NO
Required Medical Information:	Documentation of immunocompromised patient , defined as: ☐ newborns of mothers with varicella shortly before or after delivery, ☐ premature infants, neonates and infants younger than 1 year, ☐ adults without evidence of immunity, ☐ pregnant women	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ If repeat dose necessary due to re-exposure > 3weeks after initial administration	**YES** / NO
Exclusion Criteria:	☐ Coagulation disorders	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 6 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
VENTAVIS
Drug Name: VENTAVIS (iloprost)
Effective Date: 10/14/2009
Last Review Date: 10/14/2009
Part D: No Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from from benefit design.	**CONFIRMATION*** **YES** / NO
Required documentation:	☐ Documentation of complete & current treatment course required. ☐ NYHA Functional Status: ☐ Class III **OR** ☐ Class IV ☐ Mean pulmonary artery pressure is: ☐ ≥ 25 mmHg at rest **OR** ☐ ≥ 30 mmHg with exertion ☐ Acute Vasoreactivity testing must be completed ☐ Positive ☐ Negative	**YES** / NO
Appropriate Treatment Regimen:	☐ The following supportive care should be considered: ☐ Anticoagulants ☐ Diuretics ☐ Oxygen ☐ Digoxin ☐ Initial approval requires documented failure, intolerance, or clinical rationale for avoidance to the following: ☐ Calcium channel blockers ☐ Phosphodiesterase Inhibitors: Revatio, Adcirca ☐ Prostacyclin derivatives (Letairis, Tracleer, Thelin) OR ☐ High Risk Patient warrants treatment with Prostacyclin ☐ Subsequent approval requires documentation of treatment success: ☐ Defined by exercise endurance ☐ echocardiographic testing ☐ hemodynamic testing ☐ BNP, functional class	**YES** / NO
Exclusion Criteria:	☐ Prior intolerance or allergic reaction to requested medication ☐ PAH secondary to pulmonary venous hypertension (left-sided disease) or disorders of the respiratory system (eg. COPD, interstitial lung disease, OSA)	YES / **NO**

Age Restriction:	☐ ≥ 18 years	**YES** / NO
Provider Restriction:	☐ Pulmonologist or Cardiologist	**YES** / NO
Approval Duration:	☐ Initial approval = 6 months ☐ Subsequent approval = 12 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
VICTRELIS
Affected Medications: VICTRELIS (boceprevir)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	**Hepatitis C:** ☐ HCV genotype, ☐ HCV RNA level, ☐ evidence of compensated liver disease (serum bilirubin ≤ 1.5g/dL, INR WNL, serum albumin ≥ 3.4, platelets WNL, absence of encephalopathy or ascites), ☐ evidence of active liver disease (elevated LFTs, liver biopsy).	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Patient must have completed or will be completing a 4-week lead-in with peginterferon alfa and ribavirin prior to initiating boceprevir **and** ☐ boceprevir must be prescribed in combination as triple-drug therapy with peginterferon alfa and ribavirin. ☐ Prescribing must be consistent with FDA Approved Response Guided Therapy. Treatment Week Assessments at 12 weeks: ☐ HCV-RNA > 100IU/ml = discontinue, ☐ HCV-RNA ≤ 100IU/mL = addl 12wks (total 24 wks). Treatment Week Assessments at 24 weeks: ☐ HCV-RNA > 100IU/mL = discontinue, ☐ HCV-RNA ≤100IU/mL = addnl 12wks (total 36wks).	**YES** / NO
Exclusion Criteria:	☐ Use in the management of non-genotype 1 chronic HCV infection, chronic HCV and human immune deficiency (HIV) co-infection, recurrent hepatitis C after liver (or other organ) transplantation, use as monotherapy, in pediatric patients (age less than 18 years), in patients who have failed therapy with boceprevir or another NS3/4A protease inhibitor for HCV (e.g., telaprevir). ☐ Patient is pregnant or may become pregnant. ☐ Males whose femail partners are pregnant. ☐ Concomitant use of medications that are dependent on CYP3A4 or CYP3A5 metabolism.	YES / **NO**

Age Restriction:	☐ Adults	**YES** / NO
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Initial Approval = 8wks (TW12). ☐ Initial Approval = 44wk, if pt has cirrhosis.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
VIMIZIM
Affected Medications: VIMIZIM (elosulfase alfa)
Effective Date: 07/09/2014
Last Review Date: 07/09/2014
Part D: No Part B: Yes (J3490)

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ The diagnosis was confirmed by an enzyme assay or DNA testing.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ In case of anaphylaxis or severe allergic reaction, there will be appropriate medical support readily available when administered	**YES** / NO
Exclusion Criteria:	☐	N/A
Age Restriction:	☐ 5 years old or greater	**YES** / NO
Prescriber Restrictions:	☐ Geneticist	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
VPRIV
Affected Medications: VPRIV (velaglucerase alfa)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: No Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Patient has a diagnosis of type 1 Gaucher disease. ☐ Diagnosis of Gaucher disease is confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity. ☐ Therapy is initiated for a patient with one or more of the following conditions: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Concomitant therapy with miglustat	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
XALKORI
Affected Medications: XALKORI (crizotinib)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Plus, patients with non-small cell lung cancer (NSCLC) already started on crizotinib.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ For the FDA-approved indication of NSCLC for patients new to therapy, ALK status required.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ NSCLC, patient new to therapy must be ALK-positive for approval.	**YES** / NO
Exclusion Criteria:	☐ Patients with anaplastic lymphoma kinase (ALK)-negative NSCLC not already started on crizotonib. ☐ Patients with NSCLC initiating therapy whose ALK status is unknown.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Prescribed by or after consultation with an oncologist	**YES** / NO
Coverage Duration:	☐ Approval will be for 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
XELJANZ
Affected Medications: XELJANZ (Tofacitinib)
Effective Date: 06/01/2013
Last Review Date: 06/10/2013
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Documented latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) with a negative result ☐ Glomerular filtration rate > 40 ml/min. ☐ Complete set of the following laboratory tests: CBC (WBC, Hgb, Hct, Platlets), LFTs (AST / ALT), BMP (SCr)	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	**Rheumatoid arthritis (RA)** ☐ pt tried at least 2 oral DMARDs for ≥ 12wks (hydroxychloroquine, leflunomide, sulfasalazine, minocycline, methotrexate) **AND** ☐ pt has documented failure, intolerance or clinical rationale for avoidance to **TWO** of the following: Adalimumab (Humira), etanercept (Enbrel), infliximab (Remicade), golimumab (Simponi) or cetolizumab pegol (Cimzia).	N/A
Exclusion Criteria:	☐ Concurrent use with immunosuppresant medications other than methotrexate or corticosteroids. ☐ Patients with a history of diverticulitis, myelodysplastic syndromes, unresolved cytopenias, or active or progressive liver, kidney or hematologic disease. ☐ Evidence of active, latent or inadequately treated TB, herpes zoster.	N/A
Age Restriction:	☐ RA: age > 18 years.	N/A
Prescriber Restrictions:	☐ Prescribed by or in consultation with a Rheumatologist	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
XENAZINE
Affected Medications: XENAZINE (tetrabenazine)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Tardive dyskinesia (TD). ☐ Tourette syndrome and related tic disorders. ☐ Hyperkinetic dystonia. ☐ Hemiballism.	**CONFIRMATION*** **YES** / NO
Required Medical Information:		N/A
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐ Coverage is not recommended for circumstances not listed in the Covered Uses.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ For treatment of chorea associated with Huntington's disease, Tourette syndrome or related tic disorders, hyperkinetic dystonia, or hemiballism, prescribed by or after consultation with a neurologist. ☐ For TD, Xenazine must be prescribed by or after consultation with a neurologist or psychiatrist.	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
XEOMIN
Affected Medications: XEOMIN (IncobotulinumtoxinA)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: No Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Additional indications will be evaluated by a pharmacist and/or a physician on a case-by-case basis.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Documentation of product to be used, sites to be injected and the dosage used in the injections.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ For all covered uses other than focal dystonia, hemifacial spasm, orofacial dyskinesia, blepharospasm, severe writer's cramp, laryngeal spasm and dysphonia, it should be established that the patient is unresponsive to conventional treatments (medication, physical therapy or other widely accepted treatment). ☐ When available, FDA approved products will be preferred over non-FDA approved products. ☐ Coverage may be continued unless any two treatments in a row fail to produce a satisfactory clinical response. ☐ If two subsequent treatments do not produce satisfactory response, one trial authorization of an alternative botulinum toxin may be authorized.	**YES** / NO
Exclusion Criteria:	☐ Use in the management of cosmetic uses (eg, facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platsymal bands, rejuvenation of the peri-orbital region), allergic rhinitis, gait freezing in Parkinsons disease, vaginismus, dysphagia (upper esophageal sphincter dysfunction), interstitial cystitis, Crocodile tears syndrome, tension headaches, myofascial pain, irritable colon, biliary dyskinesia, other forms of smooth muscle spasm not specifically addressed in this policy, lower limb spasticity or fibromyalgia.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Chronic migraine only if prescribed by or after consultation with, a neurologist or HA specialist.	**YES** / NO
Coverage Duration:	☐ All indications approval except strabismus: 4 treatments/12 months. ☐ Stabismus approval: 6 treatments/12 months.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
XGEVA
Affected Medications: XGEVA (denosumab)
Effective Date: 01/01/2014
Last Review Date: 08/14/2013
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Patient has bone metastases from a solid tumor (e.g. breast, prostate). ☐ Documentation of complete current treatment course required. ☐ Patient has giant cell tumor of the bone. ☐ Documentation that tumor is unresectable or that surgical resection is likely to result in severe morbidity. ☐ If patient is adolescent documentation of skeletal maturity. ☐ Serum Calcium.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	Initial approval requires documented failure, intolerance, or clinical rationale for avoidance to the following: ☐ Zometa (zoledronic acid), Aredia (pamedronate) **AND** ☐ Recent oral exam to assess osteonecrosis risk **AND** ☐ Evidence of concurrent treatment with Calcium and Vitamin D. Subsequent approval requires documentation of treatment success. For treatment of Giant Cell Tumor of Bone: ☐ documentation of avoidance of bisphosphonate is not required.	**YES** / NO
Exclusion Criteria:	☐ Uncorrected hypocalcemia. ☐ Prior intolerance or allergic reaction to requested medication. ☐ Hypocalcemia. ☐ Patients at high risk for or prior incident of osteonecrosis of the jaw.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Initial approval = 6 months. ☐ Subsequent approvals = 12 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
XIFAXAN
Affected Medications: XIFAXAN (rifaximin)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Treatment of complex Clostridium difficile infection in select populations.	**CONFIRMATION*** **YES** / NO
Required Medical Information:		N/A
Appropriate Treatment Regimen & Other Criteria:	☐ For C. difficile disease: patient must have failed 1 course of metronidazole and 2 courses of oral vancomycin for coverage to be considered.	**YES** / NO
Exclusion Criteria:	☐ Xifaxan exceeding the recommended dose of two 550 mg tablets daily for treatment / prevention of hepatic enchepalopathy.	YES / **NO**
Age Restriction:	☐ ≥ 12 years	**YES** / NO
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Hepatic encephalopathy = 6 months, ☐ Other conditions, approval = 1 month or as specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
XOFIGO
Affected Medications: XOFIGO (radium 223)
Effective Date: 09/01/2013
Last Review Date: 07/10/2013
Part D: No Part B: Yes

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Diagnosis of castration-resistant prostate cancer (CRPC), symptomatic bone metastases, and no known visceral metastatic disease ☐ Documentation of progression of bone metastases post docetaxel therapy or docetaxel-ineligible.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ For Baseline CBC ☐ ANC ≥ 1.5×10^9/L ☐ Platelet count ≥ 100×10^9/L ☐ Hemoglobin ≥ 10 g/dL	**YES** / NO
Exclusion Criteria:	☐ Concomitant chemotherapy	YES / **NO**
Age Restriction:	☐ ≥ 18 years	**YES** / NO
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 6 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
XOLAIR
Affected Medications: XOLAIR (omalizumab)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: Yes

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Moderate to severe persistant asthma and SAR/PAR, baseline IgE level of at least 30 IU/mL. **Asthma,** ☐ patient has a positive skin test or in vitro testing (ie, a blood test for allergen-specific IgE antibodies such as the RAST) for 1 or more perennial aeroallergens (eg, house dust mite, animal dander [dog, cat], cockroach, feathers, mold spores) and/or for 1 or more seasonal aeroallergens (grass, pollen, weeds). **Seasonal or perennial allergic rhinitis (SAR or PAR)** ☐ patient has positive skin testing (eg, grass, tree, or weed pollen, mold spores, house dust mite, animal dander, cockroach) and/or positive in vitro testing (ie, a blood test for allergen-specific IgE antibodies) for one or more relevant allergens (eg, grass, tree, or weed pollen, mold spores, house dust mite, animal dander, cockroach).	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	**Moderate to severe persistent asthma** ☐ must meet all criteria: patient's asthma symptoms have not been adequately controlled by concomitant use of at least 2 months of inhaled corticosteroid and a long-acting beta-agonist (LABA) or LABA alternative, ☐ if LABA contraindicated or pt has intolerance then alternatives include sustained-release theophylline or a leukotriene modifier (eg, montelukast), **AND** ☐ inadequate control demonstrated by hospitalization for asthma, ☐ requirement for systemic corticosteroids to control asthma exacerbation(s), or ☐ increasing need (eg, more than 4 times a day) for short-acting inhaled beta2 agonists for symptoms (excluding preventative use for exercise-induced asthma). **Seasonal or perennial allergic rhinitis (SAR or PAR)** ☐ must meet the following criteria: patient has tried concurrent therapy with at least one drug from 2 of the following classes, a non-sedating	**YES** / NO

	or low-sedating anthistamine/nasal antihistamine, a nasal corticosteroid, or montelukast or pt has tried at least one drug from all 3 of these classes during one allergy season **AND** ☐ pt has had immunotherapy, is receiving immunotherapy, or will be receiving immunotherapy**, AND** ☐ for pts with allergies to animals, these animals must be removed from the patient's immediate environment (eg, work, home). **Eosinophilic gastroenteritis (EG), Eosinophilic esophagitisi (EE), Eosinophilic colitis (EC)** ☐ patient has tried therapy with a systemic or orally administered topical corticosteroid.	
Exclusion Criteria:	☐ For the treatment of atopic dermatitis.	YES / **NO**
Age Restriction:	☐ Patients > 12 years ☐ Asthma patients aged 6 to 12 years, if already started and stabilized on omalizumab.	**YES** / NO
Prescriber Restrictions:	☐ Moderate to severe persistent asthma if prescribed by, or in consultation with an allergist, immunologist, or pulmonologist. ☐ SAR/PAR if prescribed by an allergist, immunologist, or pulmonologist. ☐ EG/EE/EC, if prescribed by or in consultation with an aller gist, immunologist, or gastroenterologist.	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
XYREM
Affected Medications: XYREM (sodium oxybate)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Patient has a diagnosis of narcolepsy and experiences episodes of cataplexy **OR** ☐ Patient has a diagnosis of narcolepsy and experiences excessive daytime sleepiness with symptoms that limit the ability to perform normal daily activities.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ If the patient has received prior treatment with Xyrem, ☐ the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.	**YES** / NO
Exclusion Criteria:	☐ If the patient is taking alcohol (ethanol), sedative/hypnotic drugs, or other CNS depressants.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 3 months	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ZELBORAF
Affected Medications: ZELBORAF (vemurafenib)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Member: _____ DOB:_____ ID#:_____ Provider: _____ Dx: _____		
Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D. ☐ Patients with melanoma already started on vemurafenib. ☐ Malignancies not specified in Exclusion Criteria.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ FDA-approved indication of melanoma, for patients new to therapy, BRAFV600E status required.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Melanoma, patient new to therapy must have BRAFV600E mutation for approval.	**YES** / NO
Exclusion Criteria:	☐ Patients with melanoma with wild-type BRAF (ie, no detected BRAFV600E mutation) not already started on vemurafenib. ☐ Patients with melanoma initiating therapy with vemurafenib whose BRAFV600E status is unknown.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐ Prescribed by or after consultation with an oncologist	**YES** / NO
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ZORBTIVE
Affected Medications: ZORBTIVE (somatropin)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Diagnosis of short bowel syndrome (SBS).	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Patients must be receiving specialized nutritional support (e.g., TPN, IPN, PPN, rehydration solutions, electrolyte replacement, high complex-carbohydrate, low-fat diet) in conjunction with optimal management of SBS. ☐ For patients who have received at least 4 weeks of Zorbtive therapy, must show decrease in specialized nutritional support requirement as measured by total volume, total calories or infusion frequency and stabilized or increased in weight.	**YES** / NO
Exclusion Criteria:	☐ Active malignancy (newly diagnosed or recurrent). ☐ Acute critical illness due to complications following open heart or abdominal surgery, accidental trauma or acute respiratory failure.	YES / **NO**
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Initial approval: 4 weeks. ☐ Renewal: Up to maximum 8 weeks	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ZYKADIA
Affected Medications: ZYKADIA (ceritinib)
Effective Date: 07/01/2014
Last Review Date: 06/11/2014
Part D: No Part B: Yes (J9999)

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Documentation of ALK status ☐ Documentation of progression on crizotinib therapy ☐ Karnofsky Performance Status OR ECOG performance status	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:	☐ Documentation of planned monthly monitoring of liver function tests, and dose adjustment as needed ☐ Regularly scheduled Qtc monitoring with concomitant diagnosis of CHF, bradyarrhythmias, electrolyte abnormalities, or medications that prolong Qtc interval ☐ Additional authorization requires documentation of positive response to therapy	**YES** / NO
Exclusion Criteria:	☐	N/A
Age Restriction:	☐ 18 years of age and older	**YES** / NO
Prescriber Restrictions:	☐ Oncologist	**YES** / NO
Coverage Duration:	☐ Approval = 6 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		

POLICY NAME:
ZYTIGA
Affected Medications: ZYTIGA (abiraterone)
Effective Date: 01/01/2014
Last Review Date: 09/23/2012
Part D: Yes Part B: No

Covered Uses:	☐ All FDA-approved indications not otherwise excluded from Part D.	**CONFIRMATION*** **YES** / NO
Required Medical Information:	☐ Patient must have metastatic, castration-resistant prostate cancer. ☐ Patient must have tried and failed a docetaxel-containing chemotherapy regimen. ☐ Zytiga will be used in combination with prednisone.	**YES** / NO
Appropriate Treatment Regimen & Other Criteria:		N/A
Exclusion Criteria:	☐	N/A
Age Restriction:	☐	N/A
Prescriber Restrictions:	☐	N/A
Coverage Duration:	☐ Approval = 12 months, unless otherwise specified.	**YES** / NO
**Approvals require that all bolded regions in the 'confirmation' column be documented in member's chart notes.*		