Prior Authorization Requirements

Effective: 11/01/2014

This is not a complete list of drugs covered by our plan. For a complete and current listing, please call Member Services 24 hours a day, seven days a week at 1-888-244-4430 or TTY 1-855-266-4584 or visit www.chgsd.com. This is not a complete list of all formulary alternatives covered by the Part D sponsor for the drug you have selected.

Updated 10/2014

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

5HT3 ANTI-NAUSEA AGENT BVD DETERMINATION

DRUG NAME

GRANISETRON HCL | ONDANSETRON HCL | ONDANSETRON ODT

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ABATACEPT

DRUG NAME

ORENCIA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

RENEWAL: RHEUMATOID ARTHRITIS/JUVENILE IDIOPATHIC ARTHRITIS: EXPERIENCED OR MAINTAINED 20% OR GREATER IMPROVEMENT IN TENDER AND SWOLLEN JOINT COUNT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST.

COVERAGE DURATION

INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

INITIAL: FOR RHEUMATOID ARTHRITIS : TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE) AND TRIAL OF HUMIRA OR CIMZIA. FOR JUVENILE IDIOPATHIC ARTHRITIS: TRIAL OF AT LEAST ONE OF THE FOLLOWING: TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE) AND HUMIRA.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ABATACEPT SQ

DRUG NAME

ORENCIA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

RENEWAL: RHEUMATOID ARTHRITIS: EXPERIENCED OR MAINTAINED 20% OR GREATER IMPROVEMENT IN TENDER AND SWOLLEN JOINT COUNT.

AGE RESTRICTIONS

18 YEARS OR OLDER.

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST.

COVERAGE DURATION

INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

INITIAL: RHEUMATOID ARTHRITIS: TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE) AND TRIAL OF HUMIRA OR CIMZIA.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ABIRATERONE

DRUG NAME

ZYTIGA

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ADALIMUMAB

DRUG NAME

HUMIRA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECT THE HANDS, FEET, OR GENITAL AREA. RENEWAL: RHEUMATOID ARTHRITIS/JUVENILE IDOPATHIC ARTHRITIS/PSORIATIC ARTHRITIS: EXPERIENCED OR MAINTAINED 20 PERCENT IMPROVEMENT IN TENDER OR SWOLLEN JOINT COUNT WHILE ON THERAPY. ANKYLOSING SPONDYLITIS: EXPERIENCED OR MAINTAINED IMPROVEMENT OF AT LEAST 50 PERCENT OR 2 UNITS IN THE BATH ANKYLOSING SPONDYLITIS DISEASE ACTIVITY INDEX (BASDAI). PLAQUE PSORIASIS: ACHIEVED OR MAINTAINED CLEAR OR MINIMAL DISEASE OR A DECREASE IN PSORIASIS AREA AND SEVERITY INDEX (PASI) OF AT LEAST 50% OR MORE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.

OTHER CRITERIA

INITIAL: RHEUMATOID ARTHRITIS/JUVENILE IDIOPATHIC ARTHRITIS: TRIAL/FAILURE OF A DMARD (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE). PSORIATIC ARTHRITIS: TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE). PLAQUE PSORIASIS: TRIAL/FAILURE OF ONE OR MORE FORMS OF PREFERRED THERAPY (PUVA, UVB, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE). CROHN'S DISEASE: TRIAL/FAILURE OF ONE OR MORE CONVENTIONAL THERAPIES SUCH AS CORTICOSTEROIDS (BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. ULCERATIVE COLITIS: TRIAL/FAILURE OF AT LEAST ONE OF THE FOLLOWING SULFASALAZINE, CORTICOSTEROIDS, METHOTREXATE, AZATHIOPRINE, OLSALAZINE, MESALAMINE, CYCLOSPORINE, OR MERCAPTOPURINE. RENEWAL: RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS/ ANKYLOSING SPONDYLITIS: FOR HUMIRA 40 MG EVERY WEEK: TRY/FAIL AT LEAST A 3 MONTH TRIAL OF HUMIRA 40MG EVERY OTHER WEEK AND CURRENTLY TAKING OR HAS CONTRAINDICATION TO METHOTREXATE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ADO-TRASTUZUMAB EMTANSINE

DRUG NAME

KADCYLA

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

AFATINIB DIMALEATE

DRUG NAME

GILOTRIF

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

AFLIBERCEPT

DRUG NAME

ZALTRAP

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ANAKINRA

DRUG NAME

KINERET

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

RENEWAL: RHEUMATOID ARTHRITIS: EXPERIENCED OR MAINTAINED 20% OR GREATER IMPROVEMENT IN TENDER AND SWOLLEN JOINT COUNT.

AGE RESTRICTIONS

RA: 18 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST.

COVERAGE DURATION

RA: INITIAL: 3 MONTHS RENEWAL: 12 MONTHS. NOMID: 12 MONTHS.

OTHER CRITERIA

INITIAL: RHEUMATOID ARTHRITIS: TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE) AND HUMIRA OR CIMZIA.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

APREMILAST

DRUG NAME

OTEZLA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.

COVERAGE DURATION

STARTER PACK: 14 DAYS. TABLETS (NON-STARTER PACK): 12 MONTHS

OTHER CRITERIA

TRIAL OF OR CONTRAINDICATION TO HUMIRA (ADALIMUMAB) AND CIMZIA (CERTOLIZUMAB PEGOL).

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

APREPITANT BVD DETERMINATION

DRUG NAME

EMEND

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

AROMATASE INHIBITORS

DRUG NAME

ANASTROZOLE | EXEMESTANE | LETROZOLE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ASPARAGINASE

DRUG NAME

ERWINAZE

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

HYPERSENSITIVITY TO E.COLI-DERIVED ASPARAGINASE (ELSPAR OR ONCASPAR).

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

AXITINIB

DRUG NAME

INLYTA

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF AT LEAST ONE SYSTEMIC THERAPY FOR THE TREATMENT OF RCC SUCH AS NEXAVAR (SORAFENIB), TORISEL (TEMSIROLIMUS), SUTENT (SUNITINIB), VOTRIENT (PAZOPANIB), OR AVASTIN (BEVACIZUMAB) IN COMBINATION WITH INTERFERON.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

BACILLUS OF CALMETTE AND GUERIN VACCINE BVD DETERMINATION

DRUG NAME

BCG VACCINE (TICE STRAIN)

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

BEDAQUILINE FUMARATE

DRUG NAME

SIRTURO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

24 WEEKS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

BELIMUMAB

DRUG NAME

BENLYSTA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AUTOANTIBODY POSITIVE LUPUS TEST.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

INITIAL: SELENA-SELDAI SCORE GREATER THAN OR EQUAL TO 6. RENEWAL: MAINTAIN AT LEAST A 4 POINT REDUCTION IN SELENA-SELDAI SCORE FROM BASELINE. MEMBER IS CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. NO APPROVAL FOR DIAGNOSIS OF SEVERE ACTIVE LUPUS NEPHRITIS OR SEVERE CENTRAL NERVOUS SYSTEM LUPUS OR CONCURRENT USE OF BIOLOGIC AGENTS, OR INTRAVENOUS CYCLOPHOSAMIDE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

BELINOSTAT

DRUG NAME

BELEODAQ

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

BEVACIZUMAB

DRUG NAME

AVASTIN

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

BEXAROTENE

DRUG NAME

TARGRETIN

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

BOCEPREVIR

DRUG NAME

VICTRELIS

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

TREATMENT WITH BOCEPREVIR WILL NOT BE APPROVED FOR A PATIENT WHO HAS FAILED SHORT TRIAL OR HAS CONTRAINDICATION TO TELAPREVIR (INCIVEK) OR HAS PREVIOUS FAILURE OF FULL COURSE OF TRIPLE THERAPY WITH TELAPREVIR (INCIVEK) OR BOCEPREVIR (VICTRELIS) OR CURRENTLY TAKING CARBAMAZEPINE, PHENOBARBITAL, PHENYTOIN, OR RIFAMPIN OR HAS A CO-INFECTION WITH HEPATITIS B. DETECTABLE HCV RNA LEVEL/VIRAL LOAD OR HCV RNA LEVEL/VIRAL LOAD GREATER THAN OR EQUAL TO 100 IU/ML AFTER TRIPLE THERAPY.

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PATIENT 18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTIONS

GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST) OR SPECIALLY TRAINED GROUP (E.G. EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES). HEP C AND ORGAN TRANSPLANT: TRANSPLANT CENTER AND TRANSPLANT PHYSICIAN.

COVERAGE DURATION

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

OTHER CRITERIA

CONCURRENT USE OF RIBAVIRIN AND PEGINTERFERON ALFA.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

BORTEZOMIB

DRUG NAME

VELCADE

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

BOSUTINIB

DRUG NAME

BOSULIF

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CML: BCR-ABL MUTATIONAL ANALYSIS CONFIRMING THAT BOTH T315I AND V299L MUTATIONS ARE NOT PRESENT.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

C1 ESTERASE INHIBITOR

DRUG NAME

CINRYZE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST, IMMUNOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF OR INTOLERABLE SIDE EFFECTS TO DANAZOL.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CABOZANTINIB

DRUG NAME

COMETRIQ

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CALCINEURIN INHIBITORS

DRUG NAME

ELIDEL | PROTOPIC

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

NOT TRIED/FAILED OR INTOLERABLE ADVERSE EFFECTS TO TOPICAL CORTICOSTEROIDS

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CANAKINUMAB

DRUG NAME

ILARIS

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

CAPS: 4 YEARS AND OLDER. SJIA: 2 YEARS AND OLDER.

PRESCRIBER RESTRICTIONS

PRESCRIBED OR SUPERVISED BY RHEUMATOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CERITINIB

DRUG NAME

ZYKADIA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

POSITIVE FOR ANAPLASTIC LYMPHOMA KINASE (ALK) FUSION ONCOGENE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CERTOLIZUMAB PEGOL

DRUG NAME

CIMZIA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

RENEWAL: RHEUMATOID ARTHRITIS: EXPERIENCED OR MAINTAINED 20% OR GREATER IMPROVEMENT IN TENDER AND SWOLLEN JOINT COUNT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR SUPERVISED BY A GASTROENTEROLOGIST OR RHEUMATOLOGIST.

COVERAGE DURATION

INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

FOR MODERATE TO SEVERE CROHN'S DISEASE: TRIAL/FAILURE OF ONE OR MORE CONVENTIONAL THERAPIES FOR CROHN'S DISEASE SUCH AS CORTICOSTEROIDS, AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. FOR MODERATE TO SEVERE RHEUMATOID ARTHRITIS: TRIAL/FAILURE OF AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE).

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CETUXIMAB

DRUG NAME

ERBITUX

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

METASTATIC COLORECTAL CANCER : WILD TYPE KRAS (WITHOUT MUTATION)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CHENODIOL

DRUG NAME

CHENODAL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CEREBROTENDINOUS XANTHOMATOSIS.

EXCLUSION CRITERIA

RADIOLUCENT GALLSTONES: NO FAILED TREATMENT WITH URSODIOL

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CLOBAZAM

DRUG NAME

ONFI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF LAMOTRIGINE OR TOPIRAMATE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CORTICOSTEROID BVD DETERMINATION

DRUG NAME

A-HYDROCORT | CORTISONE ACETATE | DEXAMETHASONE | DEXAMETHASONE SODIUM PHOSPHATE | HYDROCORTISONE | METHYLPREDNISOLONE | METHYLPREDNISOLONE ACETATE | METHYLPREDNISOLONE SOD SUCC | PREDNISOLONE SODIUM PHOSPHATE | PREDNISONE | PREDNISONE INTENSOL | SOLU-CORTEF | SOLU-MEDROL | TRIAMCINOLONE ACETONIDE

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CORTICOTROPIN

DRUG NAME

H.P. ACTHAR

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

USED FOR DIAGNOSTIC PURPOSES. ACUTE EXACERBATION OF MULTIPLE SCLEROSIS: IV ACCESS OR IV ACCESS CAN BE OBTAINED.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

INFANTILE SPASMS: LESS THAN 2 YEARS OF AGE.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INFANTILE SPASMS: 28 DAYS. MULTIPLE SCLEROSIS: 21 DAYS.

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CRIZOTINIB

DRUG NAME

XALKORI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CYCLOPHOSPHAMIDE BVD DETERMINATION

DRUG NAME

CYCLOPHOSPHAMIDE

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CYCLOSPORINE OPHTHALMIC

DRUG NAME

RESTASIS

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

KERATOCONJUNCTIVITIS SICCA (KCS) OR DRY EYE DISEASE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

DABIGATRAN

DRUG NAME

PRADAXA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF OR CONTRAINDICATION TO XARELTO OR ELIQUIS.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

DABRAFENIB MESYLATE

DRUG NAME

TAFINLAR

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

DALFAMPRIDINE

DRUG NAME

AMPYRA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

NEUROLOGIST

COVERAGE DURATION

INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA

RENEWAL: PATIENT HAS EXPERIENCED OR MAINTAINED AT LEAST 15% IMPROVEMENT IN WALKING ABILITY.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

DASATINIB

DRUG NAME

SPRYCEL

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PREVIOUSLY TREATED CML REQUIRES MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS FOLLOWING BCR-ABL MUTATIONAL ANALYSIS - T315I, V299L, T315A, F317L/V/I/C.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

DENOSUMAB

DRUG NAME

PROLIA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

DENOSUMAB-XGEVA

DRUG NAME

XGEVA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

DIAGNOSIS OF MULTIPLE MYELOMA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

DIMETHYL FUMARATE

DRUG NAME

TECFIDERA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

18 YEARS AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF OR CONTRAINDICATION TO INTERFERON THERAPY (SUCH AS REBIF, AVONEX, BETASERON, EXTAVIA) AND COPAXONE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ELTROMBOPAG

DRUG NAME

PROMACTA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL:1 MOS. RENEWAL: CLINICAL RESPONSE: 12 MOS. MAX DOSE FOR 4 WEEKS: 1 MOS. HEP C: 12 MOS.

OTHER CRITERIA

CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIA PURPURA (ITP): INITIAL: TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY. ITP: RENEWAL: PATIENT HAS A CLINICAL RESPONSE AS DEFINED BY AN INCREASE IN PLATELET COUNT OF GREATER THAN OR EQUAL TO 50 X10^9/L (GREATER THAN OR EQUAL TO 50,0000 PER UL) AT THE MAX DOSE OF 75MG PER DAY FOR 4 WEEKS. HEPATITIS C: CONCURRENT INTERFERON THERAPY.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ENDOTHELIN RECEPTOR ANTAGONISTS

DRUG NAME

LETAIRIS | OPSUMIT | TRACLEER

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

CARDIOLOGIST OR PULMONOLOGIST.

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ENZALUTAMIDE

DRUG NAME

XTANDI

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF OR CONTRAINDICATION TO DOCETAXEL.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

EPIDERMAL GROWTH FACTOR RECEPTOR INHIBITORS - ERLOTNIB

DRUG NAME

TARCEVA

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ERIBULIN

DRUG NAME

HALAVEN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

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

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ERYTHROPOIESIS STIMULATING AGENTS - EPOETIN ALFA

DRUG NAME

EPOGEN | PROCRIT

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

CHRONIC RENAL FAILURE HEMAGLOBIN LEVELS LESS THAN 10 G/DL IF NOT ON DIALYSIS AND LESS THAN 11 G/DL IF ON DIALYSIS OR HEMOGLOBIN HAS REACHED 11 G/DL IF ON DIALYSIS AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS OR HEMOGLOBIN HAS REACHED 10 G/DL IF NOT ON DIALYSIS AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CANCER CHEMOTHERAPY: HEMOGLOBIN LEVELS BETWEEN 10 AND 12 G/DL OR HEMOGLOBIN LEVEL LESS THAN 11 G/DL OR HEMOGLOBIN LEVEL DECREASED AT LEAST 2 G/DL BELOW THEIR BASELINE. ZIDOVUDINE THERAPY: HEMOGLOBIN LEVEL BETWEEN 10 AND 12 G/DL OR HEMOGLOBIN LESS THAN 10 G/DL. ELECTIVE, NONCARDIAC, NONVASCULAR SURGERY: HEMOGLOBIN LESS THAN 13 G/DL. CONCURRENT HEPATITIS C TREATMENT: HEMOGLOBIN LESS BETWEEN 10 AND 12 G/DL FOR PATIENTS CURRENTLY TAKING REQUESTED MEDICATION OR CONTRAINDICATION TO RIBAVIRIN DOSE REDUCTION AND HEMOGLOBIN LESS THAN 10 G/DL FOR NEW STARTS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

ANEMIA FROM MYELOSUPPRESSIVE CHEMO/CKD W/O DIALYSIS/ZIDOVUDINE:12 MOS. SURGERY:1 MO. HEP C:6 MOS.

OTHER CRITERIA

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

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ESRD BVD DETERMINATION

DRUG NAME

CALCITRIOL | CUBICIN | DOXERCALCIFEROL | HEPARIN SODIUM | IBANDRONATE SODIUM | LEVOCARNITINE | LIDOCAINE | LIDOCAINE HCL | LIDOCAINE-PRILOCAINE | MIACALCIN | PAMIDRONATE DISODIUM | PARICALCITOL | VANCOMYCIN HCL | ZEMPLAR

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ETANERCEPT

DRUG NAME

ENBREL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECT THE HANDS, FEET, OR GENITAL AREA. RENEWAL: RHEUMATOID ARTHRITIS/JUVENILE IDIOPATHIC ARTHRITIS/PSORIATIC ARTHRITIS: EXPERIENCED OR MAINTAINED 20 PERCENT OR GREATER IMPROVEMENT IN TENDER OR SWOLLEN JOINT COUNT WHILE ON THERAPY. ANKYLOSING SPONDYLITIS: EXPERIENCED OR MAINTAINED IMPROVEMENT OF AT LEAST 50 PERCENT OR 2 UNITS IN THE BATH ANKYLOSING SPONDYLITIS DISEASE ACTIVITY INDEX (BASDAI). PLAQUE PSORIASIS: ACHIEVED OR MAINTAINED CLEAR OR MINIMAL DISEASE OR A DECREASE IN PSORIASIS AREA AND SEVERITY INDEX (PASI) OF AT LEAST 50% OR MORE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST OR DERMATOLOGIST.

COVERAGE DURATION

INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

INITIAL: FOR RHEUMATOID ARTHRITIS: TRIAL OF HUMIRA OR CIMIZIA AND TRIAL/FAILURE OF AT LEAST ONE DMARD AGENT (METHOTREXATE,

LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE). FOR JUVENILE IDOPATHIC ARTHRITIS: TRIAL OF HUMIRA AND TRIAL/FAILURE TO AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE). FOR ANKYLOSING SPONDYLITIS: TRIAL OF HUMIRA. FOR PSORIATIC ARTHRITIS: TRIAL OF HUMIRA AND TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE). FOR MODERATE TO SEVERE PLAQUE PSORIASIS: TRIAL OF HUMIRA AND TRIAL/FAILURE OF ONE OR MORE FORMS OF PREFERRED THERAPY (PUVA, UVG, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE).

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

EVEROLIMUS

DRUG NAME

AFINITOR | AFINITOR DISPERZ

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

ADVANCED RENAL CELL CARCINOMA (RCC): TRIAL OF OR CONTRAINDICATION TO SUTENT OR NEXAVAR.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

FENTANYL NASAL SPRAY

DRUG NAME

LAZANDA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

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

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

FENTANYL TRANSDERMAL PATCH

DRUG NAME

FENTANYL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE SUSTAINED-RELEASE MORPHINE PRODUCT. EVERY 48 HOUR DOSING CONSIDERED FOR PATIENTS WHO FAIL EVERY 72 HOUR DOSING. NO APPROVAL WHEN PRESCRIBED FOR AS NEEDED DOSAGE FREQEUNCY.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

FENTANYL TRANSMUCOSAL AGENTS - FENTANYL CITRATE

DRUG NAME

FENTANYL CITRATE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

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

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

FINGOLIMOD

DRUG NAME

GILENYA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OR CONTRAINDICATION TO INTERFERON THERAPY (AVONEX, BETASERON, EXTAVIA, OR REBIF) AND COPAXONE, OR RAPIDLY PROGRESSING DISEASE WHILE ON INTERFERON THERAPY OR COPAXONE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

GLP-1 ANALOGS

DRUG NAME

VICTOZA 3-PAK

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FAILURE TO REACH TREATMENT GOALS WITH METFORMIN, METFORMIN ER, GLYBURIDE/METFORMIN, GLIPIZIDE/METFORMIN, A FORMULARY SULFONYLUREA (GLYBURIDE, GLIPIZIDE), PIOGLITAZONE (ACTOS), PIOGLITAZONE/METFORMIN (ACTOSPLUS MET), OR PIOGLITAZONE/GLIMEPIRIDE (DUETACT) AND EXENATIDE EXTENDED RELEASE (BYDUREON).

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

GLYCEROL PHENYLBUTYRATE

DRUG NAME

RAVICTI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF OR CONTRAINDICATION TO SODIUM PHENYLBUTYRATE (BUPHENYL).

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

GOLIMUMAB

DRUG NAME

SIMPONI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

18 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

INITIAL: 3 MONTHS RENEWAL: 12 MONTHS. UC: 12 MONTHS.

OTHER CRITERIA

ACTIVE RHEUMATOID ARTHRITIS INITIAL: TRIAL OF HUMIRA OR CIMZIA AND TRIAL/FAILURE OF AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE). PSORIATIC ARTHRITIS: TRIAL OF HUMIRA AND TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE) AND HUMIRA. ANKYLOSING SPONDYLITIS: TRIAL OF HUMIRA. ULCERATIVE

COLITIS: TRIAL OF OR CONTRAINDICATION TO SULFASALAZINE, CORTICOSTEROIDS, METHOTREXATE, AZATHIOPRINE, OLSALAZINE, MESALAMINE, CYCLOSPORINE, OR MERCAPTOPURINE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

GOLIMUMAB - SIMPONI ARIA

DRUG NAME

SIMPONI ARIA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

PRESCRIBED OR SUPERVISED BY A RHEUMATOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

RHEUMATOID ARTHRITIS: INITIAL: TRIAL/FAILURE OF AT LEAST ONE OF THE FOLLOWING DMARD AGENTS: METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

HEPATITIS B VACCINE BVD DETERMINATION

DRUG NAME

ENGERIX-B ADULT | ENGERIX-B PEDIATRIC-ADOLESCENT | RECOMBIVAX HB

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - ANTI-INFECTIVE

DRUG NAME

NITROFURANTOIN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

MEMBERS 65 YEARS OR OLDER WILL BE EVALUATED FOR LIMITED PRESCRIPTION USE TO NO MORE THAN 90 DAYS (TOTAL) OF CUMULATIVE USE. REQUESTS FOR GREATER THAN 90 DAYS OF CUMULATIVE USE WILL REQUIRE TRIAL OF OR CONTRAINDICATION TO SULFAMETHOXAZOLE/TRIMETHOPRIM (TMP-SMX) OR TRIMETHOPRIM.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS

DRUG NAME

CARBINOXAMINE MALEATE | CLEMASTINE FUMARATE | CYPROHEPTADINE HCL | PALGIC

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: TRIAL OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE. ANXIETY: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - BUSPIRONE, PAROXETINE, DULOXETINE, OR VENLAFAXINE. MOTION SICKNESS: TRIAL OR CONTRAINDICATION TO MECLIZINE. INSOMNIA: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - BENZTROPINE_TRIHEXYPHENIDYL

DRUG NAME

BENZTROPINE MESYLATE | TRIHEXYPHENIDYL HCL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - HYDROXYZINE

DRUG NAME

HYDROXYZINE HCL | HYDROXYZINE PAMOATE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: TRIAL OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE. ANXIETY: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - BUSPIRONE, PAROXETINE, DULOXETINE, OR VENLAFAXINE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - PROMETHAZINE

DRUG NAME

PHENADOZ | PROMETHAZINE HCL | PROMETHEGAN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: TRIAL OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE. ANXIETY: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - BUSPIRONE, PAROXETINE, DULOXETINE, OR VENLAFAXINE. MOTION SICKNESS: TRIAL OR CONTRAINDICATION TO MECLIZINE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - BARBITURATE COMBINATIONS

DRUG NAME

ACETAMINOPHEN-BUTALBITAL | ALAGESIC LQ | ASCOMP WITH CODEINE | BUTALB-CAFF-ACETAMINOPH-CODEIN | BUTALBITAL-ACETAMINOPHEN-CAFFE | BUTALBITAL-ASPIRIN-CAFFEINE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - CARDIOVASCULAR

DRUG NAME

GUANFACINE HCL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

HYPERTENSION: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - BENAZEPRIL, BENAZEPRIL/HYDROCHLOROTHIAZIDE, CAPTOPRIL, CAPTOPRIL/HYDROCHLOROTHIAZIDE, ENALAPRIL, ENALAPRIL/HYDROCHLOROTHIAZIDE, FOSINOPRIL, FOSINOPRIL/HYDROCHLOROTHIAZIDE, LISINOPRIL, LISINOPRIL/HYDROCHLOROTHIAZIDE, QUINAPRIL, QUINALPRIL/HYDROCHLOROTHIAZIDE, RAMIPRIL, MOEXIPRIL, MOEXIPRIL/HYDROCHLOROTHIAZIDE, PERINDOPRIL ERBUMINE, QUNINAPRIL, QUINAPRIL/HYDROCHLOROTHIAZIDE, TRANDOLAPRIL, TRANDOLAPRIL/VERAPAMIL, LOSARTAN, LOSARTAN/HYDROCHLOROTHIAZIDE, IRBESARTAN, IRBESARTAN/HYDROCHLOROTHIAZIDE, OLMESARTAN, OLMESARTAN/HYDROCHLOROTHIAZIDE,

OLEMSARTAN/AMILODIPINE/HYDROCHLOROTHIAZIDE, VALSARTAN, VALSARTAN/HYDROCLOROTHIAZIDE, DILTIAZEM HCL, DILTIAZEM SUSTAINED RELEASE, VERAPAMIL, VERAPAMIL SUSTAINED RELEASE, ATENOLOL, ATENOLOL/HCLORTHALIDONE, BISOPROLOL, BISOPROLOL/HYDROCHLOROTHIAZIDE, CARVEDILOL, METOPROLOL TARTRATE, NADOLOL, ACEBUTOLOL, BETAXOLOL, LABETAOL, METOPROLOL SUCCINATE, METOPROLOL/HYDROCHLOROTHIAZIDE, PINDOLOL, PROPANOLOL, PROPRANOLOL/HYDROCHLOROTHIAZIDE, SOTALOL, TIMOLOL MALEATE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - CENTRAL NERVOUS SYSTEM - THIORIDAZINE

DRUG NAME

THIORIDAZINE HCL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

65 YEARS AND OLDER: SCHIZOPHRENIA - PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - DIGOXIN

DRUG NAME

DIGOX | DIGOXIN | LANOXIN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIGOXIN LEVEL

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

APPROVAL FOR MEMBERS STABLE ON 250 MCG WITH DOCUMENTED THERAPEUTIC DIGOXIN LEVEL TAKEN WITHIN THE PAST YEAR.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - ESTROGEN

DRUG NAME

COMBIPATCH | DUAVEE | ESTRADIOL | ESTRADIOL-NORETHINDRONE ACETAT | ESTROPIPATE | JINTELI | MENEST | MIMVEY LO | PREMARIN | PREMPHASE | PREMPRO | VIVELLE-DOT

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

VULVAR/VAGINAL ATROPHY: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - ESTRACE VAGINAL CREAM, PREMARIN VAGINAL CREAM, OR VAGIFEM. OSTEOPOROSIS: TRIAL OR CONTRAINDICATION TO ONE OF THE FOLLOWING - ALENDRONATE, IBANDRONATE, OR RALOXIFENE. VASOMOTOR SYMPTOMS OF MENOPAUSE: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER. ALL OTHER FDA APPROVED INDICATIONS, SUCH AS PALLIATION TREATMENT, NOT PREVIOUSLY MENTIONED IN THIS SECTION, ARE TO BE APPROVED WITHOUT A TRIAL OF FORMULARY ALTERNATIVES.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - GLYBURIDE

DRUG NAME

GLYBURIDE | GLYBURIDE MICRONIZED | GLYBURIDE-METFORMIN HCL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - INDOMETHACIN

DRUG NAME

INDOMETHACIN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF OR CONTRAINDICATION TO CELECOXIB OR A TOPICAL NON-STEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) SUCH AS VOLTAREN GEL OR FLECTOR. PRESCRIPTIONS WRITTEN BY A RHEUMATOLOGIST DO NOT REQUIRE TRIAL OF FORMULARY ALTERNATIVES.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - NON-BENZODIAZEPINE

DRUG NAME

ZALEPLON | ZOLPIDEM TARTRATE | ZOLPIDEM TARTRATE ER

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

MEMBERS 65 YEARS OR OLDER WILL BE EVALUATED FOR LIMITED PRESCRIPTION USE TO NO MORE THAN 90 DAYS (TOTAL) OF CUMULATIVE USE WITHIN THE CURRENT PLAN YEAR. REQUESTS GREATER THAN 90 DAYS OF CUMULATIVE USE REQUIRES PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - SKELETAL MUSCLE RELAXANTS

DRUG NAME

CARISOPRODOL | CHLORZOXAZONE | CYCLOBENZAPRINE HCL | METAXALONE | METHOCARBAMOL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - TCA

DRUG NAME

AMITRIPTYLINE HCL | CLOMIPRAMINE HCL | DOXEPIN HCL | IMIPRAMINE HCL | IMIPRAMINE PAMOATE | PERPHENAZINE-AMITRIPTYLINE | TRIMIPRAMINE MALEATE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

APPLIES TO MEMBERS 65 YEARS AND OLDER FOR THE FOLLOWING: MIGRAINE PROPHYLAXIS: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - PROPRANOLOL, TIMOLOL, TOPIRAMATE, VALPROIC ACID, OR DIVALPROEX. DEPRESSION: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - PAROXETINE, SERTRALINE, VENLAFAXINE, DULOXETINE, CITALOPRAM, ESCITALOPRAM, FLUOXETINE, OR TRAZODONE. POSTHERPERTIC NEURALGIA: TRIAL OR CONTRAINDICATION TO GABAPENTIN OR PREGABALIN.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

IBRUTINIB

DRUG NAME

IMBRUVICA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

IDELALISIB

DRUG NAME

ZYDELIG

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

IMATINIB MESYLATE

DRUG NAME

GLEEVEC

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

ALL DIAGNOSIS: 12 MONTHS. GIST (TWICE DAILY DOSE): 36 MONTHS.

OTHER CRITERIA

GASTROINTESTINAL STROMAL TUMOR (GIST) KIT (CD117) POSITIVE USE FOR GLEEVEC 400MG TWICE DAILY: TRIAL OF GLEEVEC 400MG ONCE DAILY OR GIST TUMOR EXPRESSING A KIT EXON 9 MUTATION. PREVIOUSLY TREATED CML REQUIRES MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS FOLLOWING BCR-ABL MUTATIONAL ANALYSIS - T315I, V299L, F317L/V/I/C, Y253H, E255K/V, F359V/C/I.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

IMIQUIMOD - ALDARA

DRUG NAME

IMIQUIMOD

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

4 MONTHS

OTHER CRITERIA

CRITERIA APPLIES TO NEW STARTS ONLY. ACTINIC KERATOSIS: TRIAL OF TOPICAL 5-FLUOROURACIL. ACTINIC KERATOSIS BRAND DRUG REQUEST: TRIAL/FAILURE OF GENERIC IMIQUIMOD 5%. SUPERFICIAL BASAL CELL CARCINOMA: LESS THAN 2CM IN SIZE AND NOT ON THE FACE. MOLLUSCUM CONTAGISOUM LIMITED TO THE FACE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

IMMUNE GLOBULIN BVD DETERMINATION

DRUG NAME

CARIMUNE NF NANOFILTERED | GAMMAGARD LIQUID | GAMMAPLEX | GAMUNEX-C | PRIVIGEN

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

IMMUNOSUPPRESSANT BVD DETERMINATION

DRUG NAME

ASTAGRAF XL | AZATHIOPRINE | CELLCEPT | CYCLOSPORINE | CYCLOSPORINE MODIFIED | GENGRAF | MYCOPHENOLATE MOFETIL | MYCOPHENOLIC ACID | NULOJIX | PROGRAF | RAPAMUNE | SIMULECT | SIROLIMUS | TACROLIMUS | ZORTRESS

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

INFLIXIMAB

DRUG NAME

REMICADE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 10 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECT THE HANDS, FEET, OR GENITAL AREA. RENEWAL: RHEUMATOID/PSORIATIC ARTHRITIS: MAINTAINED OR EXPERIENCED GREATER THAN 20% IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT. PLAQUE PSORIASIS: MAINTAINED OR EXPERIENCED PASI OF GREATER THAN 50% OR SIGNIFCANT IMPROVEMENT IN QUALITY OF LIFE OBSERVED BY PHYSICIAN AND PATIENT. ANKYLOSING SPONDYLITIS: MAINTAINED OR EXPERIENCED IMPROVEMENT OF AT LEAST 50%, OR 2 UNITS (SCALE OF 1-10), IN THE BATH ANKYLOSING SPONDYLITIS DISEASE ACTIVITY INDEX (BASDAI) OR IMPROVEMENT OF AT LEAST 20% IN THE ASSESSMENT IN ANKYLOSING SPONDYLITIS (ASAS20) CRITERIA.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

UC: 12 MO. OTHER INDICATIONS INITIAL: 4 MO RENEWAL: 12 MO

OTHER CRITERIA

INITIAL: MODERATE TO SEVERE CROHN'S DISEASE/ULCERATIVE COLITIS/ACUTE ENTEROCUTANEOUS FISTULA: TRIAL/FAILURE OF ONE OR MORE OF THE FOLLOWING PREFERRED THERAPY AGENTS SUCH AS SULFASALAZINE, CORTICOSTEROIDS, AZATHIOPRINE, METHOTREXATE, OLSALAZINE, MESALAMINE, CYCLOSPORINE,OR MERCAPTOPURINE. FOR MODERATE TO SEVERE RHEUMATOID ARTHRITIS: TRIAL OF HUMIRA OR CIMZIA AND TRIAL/FAILURE TO AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE). FOR PSORIATIC ARTHRITIS: TRIAL OF HUMIRA AND TRIAL/FAILURE TO AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. FOR SEVERE PLAQUE PSORIASIS COVERING 10% BSA: TRIAL/FAILURE/INTOLERABLE SIDE AFFECTS TO AT LEAST ONE PREFERRED THERAPY (PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE). RENEWAL: FOR RHEUMATOID ARTHRITIS: CONCOMITANT METHOTREXATE USE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

INFUSIBLE DRUG BVD DETERMINATION

DRUG NAME

ABELCET | ACYCLOVIR SODIUM | AMPHOTERICIN B | BLEOMYCIN SULFATE | CLADRIBINE | CYTARABINE | FLUOROURACIL | FOSCARNET SODIUM | GANCICLOVIR SODIUM | IFOSFAMIDE | METHOTREXATE | MITOMYCIN | REMODULIN | TORISEL | VINBLASTINE SULFATE | VINCRISTINE SULFATE

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

INTERFERON AGENTS - INTERFERON ALFA-2B

DRUG NAME

INTRON A

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

HEP C: PRETREATMENT HCV RNA LEVEL GREATER THAN OR EQUAL TO 50 IU/ML.

AGE RESTRICTIONS

HEP C: 3 YEARS OR OLDER.

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

INITIAL HEP C: 2 TO 6 MOS. ALL OTHERS: 4 MOS. RENEWAL HEP C AND ALL OTHERS: 6 MOS.

OTHER CRITERIA

HEP C: DRUG MUST BE USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

INTERFERON AGENTS - PEG-INTERFERON ALFA-2A

DRUG NAME

PEGASYS | PEGASYS PROCLICK

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

INITIAL: HEP C: PRETREATMENT HCV RNA LEVEL GREATER THAN OR EQUAL TO 50 IU/ML. HEP C WITH HIV: CD4 COUNT GREATER THAN 100 CELLS/MM3, HCV RNA LEVELS/VIRAL LOAD GREATER THAN OR EQUAL TO 50 IU/ML. RENEWAL: HCV RNA LEVELS TO DETERMINE LENGTH OF TREATMENT.

AGE RESTRICTIONS

5 YEARS OR OLDER.

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

INITIAL HEP B: 6 MOS HEP C 2 TO 6 MOS. RENEWAL HEP B: 6 MOS. HEP C: 1 TO 12 MOS.

OTHER CRITERIA

HEP C: TRIAL OR CONTRAINDICATION TO PEGINTRON. DRUG MUST BE USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED. RENEWAL: HEP C: USED IN COMBINATION OR CONTRAINDICATION WITH RIBAVIRIN. GENOTYPE 2 OR 3: NO RENEWAL.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

INTERFERON AGENTS - PEG-INTERFERON ALFA-2B

DRUG NAME

PEGINTRON | PEGINTRON REDIPEN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

INITIAL: HEP C: PRETREATMENT HCV RNA LEVEL GREATER THAN OR EQUAL TO 50 IU/ML. RENEWAL: HCV RNA LEVELS TO DETERMINE LENGTH OF TREATMENT.

AGE RESTRICTIONS

3 YEARS OR OLDER.

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

INITIAL HEP C: 2 TO 6 MOS. RENEWAL HEP C: 1 TO 12 MOS.

OTHER CRITERIA

HEP C: DRUG MUST BE USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED. RENEWAL HEP C: USED IN COMBINATION OR CONTRAINDICATION WITH RIBAVIRIN. GENOTYPE 2 OR 3: NO RENEWAL.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

IPILIMUMAB

DRUG NAME

YERVOY

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

IVACAFTOR

DRUG NAME

KALYDECO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

G551D MUTATION

AGE RESTRICTIONS

6 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

LENALIDOMIDE

DRUG NAME

REVLIMID

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

METHOTREXATE BVD DETERMINATION

DRUG NAME

METHOTREXATE | TREXALL

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

METHYLNALTREXONE

DRUG NAME

RELISTOR

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

CONSTIPATION DUE TO OPIOIDS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

UP TO 6 MONTHS

OTHER CRITERIA

PATIENT IS RECEIVING PALLIATIVE CARE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

MIFEPRISTONE

DRUG NAME

KORLYM

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

MIPOMERSEN

DRUG NAME

KYNAMRO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

PATIENT IS CONCURRENTLY RECEIVING LDL APHERESIS.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

USE IN COMBINATION WITH A STATIN (EXAMPLE: SIMVASTATIN, ATORVASTATIN), BILE ACID SEQUESTRANT FENOFIBRATE OR NIACIN.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

MODAFINIL AND ARMODAFINIL - PROVIGIL

DRUG NAME

MODAFINIL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL COVERAGE CONSIDERATION FOR CHRONIC FATIGUE SYNDROME RELATED TO MULTIPLE SCLEROSIS.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

NARCOLEPSY: TRIAL OF OR CONTRAINDICATION TO AMPHETAMINE, DEXTROAMPHETAMINE, OR METHYLPHENDATE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

NATALIZUMAB

DRUG NAME

TYSABRI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

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

OTHER CRITERIA

MULTIPLE SCLEROSIS: TRIAL OF AN INTERFERON OR COPAXONE. CROHN'S DISEASE: TRIAL OF A TNF-ALPHA INHIBITOR. RENEWAL: CROHN'S: PATIENT IS NOT ON CONCOMITANT CORTICOSTEROID TREATMENT AFTER 6 MONTHS ON NATALIZUMAB, OR HAS NOT RECEIVED MORE THAN 3 MONTHS OF A CORTICOSTEROID WITHIN THE PAST 12 MONTHS.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

NEBULIZER BVD DETERMINATION

DRUG NAME

ACETYLCYSTEINE | ALBUTEROL SULFATE | BETHKIS | CROMOLYN SODIUM | NEBUPENT | PULMOZYME | TOBRAMYCIN | TYVASO | VENTAVIS

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

NILOTINIB

DRUG NAME

TASIGNA

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PREVIOUSLY TREATED CML REQUIRES MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS FOLLOWING BCR-ABL MUTATIONAL ANALYSIS - T315I, Y253H, E255K/V, F359V/C/I.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

OFATUMUMAB

DRUG NAME

ARZERRA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

CHRONIC LYMPHOCYTIC LEUKEMIA: NO FAILED TREATMENT WITH FLUDARABINE AND ALEMTUZUMAB

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

OMACETAXINE

DRUG NAME

SYNRIBO

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INDUCTION: 3 MONTHS. POST INDUCTION/RENEWAL: 3 TO 12 MONTHS

OTHER CRITERIA

CML INDUCTION THERAPY: TRIAL OF OR CONTRAINDICATION TO AT LEAST TWO OF THE FOLLOWING GLEEVEC, SPRYCEL, TASIGNA, BOSULIF, OR ICLUSIG. DETERMINATION FOR THERAPY LENGTH OF APPROVAL THAT IS NOT INDUCTION THERAPY WILL DEPEND ON THE PATIENTS HEMATOLOGIC RESPONSE (DEFINED AS ABSOLUTE NEUTROPHIL COUNT (ANC) GREATER THAN OR EQUAL TO 1.5 X 10^9/L AND PLATELETS GREATER THAN OR EQUAL TO 100 X 10^9/L AND NO BLOOD BLASTS OR BONE MARROW BLASTS LESS THAN 5%). IF MEETS HEMATOLOGIC RESPONSE CRITERIA APPROVAL WILL BE 12 MONTHS. IF HEMATOLOGIC RESPONSE CRITERIA IS NOT MET APPROVAL WILL BE FOR 3 MONTHS.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

OMALIZUMAB

DRUG NAME

XOLAIR

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PATIENT 12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

SPECIALIST IN ALLERGY OR PULMONARY MEDICINE ONLY

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

OPIOID DEPENDENCY AGENTS

DRUG NAME

BUPRENORPHINE HCL | BUPRENORPHINE-NALOXONE | SUBOXONE | ZUBSOLV

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PSYCHOSOCIAL COUNSELING

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBING PHYSICIAN MUST BE CERTIFIED TO PRESCRIBE BUPRENORPHINE FOR OPIOID DEPENDENCE.

COVERAGE DURATION

BUPRENORPHINE: 1 WEEK. RENEWAL: 6 MOS. BUPRENOR/NALOX: 6 MOS

OTHER CRITERIA

PATIENT CANNOT BE CURRENTLY TAKING OPIOID ANALGESICS. CONTINUATION OF THERAPY WITH BUPRENORPHINE: CONTRAINDICATION OR UNABLE TO TOLERATE NALOXONE IN COMBINATION WITH BUPRENORPHINE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

PANITUMUMAB

DRUG NAME

VECTIBIX

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

PAZOPANIB

DRUG NAME

VOTRIENT

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

DRUG NAME

ADCIRCA | REVATIO | SILDENAFIL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

CARDIOLOGIST OR PULMONOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

REQUEST FOR ADCIRCA REQUIRE TRIAL OR CONTRAINDICATION TO REVATIO.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

PEG-INTERFERON ALFA-2B-SYLATRON

DRUG NAME

SYLATRON 4-PACK

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

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

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

PERTUZUMAB

DRUG NAME

PERJETA

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

PLERIXAFOR

DRUG NAME

MOZOBIL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

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

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

POMALIDOMIDE

DRUG NAME

POMALYST

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

PRAMLINTIDE

DRUG NAME

SYMLINPEN 120 | SYMLINPEN 60

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

QUININE SULFATE

DRUG NAME

QUININE SULFATE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

RABIES VACCINE BVD DETERMINATION

DRUG NAME

IMOVAX RABIES VACCINE | RABAVERT

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

REGORAFENIB

DRUG NAME

STIVARGA

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OR CONTRAINDICATION TO ANTI-EGFR THERAPY SUCH AS ERBITUX OR VECTIBIX. TRIAL OR CONTRAINDICATION TO ANTI-VEGF THERAPY SUCH AS AVASTIN OR ZALTRAP AND A FLUOROPYRMIDE-, OXAPLATIN- AND IRINOTECAN-BASED CHEMOTHERAPY SUCH AS FOLFOX, FOLFIRI,CAPEOX, INFUSIONAL 5-FU/LV OR CAPECITABINE, AND FOLFOXIRI.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

RIFAXIMIN

DRUG NAME

XIFAXAN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

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

OTHER CRITERIA

TRAVELERS' DIARRHEA: TRIAL OF CIPROFLOXACIN OR AZITHROMYCIN. HEPATIC ENCEPHALOPATHY: TRIAL OF LACTULOSE MONOTHERAPY.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

RIOCIGUAT

DRUG NAME

ADEMPAS

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY A CARDIOLOGIST OR PULMONOLOGIST.

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

RITUXIMAB

DRUG NAME

RITUXAN

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

RENEWAL: ACTIVE RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS: GREATER THAN 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

RA: INITIAL AND RENEWAL 4 MO. HNL: 1 YEAR. CLL: 6 MO. WG, MPA: 1 MO.

OTHER CRITERIA

INITIAL: RHEUMATOID ARTHRITIS: CURRENTLY TAKING OR HAVE A CONTRAINDICATION TO THE USE OF METHOTREXATE AND TRIAL/FAILURE OF ONE TNF BLOCKER (ENBREL, HUMIRA, SIMPONI, CIMZIA). NON HODGKIN'S LYMPHOMA/CHRONIC LYMPHOCYTIC LEUKEMIA: USED IN COMBINATION WITH CHEMOTHERAPY. WEGNER'S GRANULOMATOSIS/MICROSCOPIC POLYANGIITIS: CONCURRENT GLUCOCORTICOID USE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ROMIDEPSIN

DRUG NAME

ISTODAX

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

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

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

RUXOLITINIB

DRUG NAME

JAKAFI

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SILTUXIMAB

DRUG NAME

SYLVANT

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SIMEPREVIR

DRUG NAME

OLYSIO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

HCV RNA LEVEL OR VIRAL LOAD. FOR ALL GENOTYPE 1, INTERFERON INELIGIBLE PATIENTS USING OLYSIO AND SOVALDI AND HAVE GENOTYPE 1A: NS3 80K POLYMORPHISM LAB TEST AT BASELINE.

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

12 WEEKS. SEE OTHER CRITERIA FIELD FOR MORE INFORMATION.

OTHER CRITERIA

GENOTYPE 1A NOT POSITIVE FOR NS3 Q80K POLYMORPHISM OR 1B WITH USE IN COMBINATION WITH RIBAVIRIN AND PEG-INTERFERON ALFA: MAXIMUM DURATION OF 12 WEEKS. GENOTYPE 1A NOT POSITIVE FOR NS3 Q80K POLYMORPHISM OR 1B AND NOT USING RIBAVIRIN PLUS PEG-INTERFERON WITH CONTRAINDICATION TO INTERFERON (SUCH AS CONCURRENT DIAGNOSIS OF AUTOIMMUNE HEPATITIS OR HAS KNOWN HYPERSENSITIVITY REACTION SUCH AS

URTICARIA, ANGIOEDEMA, BRONCHOSPASM AND ANAPHYLAXIS TO ALPHA INTERFERONS OR ANY COMPONENT OF THE PRODUCT, DOCUMENTATION OF DEPRESSION, DECOMPENSATED HEPATIC DISEASE, A BASELINE NEUTROPHIL COUNT BELOW 1500 PER MICROLITER, A BASELINE PLATELET COUNT BELOW 90,000, OR A BASELINE HEMOGLOBIN BELOW 10G/DL THAT HAS NOT RESPONDED TO TREATMENT): COMBINATION REGIMEN SOVALDI AND OLYSIO FOR 12 WEEKS AS LONG AS PATIENT HAS NOT COMPLETED A PRIOR COURSE OF THERAPY WITH ANY HCV PROTEASE INHIBITOR (SUCH AS INCIVEK OLYSIO, OR VICTRELIS) AND HAS NOT ACHIEVED A SUSTAINED VIROLOGIC RESPONSE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SOFOSBUVIR

DRUG NAME

SOVALDI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

PATIENT WITH END STAGE RENAL DISEASE OR REQUIRES DIALYSIS.

REQUIRED MEDICAL INFORMATION

FOR ALL GENOTYPE 1, INTERFERON INELIGIBLE PATIENTS USING OLYSIO AND SOVALDI AND HAVE GENOTYPE 1A: NS3 80K POLYMORPHISM LAB TEST AT BASELINE.

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

DURATION PER GENOTYPE DIAGNOSIS. SEE OTHER CRITERIA FIELD FOR MORE INFORMATION.

OTHER CRITERIA

HEPATITIS C: USE WITH RIBAVIRIN: GENOTYPE 1, 2, 3, 4, 5 OR 6 WITH HEPATOCELLULAR CARCINOMA (THAT MEETS MILAN CRITERIA) AND IS AWAITING LIVER TRANSPLANT: MAXIMUM DURATION OF TREATMENT UP TO 48 WEEKS. GENOTYPE 1 WITHOUT USE OF RIBAVIRIN AND WITH CONTRAINDICATION

TO INTERFERON (SUCH AS CONCURRENT DIAGNOSIS OF AUTOIMMUNE HEPATITIS OR HAS KNOWN HYPERSENSITIVITY REACTION SUCH AS URTICARIA, ANGIOEDEMA, BRONCHOSPASM AND ANAPHYLAXIS TO ALPHA INTERFERONS OR ANY COMPONENT OF THE PRODUCT, DOCUMENTATION OF DEPRESSION, DECOMPENSATED HEPATIC DISEASE, A BASELINE NEUTROPHIL COUNT BELOW 1500 PER MICROLITER, A BASELINE PLATELET COUNT BELOW 90,000, OR A BASELINE HEMOGLOBIN BELOW 10G/DL THAT HAS NOT RESPONDED TO TREATMENT): COMBINATION REGIMEN SOVALDI AND OLYSIO FOR 12 WEEKS AS LONG AS PATIENT HAS NOT COMPLETED A PRIOR COURSE OF THERAPY WITH ANY HCV PROTEASE INHIBITOR (SUCH AS INCIVEK OLYSIO, OR VICTRELIS) AND HAS NOT ACHIEVED A SUSTAINED VIROLOGIC RESPONSE UP TO 12 WEEKS FOR GENOTYPE 1B OR GENOTYPE 1A WITHOUT A NS3 Q80K POLYMORPHISM. GENOTYPE 1, 4, 5, OR 6 WITH USE OF PEGINTERFERON AND RIBAVIRIN: MAXIMUM UP TO 12 WEEKS WITHOUT USE OF CONCURRENT PRESCRIPTION FOR ANY HCV PROTEASE INHIBITOR (SUCH AS INCIVEK OLYSIO, OR VICTRELIS). GENOTYPE 2 WITH RIBAVIRIN: MAXIMUM DURATION UP TO 12 WEEKS. GENOTYPE 3 WITH PEGINTERFERON AND RIBAVIRIN: MAXIMUM DURATION UP TO 12 WEEKS. GENOTYPE 3 WITH RIBAVIRIN (CONTRAINDICATION TO INTERFERON): MAXIMUM DURATION UP TO 24 WEEKS. GENOTYPE 1 OR 1A WITH CONTRAINDICATION TO INTERFERON, WHEN USED WITH RIBAVIRIN (TREATMENT NAIVE OR WITH N3 Q80K POLYMORPHISM OR WITH PREVIOUS FAILURE OF A HCV PROTEASE INHIBITOR): MAXIMUM DURATION UP TO 24 WEEKS.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SOMATROPIN - GROWTH HORMONE

DRUG NAME

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

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES, GROWTH FAILURE DUE TO CHRONIC RENAL INSUFFICIENCY(CRI) IF PATIENT HAS HAD A RENAL TRANSPLANT, OR GROWTH FAILURE DUE TO CRI WITH CLOSED EPIPHYSES.

REQUIRED MEDICAL INFORMATION

INDUCTION - PATIENT'S HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. RENEWAL: GROWTH VELOCITY AND/OR TARGET HEIGHT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ENDOCRINOLOGIST.

COVERAGE DURATION

12 MONTHS.

OTHER CRITERIA

FOR GROWTH FAILURE DUE TO (CRI): PATIENT HAS NOT UNDERGONE A RENAL TRANSPLANT. RENEWAL: GROWTH VELOCITY OF 2 CM OR MORE COMPARED WITH WHAT WAS OBSERVED FROM THE PREVIOUS YEAR AND/OR PATIENT HAS NOT REACHED 50TH PERCENTILE FOR TARGET HEIGHT FOLLOWING GROWTH HORMONE THERAPY.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SOMATROPIN - SEROSTIM

DRUG NAME

SEROSTIM

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

HIV/AIDS: 3 MONTHS.

OTHER CRITERIA

HIV/WASTING: CURRENTLY ON ANTIRETROVIRAL THERAPY. IF CURRENTLY ON GROWTH HORMONE, PATIENT HAS SHOWN CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT OR IF NOT ON GROWTH HORMONE, PATIENT HAS HAD INADEQUATE RESPONSE TO PREVIOUS THERAPY. (I.E. EXERCISE TRAINING, NUTRITIONAL SUPPLEMENTS, APPETITE STIMULANTS OR ANABOLIC STEROIDS).

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SOMATROPIN - ZORBTIVE

DRUG NAME

ZORBTIVE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES

REQUIRED MEDICAL INFORMATION

SHORT-BOWEL SYNDROME: CURRENTLY ON SPECIALIZED NUTRITIONAL SUPPORT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

SHORT BOWEL: 4 WEEK ONCE.

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SORAFENIB TOSYLATE

DRUG NAME

NEXAVAR

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SUNITINIB MALATE

DRUG NAME

SUTENT

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

GASTROINTESTIONAL STROMAL TUMORS (GIST): TRIAL OF OR CONTRAINDICATION TO GLEEVEC.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TELAPREVIR

DRUG NAME

INCIVEK

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

COMPLETED PRIOR COURSE OF THERAPY WITH TELAPREVIR (INCIVEK) OR BOCEPREVIR (VICTRELIS) AND DID NOT ACHIEVE A SUSTAINED VIROLOGIC RESPONSE. CURRENTLY TAKING RIFAMPIN OR HAS A CO-INFECTION WITH HEPATITIS B.

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PATIENT 18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTIONS

GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST) OR SPECIALLY TRAINED GROUP (E.G. EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES). HEP C AND ORGAN TRANSPLANT: TRANSPLANT CENTER AND TRANSPLANT PHYSICIAN.

COVERAGE DURATION

INITIAL: 8 WEEKS RENEWAL: 4 WEEKS

OTHER CRITERIA

HEP C: CONCURRENT USE OF RIBAVIRIN AND PEGINTERFERON ALFA.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TERIFLUNOMIDE

DRUG NAME

AUBAGIO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF OR CONTRAINDICATION TO ONE INTERFERON THERAPY (SUCH AS AVONEX, BETASERON, EXTAVIA, OR REBIF) AND TO COPAXONE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TERIPARATIDE

DRUG NAME

FORTEO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

GREATER THAN 24 MONTHS OF THERAPY.

REQUIRED MEDICAL INFORMATION

A PATIENT WITH EITHER A DIAGNOSIS OF SEVERE OSTEOPOROSIS (T-SCORE LESS THAN -2.5 WITH FRAGILITY FRACTURE) OR A T SCORE EQUAL TO OR LESS THAN -2.5 AND MULTIPLE RISK FACTORS FOR FRACTURE (E.G. HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS), OR FAILED AN ADEQUATE TRIAL OF BISPHOSPHONATES, IS INTOLERANT, OR HAS A CONTRAINDICATION TO BISPHOSPHONATES.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TESTOSTERONE

DRUG NAME

ANDRODERM | ANDROGEL | AXIRON | TESTOSTERONE CYPIONATE | TESTOSTERONE ENANTHATE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

MALE HYPOGONADISM CONFIRMED BY EITHER: 1) LAB CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL OF LESS THAN 300 NG/DL OR 2) A LOW TOTAL SERUM TESTOSTERONE LEVEL AS INDICATED BY A LAB RESULT WITH A REFERENCE RANGE OBTAINED WITHIN 90 DAYS, OR 3) A FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 50 NG/L.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

LIFETIME OF MEMBERSHIP IN PLAN

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TETANUS TOXOID VACCINE BVD DETERMINATION

DRUG NAME

TETANUS TOXOID ADSORBED

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TETRABENAZINE

DRUG NAME

XENAZINE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

NEUROLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

THALIDOMIDE

DRUG NAME

THALOMID

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL COVERAGE CONSIDERATION FOR ANEMIA DUE TO MYELODYSPLASTIC SYNDROME AND WALDENSTROM'S MACROGLOBULINEMIA.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

THIAZOLIDINEDIONE

DRUG NAME

AVANDAMET | AVANDARYL | AVANDIA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

APPLIES TO NEW STARTS ONLY. TRIAL OR CONTRAINDICATION TO METFORMIN, METFORMIN ER, GLYBURIDE/METFORMIN, GLIPIZIDE/METFORMIN OR A SULFONYLUREA AND PIOGLITAZONE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TOCILIZUMAB

DRUG NAME

ACTEMRA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

ACTIVE RHEUMATOID ARTHRITIS, SJIA, OR PJIA RENEWAL: AT LEAST 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT.

AGE RESTRICTIONS

JIA: 2 YEARS AND OLDER

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR RECOMMENDED BY A RHEUMATOLOGIST.

COVERAGE DURATION

RA INITIAL: 6 MONTHS. RENEWAL: 6 MONTHS. JIA: 12 MONTHS.

OTHER CRITERIA

TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE OF THE FOLLOWING: ENBREL, HUMIRA, REMICADE, SIMPONI OR CIMZIA.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TOCILIZUMAB SC

DRUG NAME

ACTEMRA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR RECOMMENDED BY A RHEUMATOLOGIST.

COVERAGE DURATION

INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA

TRIAL OF HUMIRA AND CIMZIA.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TOFACITINIB

DRUG NAME

XELJANZ

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

RENEWAL: RHEUMATOID ARTHRITIS: EXPERIENCED OR MAINTAINED 20 PERCENT IMPROVEMENT IN TENDER OR SWOLLEN JOINT COUNT WHILE ON THERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

RHEUMATOLOGIST

COVERAGE DURATION

RA: INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.

OTHER CRITERIA

RHEUMATOID ARTHRITIS INITIAL: TRIAL OR CONTRAINDICATION TO HUMIRA AND CIMZIA.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TOPICAL TRETINOIN

DRUG NAME

AVITA | TRETINOIN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

WRINKLES, PHOTOAGING, MELASMA.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

BRAND TRETINON WILL REQUIRE TRIAL OF GENERIC TOPICAL TRETINOIN.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TOTAL PARENTARAL NUTRITION AGENT BVD DETERMINATION

DRUG NAME

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

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TRAMETINIB DIMETHYL SULFOXIDE

DRUG NAME

MEKINIST

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TRASTUZUMAB

DRUG NAME

HERCEPTIN

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

BREAST CANCER, METASTATIC BREAST CANCER, GASTRIC CANCER: HER2 POSITIVE

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

B VS D COVERAGE CONSIDERATION. BREAST CANCER: USED IN COMBINATION WITH CHEMOTHERAPY (EXAMPLES INCLUDE: DOXORUBICIN AND CYCLOPHOSPHAMIDE FOLLOWED BY PACLITAXEL OR DOCETAXEL AND CARBOPLATIN OR DOCETAXEL FOLLOWED BY FLUOROURICIL/EPIRUBICIN/CYCLOPHOSPHAMIDE OR DOXORUBICIN/CYCLOPHOSPHAMIDE FOLLOWED BY DOCETAXEL OR PACLITAXEL. GASTRIC CANCER: USED IN COMBINATION WITH CHEMOTHERAPY (EXAMPLES INCLUDE: CISPLATIN AND FLUOROPYRIMIDINE.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TREPROSTINIL DIOLAMINE

DRUG NAME

ORENITRAM ER

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED OR IN CONSULTATION WITH A CARDIOLOGIST OR A PULMONOLOGIST.

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

USTEKINUMAB

DRUG NAME

STELARA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 10 PERCENT BODY SURFACE AREA OR PASI SCORE GREATER THAN OR EQUAL TO 12. PATIENT'S WEIGHT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

DERMATOLOGIST OR RHEUMATOLOGIST

COVERAGE DURATION

INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA

**FOR SEVERE PLAQUE PSORIASIS COVERING 10% BSA:
TRIAL/FAILURE/INTOLERABLE SIDE AFFECTS TO AT LEAST ONE PREFERRED THERAPY (PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE).
RENEWAL: PHYSICIAN'S GLOBAL ASSESMENT EQUAL TO ZERO OR ONE OR A DECREASE OF PASI OF AT LEAST 50% OR GREATER.**

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

VANDETANIB

DRUG NAME

CAPRELSA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CRITERIA APPLIES TO NEW STARTS ONLY.

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

VEMURAFENIB

DRUG NAME

ZELBORAF

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

BRAFV600E MUTATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

VILAZODONE

DRUG NAME

VIIBRYD

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF OR CONTRAINDICATION TO A SSRI (PAROXETINE, SERTARLINE, CITALOPRAM, FLUOXETINE, OR ESCITALOPRAM) AND A SECOND AGENT (BUPROPION HCL (IR, SR, OR XL), MIRTAZAPINE, OR VENLAFAXINE (IR OR XR)).

CommuniCare Advantage (HMO-SNP)

Prior Authorization Requirements

Effective Date: 11/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

VISMODEGIB

DRUG NAME

ERIVEDGE

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA