

2010 Prior Authorization Criteria



ADAGEN	8
ADAGEN®	8
ADCIRCA	9
ADCIRCA®	9
AFINITOR	10
AFINITOR®	10
ALDURAZYME	11
ALDURAZYME®	11
ANADROL-50	12
ANADROL-50®	12
ANAGRELIDE	13
ANAGRELIDE HCL	13
ARANESP	14
ARANESP®	14
B vs D - Part B versus Part D Coverage PA	16
ALBUTEROL SULFATE	16
AZATHIOPRINE	16
CELLCEPT®	16
CROMOLYN SODIUM	16
CYCLOPHOSPHAMIDE	16
CYCLOSPORINE	16
CYCLOSPORINE MODIFIED	16
ENGERIX-B®	16

GAMMAGARD LIQUID®	16
GAMUNEX®	16
GENGRAF	16
GRANISETRON HCL	16
GRANISOL	16
METHOTREXATE	16
MITOXANTRONE HCL	16
MYCOPHENOLATE MOFETIL	16
MYFORTIC®.....	16
NEORAL®	16
ONDANSETRON HCL.....	16
ONDANSETRON ODT.....	16
PROGRAF®.....	16
RAPAMUNE®.....	16
RECOMBIVAX HB®	16
SANDIMMUNE®.....	16
VIDAZA®	16
BETASERON	17
BETASERON®	17
BYETTA	18
BYETTA®	18
CAMPATH.....	19
CAMPATH®.....	19
CANCIDAS.....	20
CANCIDAS®.....	20

COPAXONE.....	21
COPAXONE®.....	21
ELITEK.....	22
ELITEK®.....	22
EMEND.....	23
EMEND®.....	23
ENBREL.....	24
ENBREL®.....	24
ENTOCORT EC.....	25
ENTOCORT EC®.....	25
FENTANYL CITRATE TRANSMUCOSAL.....	26
FENTANYL CITRATE.....	26
FORTEO.....	27
FORTEO®.....	27
GENOTROPIN.....	28
GENOTROPIN®.....	28
GLEEVEC.....	29
GLEEVEC®.....	29
HUMIRA.....	30
HUMIRA®.....	30
HUMIRA CROHNS.....	31
HUMIRA®.....	31
INCRELEX.....	32
INCRELEX®.....	32
LIPITOR (80MG ONLY).....	33

LIPITOR®	33
LOVAZA	34
LOVAZA®	34
LYRICA	35
LYRICA®	35
MIACALCIN INJECTION.....	36
MIACALCIN®.....	36
NAGLAZYME	37
NAGLAZYME®	37
NEUPOGEN.....	38
NEUPOGEN®.....	38
NEUTREXIN	39
NEUTREXIN®.....	39
NEXAVAR	40
NEXAVAR®	40
NOXAFIL	41
NOXAFIL®.....	41
ONTAK.....	42
ONTAK®.....	42
ORFADIN	43
ORFADIN®	43
PEGASYS	44
PEGASYS®.....	44
PEG-INTRON.....	45
PEGINTRON REDIPEN®.....	45

PEGINTRON®	45
PROCRIT	46
PROCRIT®	46
PROLEUKIN	48
PROLEUKIN®	48
PROVIGIL	49
PROVIGIL®	49
RANEXA	50
RANEXA®	50
RELISTOR	51
RELISTOR®	51
REMICADE	52
REMICADE®	52
REVATIO	54
REVATIO®	54
RITUXAN	55
RITUXAN®	55
SIMPONI	56
SIMPONI®	56
SOMAVERT	57
SOMAVERT®	57
SORIATANE CK	58
SORIATANE CK®	58
SPRYCEL	59
SPRYCEL®	59

STRATTERA.....	60
STRATTERA®.....	60
SUTENT.....	61
SUTENT®.....	61
SYMLIN.....	62
SYMLIN®.....	62
SYMLINPEN	63
SYMLINPEN 120®.....	63
SYMLINPEN 60®.....	63
TARGRETIN	64
TARGRETIN®.....	64
TASIGNA	65
TASIGNA®.....	65
THALOMID.....	66
THALOMID®.....	66
THIOGUANINE	67
THIOGUANINE®	67
TRISENOX.....	68
TRISENOX®.....	68
TYKERB.....	69
TYKERB®.....	69
VELCADE	70
VELCADE®.....	70
VOTRIENT	71
VOTRIENT®	71

ZAVESCA	72
ZAVESCA®.....	72
ZOLINZA	73
ZOLINZA®.....	73

ADAGEN

Affected Drugs

ADAGEN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

The patient is a candidate for and has not failed bone marrow transplant therapy. The patient is a candidate for HLA identical bone marrow transplant therapy. Adagen will be used as a replacement for continued close medical supervision and the initiation of appropriate diagnostic tests and therapy (e. g. , antibiotics, nutrition, oxygen, gammaglobulin) as indicated for intercurrent illnesses. Adagen is furnished “incident to” a physician service.

Required Medical Information

The diagnosis of Adenosine Deaminase Deficiency must be confirmed by Immunologic, Imaging, or Genetic studies.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

Part D coverage if dispensed by a pharmacy (If a pharmacy furnishes this drug to a member who is in a Medicare Part A stay: Hospital or Skilled Nursing Facility, the drug will not be covered under Part D). .

ADCIRCA

Affected Drugs

ADCIRCA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

The concurrent use of nitrates. The concomitant use of potent CYP 3A inhibitors, such as ketoconazole and itraconazole. Co-administration with PDE5 inhibitors, such as Cialis, Viagra. .

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Pulmonologist, Cardiologist.

Coverage Duration

12 Months.

Other Criteria

N/A

AFINITOR

Affected Drugs

AFINITOR®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Co-administration of Afinitor with strong or moderate inhibitors of CYP3A4 and PgP, such as ketoconazole, itraconazole, erythromycin, verapamil, diltiazem.

Required Medical Information

CBC, SrCr, BUN, serum glucose, lipid panel.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist.

Coverage Duration

12 Months.

Other Criteria

The documented use of Sutent or Nexavar or both is required prior to the initiation of Afinitor.

ALDURAZYME

Affected Drugs

ALDURAZYME®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Aldurazyme is furnished "incident to" a physician service.

Required Medical Information

The diagnosis of Mucopolysaccharidosis I must be confirmed by Laboratory, or Imaging, or Genetic studies.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

Part D coverage if dispensed by a pharmacy (If a pharmacy furnishes this drug to a member who is in a Medicare Part A stay: Hospital or Skilled Nursing Facility, the drug will not be covered under Part D).

ANADROL-50

Affected Drugs

ANADROL-50®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

The patient's iron, folic acid, vitamin B12 or pyridoxine deficiencies have not been corrected prior to the initiation of treatment with Anadrol-50. Documented history of one of the following: prostate cancer, breast cancer, severe hepatic dysfunction, liver cell tumors, coronary arterial disease, hyperlipidemia. .

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

ANAGRELIDE

Affected Drugs

ANAGRELIDE HCL

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist.

Coverage Duration

12 Months.

Other Criteria

N/A

ARANESP

Affected Drugs

ARANESP®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and other medically accepted indication(s), such as treatment of anemia in low or intermediate-1 risk Myelodysplastic Syndrome patients .

Exclusion Criteria

In patients with Chronic Kidney Disease (CKD), the exclusion criteria is the following: the patient is on dialysis (Part B benefit), the patient's serum creatinine (SrCr) is equal or less than 2.0 mg/dl or clearance creatinine (ClCr) is equal or greater than 45 ml/min, the patient's iron deficiency has not been corrected, the patient's current (or pre-transfusion) hemoglobin level is 10 g/dl or greater unless this is a diabetic patient with a symptomatic anemia, the patient's target hemoglobin level is not within the range of 10-12 g/dl. In patients with Non-Myeloid malignancies receiving concomitant myelosuppressive chemotherapy, the exclusion criteria is the following: the patient's current hemoglobin level is 10 g/dl or greater. .

Required Medical Information

In patients with CKD [Chronic Kidney Disease], SrCr is greater than 2 mg/dl or ClCr is less than 45ml/min, the current (or pre-transfusion) hemoglobin is less than 10g/dl, the target hemoglobin is within the range of 10-12 g/dl. In patients with non-myeloid malignancies receiving concomitant myelosuppressive chemotherapy, the current hemoglobin is less than 10 g/dl. Patients with low or intermediate-1 risk Myelodysplastic Syndrome must be transfusion-dependent or symptomatic from anemia. .

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 months. In patients on myelosuppressive chemo, duration is the length of treatment with chemo. .

Other Criteria

The use of Procrit for greater than one month is required prior to the initiation of Aranesp.

B VS D - PART B VERSUS PART D COVERAGE PA

Affected Drugs

ALBUTEROL SULFATE
AZATHIOPRINE
CELLCEPT®
CROMOLYN SODIUM
CYCLOPHOSPHAMIDE
CYCLOSPORINE
CYCLOSPORINE MODIFIED
ENGERIX-B®
GAMMAGARD LIQUID®
GAMUNEX®
GENGRAF
GRANISETRON HCL
GRANISOL
METHOTREXATE
MITOXANTRONE HCL
MYCOPHENOLATE MOFETIL
MYFORTIC®
NEORAL®
ONDANSETRON HCL
ONDANSETRON ODT
PROGRAF®
RAPAMUNE®
RECOMBIVAX HB®
SANDIMMUNE®
VIDAZA®

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.

BETASERON

Affected Drugs

BETASERON®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Neurologist, Multiple Sclerosis Specialist.

Coverage Duration

12 Months.

Other Criteria

N/A

BYETTA

Affected Drugs

BYETTA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

The patient has an acute pancreatitis or the history of pancreatitis.

Required Medical Information

Diagnosis of Diabetes Mellitus type II, current use of metformin, a sulfonylurea, or a thiazolidinedione, or a combination of metformin and a sulfonylurea, or a combination of metformin and a thiazolidinedione. Hemoglobin A1C.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

CAMPATH

Affected Drugs

CAMPATH®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and other medically accepted indications, such as treatment of rheumatoid arthritis and multiple sclerosis. .

Exclusion Criteria

Campath is furnished “incident to” a physician service.

Required Medical Information

Member’s baseline ANC of greater than 250/ μ L and/or a baseline platelet count of greater than 25, 000/ μ L. Concurrent use of medications indicated for PCP and herpes viral prophylaxis. .

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist, Rheumatoid Arthritis specialist, Multiple Sclerosis specialist or other specialist experienced in prescribing antineoplastic medications.

Coverage Duration

12 Months.

Other Criteria

Part D coverage if dispensed by a pharmacy (If a pharmacy furnishes this drug to a member who is in a Medicare Part A stay: Hospital or Skilled Nursing Facility, the drug will not be covered under Part D).

CANCIDAS

Affected Drugs

CANCIDAS®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Cancidas is furnished "incident to" a physician service.

Required Medical Information

The diagnosis must be confirmed by laboratory testing.

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Infectious Disease Specialist.

Coverage Duration

12 Months.

Other Criteria

Part D coverage if dispensed by a pharmacy (If a pharmacy furnishes this drug to a member who is in a Medicare Part A stay: Hospital or Skilled Nursing Facility, the drug will not be covered under Part D).

COPAXONE

Affected Drugs

COPAXONE®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

In patients who have experienced a first clinical episode, MRI features must be consistent with Multiple Sclerosis. .

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

ELITEK

Affected Drugs

ELITEK®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and other medically accepted indications, such as prevention and reduction of chemotherapy-induced tumor lysis syndrome and elevated plasma uric acid concentrations in adults with leukemia, lymphoma, or solid tumors. .

Exclusion Criteria

Elitek is furnished “incident to” a physician service. In patients deficient in glucose-6-phosphate dehydrogenase (G6PD).

Required Medical Information

Plasma Uric acid.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist.

Coverage Duration

12 Months.

Other Criteria

Part D coverage if dispensed by a pharmacy (If a pharmacy furnishes this drug to a member who is in a Medicare Part A stay: Hospital or Skilled Nursing Facility, the drug will not be covered under Part D). .

EMEND

Affected Drugs

EMEND®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

If used as full therapeutic replacement for IV anti-emetic drugs within 2 hours prior to administration of the anti-cancer treatment and will not exceed 48 hours after the treatment. If used in combination with a 5-HT3 antagonist (ondansetron (Zofran), granisetron (Kytril), or Anzemet) and dexamethasone and when patient is receiving one or more of the following anti-cancer agents: BiCNU, Gliadel, Cisplatin, Cyclophosphamide, Dacarbazine, Doxorubicin, Ellence, CeeNU, Mustargen, Zanosar (Part B Benefit). .

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

6 Months.

Other Criteria

The use of 5-HT3 antagonists: ondansetron, granisetron/granisol is required prior to the initiation of Emend. .

ENBREL

Affected Drugs

ENBREL®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

The concurrent administration of the following drugs: Humira, Kineret, Orencia or Remicade with Enbrel. .

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

The documented use of Humira for greater than one month is required prior to the initiation of Enbrel. In patients with active Rheumatoid Arthritis, the documented use of at least one Disease-Modifying Anti-Rheumatic Drug is required for the current condition prior to the initiation of Enbrel. In patients with Psoriatic Arthritis, Polyarticular-Course Juvenile Rheumatoid Arthritis, the documented use of methotrexate is required for the current condition prior to the initiation of Enbrel. In patients with Ankylosing Spondylitis, the documented use of at least 2 NSAIDs [Non-steroidal anti-inflammatory drugs] is required for the current condition prior to the initiation of Enbrel. In patients with plaque psoriasis, the documented use of phototherapy or systemic therapy is required if a patient is a candidate for phototherapy or systemic therapy prior to the initiation of Enbrel. .

ENTOCORT EC

Affected Drugs

ENTOCORT EC®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

The documented use of oral aminosalicylates and oral prednisone/prednisolone is required prior to the initiation of Entocort EC.

FENTANYL CITRATE TRANSMUCOSAL

Affected Drugs

FENTANYL CITRATE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Management of acute, intermittent or postoperative pain. Opioid naïve patients, such as patients who are not taking at least 60 mg morphine per day, or 25 mcg transdermal fentanyl per hour, or 30 mg oxycodone per day, or 8 mg oral hydromorphone daily, or an equianalgesic dose of another opioid for a week or longer. .

Required Medical Information

Documented history of Opioid use.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Pain Specialist.

Coverage Duration

12 Months.

Other Criteria

N/A

FORTEO

Affected Drugs

FORTEO®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Patients have increased baseline risk for osteosarcoma (e. g. , those with Paget/Es disease of bone or unexplained elevations of alkaline phosphatase, pediatric and young adult patients with open epiphyses, or prior external beam or implant radiation therapy involving the skeleton).

Required Medical Information

Documented history of one of the following: 1. The patient is at high risk for fractures (BMD T score below \hat{u} 2. 0, steroids use) or has a history of two or more osteoporotic fractures. 2. The patient had a fracture and/or 10% or greater loss in bone density while on either Alendronate (Fosamax), Actonel, Fosamax, or Evista for at least one year. 3. The patient is not a candidate for bisphosphonates or intolerant to them. .

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

GENOTROPIN

Affected Drugs

GENOTROPIN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

In patients with Acute Critical Illness due to complications following open heart surgery, abdominal surgery or multiple accidental trauma, or those with acute respiratory failure. In children with Prader-Willi syndrome who are severely obese or have severe respiratory impairment. In patients with Active Malignancy. In Patients with Active Proliferative or Severe Non-Proliferative Diabetic Retinopathy. In children with closed epiphyses. .

Required Medical Information

Diagnoses of Prader-Willi syndrome and Turner Syndrome are confirmed by genetic testing. In adults with Growth Hormone Deficiency, IGF-1 level of less than 84 ng/ml or Growth hormone stimulation tests, e. g. , insulin tolerance test (ITT) with GH [growth hormone] level of less than 5 mcg/L, GHRH [growth hormone releasing hormone] with arginine with GH [growth hormone] level of less than 4. 1 mcg/L. .

Age Restrictions

N/A

Prescriber Restrictions

Endocrinologist.

Coverage Duration

12 Months.

Other Criteria

N/A

GLEEVEC

Affected Drugs

GLEEVEC®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist.

Coverage Duration

12 Months.

Other Criteria

N/A

HUMIRA

Affected Drugs

HUMIRA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

The concurrent administration of the following drugs: Enbrel, Kineret, Orencia, or Remicade with Humira. .

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

In patients with active Rheumatoid Arthritis, the documented use of at least one Disease-Modifying Anti-Rheumatic Drug is required for the current condition prior to the initiation of Humira. In patients with Psoriatic Arthritis, Polyarticular-Course Juvenile Rheumatoid Arthritis, the documented use of methotrexate is required for the current condition prior to the initiation of Humira. In patients with Ankylosing Spondylitis, the documented use of at least 2 NSAIDs [Non-steroidal anti-inflammatory drugs] is required for the current condition prior to the initiation of Humira. In patients with plaque psoriasis, the documented use of phototherapy or systemic therapy is required if a patient is a candidate for phototherapy or systemic therapy prior to the initiation of Humira. In patients with Crohn's disease, the documented use of conventional therapy agents: aminosalicylates, corticosteroids, immunomodulators or Remicade is required prior to the initiation of Humira. .

HUMIRA CROHNS

Affected Drugs

HUMIRA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

The documented use of at least one medication that belongs to any of the following pharmacologic classes: aminosalicylates or corticosteroids or immunomodulators (e. g. , 6-mercaptopurine or azathioprine) or trial of Remicade is required prior to the initiation of Humira Crohns. .

INCRELEX

Affected Drugs

INCRELEX®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

In patients with secondary forms of IGF-1 deficiency, such as Growth Hormone (GH) deficiency, malnutrition, hypothyroidism, and chronic treatment with pharmacologic doses of anti-inflammatory steroids. In patients with closed epiphyses. In patients with active or suspected neoplasia. In adult patients. .

Required Medical Information

In growth failure patients with Severe Primary IGF-1 deficiency, Severe Primary IGF-1 deficiency is defined by: height standard deviation score is 3.0 or less and basal IGF-1 standard deviation score is 3.0 or less and normal or elevated GH [growth hormone]. In growth failure patients with GH [growth hormone] gene deletion who have developed neutralizing antibodies to GH [growth hormone], the diagnosis must be confirmed by Laboratory or Genetic testing. .

Age Restrictions

Approve in children 2 years old and older.

Prescriber Restrictions

Endocrinologist.

Coverage Duration

12 Months.

Other Criteria

N/A

LIPITOR (80MG ONLY)

Affected Drugs

LIPITOR®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

The documented use of Vytorin 10/40mg per day or 10/80mg per day for at least one month is required prior to the initiation of Lipitor 80mg.

LOVAZA

Affected Drugs

LOVAZA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Current triglyceride level of greater than 500mg/dl.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

In patients who don't have contraindications to fibrate products, the documented use of formulary fibrates: Fenofibrate, Tricor, or Gemfibrozil for at least three months is required prior to the initiation of Lovaza. .

LYRICA

Affected Drugs

LYRICA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

In patients with one of the following diagnoses: Seizure Disorder, Diabetic Peripheral Neuropathy, Post-herpetic neuralgia, the documented use of the total daily dose of gabapentin 600mg or greater is required prior to the initiation of Lyrica. .

MIACALCIN INJECTION

Affected Drugs

MIACALCIN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

NAGLAZYME

Affected Drugs

NAGLAZYME®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Naglazyme is furnished “incident to” a physician service.

Required Medical Information

The diagnosis must be confirmed by laboratory or genetic testing.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

Part D coverage if dispensed by a pharmacy (If a pharmacy furnishes this drug to a member who is in a Medicare Part A stay: Hospital or Skilled Nursing Facility, the drug will not be covered under Part D). .

NEUPOGEN

Affected Drugs

NEUPOGEN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and other medically accepted indications, such as treatment of graft failure after bone marrow transplantation, neutropenia associated with myelodysplastic syndrome, hairy cell leukemia, aplastic anemia, severe neutropenia in HIV-infected patients on antiretroviral therapy. .

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

NEUTREXIN

Affected Drugs

NEUTREXIN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Neutrexin is furnished "incident to" a physician service.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

In patients who don't have contraindications to trimethoprim-sulfamethaxazole therapy, the documented use of trimethoprim-sulfamethaxazole is required prior to the initiation of Neutrexin. Concurrent administration of Leucovorin with Neutrexin is required. Part D coverage if dispensed by a pharmacy (If a pharmacy furnishes this drug to a member who is in a Medicare Part A stay: Hospital or Skilled Nursing Facility, the drug will not be covered under Part D). .

NEXAVAR

Affected Drugs

NEXAVAR®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Oncologist.

Coverage Duration

12 Months.

Other Criteria

N/A

NOXAFIL

Affected Drugs

NOXAFIL®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Current use of one of the following: Orap, quinidine, or ergot alkaloids. .

Required Medical Information

For prevention of invasive Aspergillus and Candida infections, documentation is required that the patients are at high risk of developing these infections due to being severely immunocompromised, such as hematopoietic stem cell transplant (HSCT) recipients with graft-versus-host disease (GVHD) or those with hematologic malignancies with prolonged neutropenia from chemotherapy. .

Age Restrictions

Approve if 13 years old or older.

Prescriber Restrictions

The prescription is recommended or initially written by Infectious Disease Specialist.

Coverage Duration

Oropharyngeal Candidiasis (OC): 14 days. Refractory OC: 1 month. Other indications: 1 year.

Other Criteria

The documented use of itraconazole or fluconazole is required prior to the initiation of Noxafil in patients with refractory oropharyngeal candidiasis.

ONTAK

Affected Drugs

ONTAK®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and other medically accepted indications, such as treatment of chronic lymphocytic leukemia refractory to fludarabine, non-Hodgkin lymphoma. .

Exclusion Criteria

Ontak is furnished “incident to” a physician service.

Required Medical Information

In patients with persistent or recurrent cutaneous T-cell lymphoma, CD25 expression confirmed by laboratory testing. CBC, ALT, AST, serum albumin, chem panel. .

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist.

Coverage Duration

12 Months.

Other Criteria

Part D coverage if dispensed by a pharmacy for administration under the supervision of a Healthcare Professional who is experienced in the use of antineoplastic therapy. The place of administration of Ontak must be equipped for cardiopulmonary resuscitation and the patient must be closely monitored. (If a pharmacy furnishes this drug to a member who is in a Medicare Part A stay: Hospital or Skilled Nursing Facility, the drug will not be covered under Part D). .

ORFADIN

Affected Drugs

ORFADIN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

The diagnosis must be confirmed by laboratory or genetic testing.

Age Restrictions

N/A

Prescriber Restrictions

The prescription is recommended or initially written by a specialist experienced in the treatment of Hereditary Tyrosinemia type 1.

Coverage Duration

12 Months.

Other Criteria

N/A

PEGASYS

Affected Drugs

PEGASYS®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and other medically accepted indications, such as Renal Cell Carcinoma and Chronic Myelogenous Leukemia. .

Exclusion Criteria

The previous use of interferon alpha in patients with chronic hepatitis C virus infection.

Required Medical Information

Hepatitis B or Hepatitis C Serology in patients with chronic Hepatitis B and chronic Hepatitis C infections.

Age Restrictions

N/A

Prescriber Restrictions

Infectious Disease Specialist, Oncologist, Nephrologist, Transplant Physician, Gastroenterologist. .

Coverage Duration

12 Months.

Other Criteria

N/A

PEG-INTRON

Affected Drugs

PEGINTRON REDIPEN®
PEGINTRON®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

The previous use of interferon alpha in patients using Peg-Intron as monotherapy.

Required Medical Information

HCV RNA levels are greater than 50 IU per ml.

Age Restrictions

Approve if 3 years old or older if Peg-Intron is used as combination therapy with ribavirin. Approve if 18 years old or older if Peg-Intron is used as monotherapy in patients previously untreated with intereron alpha.

Prescriber Restrictions

Infectious Disease Specialist, Gastroenterologist. .

Coverage Duration

12 Months.

Other Criteria

N/A

PROCRIT

Affected Drugs

PROCRIT®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and other medically accepted indication(s), such as treatment of anemia in low or intermediate-1 risk Myelodysplastic Syndrome patients .

Exclusion Criteria

In patients with Chronic Kidney Disease (CKD), the exclusion criteria is the following: the patient is on dialysis (Part B benefit), the patient's serum creatinine (SrCr) is equal or less than 2.0 mg/dl or clearance creatinine (ClCr) is equal or greater than 45 ml/min, the patient's iron deficiency has not been corrected, the patient's current (or pre-transfusion) hemoglobin (Hgb) level is 10 g/dl or greater, unless this is a diabetic patient with a symptomatic anemia or unless this is a surgery patient (the surgery patient's pretreatment Hgb level should be 10-13 g/dl). In patients with CKD [Chronic Kidney Disease], the patient's target Hgb level is not within the range of 10-12 g/dl (these exclusion criteria are only applicable to CKD [Chronic Kidney Disease] patients and not applicable to surgery patients). In patients with Non-Myeloid malignancies receiving the concomitant myelosuppressive chemotherapy, the exclusion criteria is the following: the patient's current Hgb level is 10 g/dl or greater (these exclusion criteria are not applicable to surgery patients). In patients scheduled to undergo noncardiac, nonvascular surgery, the exclusion criteria is the following: the antithrombotic prophylaxis is not considered. In HIV-infected patients with anemia related to zidovudine-treatment, the exclusion criteria is the following: the pretreatment endogenous serum erythropoietin level is greater than 500 microunits/ml. .

Required Medical Information

In patients with CKD [Chronic Kidney Disease], SrCr is greater than 2 mg/dl or ClCr is less than 45ml/min, the current (or pre-transfusion) Hgb is less than 10g/dl, the target Hgb is within the range of 10-12 g/dl (this is only applicable to CKD [Chronic Kidney Disease] patients and not applicable to surgery patients). In surgery patients, the pretreatment Hgb level should be 10-13 g/dl. In patients with non-myeloid malignancies receiving the concomitant myelosuppressive chemotherapy, the current Hgb is less than 10 g/dl (this is not applicable to surgery patients). In HIV-infected patients with anemia related to zidovudine-treatment, the pretreatment endogenous serum erythropoietin level is less than 500 microunits/ml. Patients with low or intermediate-1 risk Myelodysplastic Syndrome must be transfusion-dependent or symptomatic from anemia. .

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 months. In patients on myelosuppressive chemo, duration is the length of treatment with chemo. .

Other Criteria

N/A

PROLEUKIN

Affected Drugs

PROLEUKIN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and other medically accepted indications, such as in HIV patients in combination with highly active antiretroviral therapy, in combination for treatment of cutaneous T-cell lymphoma, in treatment of colorectal cancer, non-Hodgkin lymphoma, Acute Myelogenous Leukemia, after autologous bone marrow transplantation. .

Exclusion Criteria

Proleukin is furnished "incident to" a physician service.

Required Medical Information

ECOG performance status is equal or less than 1. The patient's cardiac and pulmonary function defined by thallium stress testing and pulmonary function testing are within normal limits.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist.

Coverage Duration

12 Months.

Other Criteria

Part D coverage if dispensed by a pharmacy for administration under the supervision of a specialist experienced in the use of anticancer agents. Specialists skilled in cardiopulmonary or intensive care medicine must be available. (If a pharmacy furnishes this drug to a member who is in a Medicare Part A stay: Hospital or Skilled Nursing Facility, the drug will not be covered under Part D). .

PROVIGIL

Affected Drugs

PROVIGIL®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

In patients with excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome and only if continuous positive airway pressure (CPAP) is the treatment of choice for these patients, the exclusion criteria is the following: the patient has not tried and failed CPAP [Continuous positive airway pressure]. .

Required Medical Information

In patients with excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome, documented history of CPAP [Continuous positive airway pressure] use. .

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

In patients with narcolepsy, the documented use of methylphenidate and dextroamphetamine is required prior to the initiation of Provigil (A trial of methylphenidate and dextroamphetamine is not required if patient with narcolepsy has a history of stimulant drug abuse and dependence or other contraindications to methylphenidate and dextroamphetamine).

RANEXA

Affected Drugs

RANEXA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Current use of drugs that prolong QTc interval. Strong CYP3A4 inhibitors use, such as ketoconazole, itraconazole, clarithromycin, nefazodone, Viracept, Norvir, Crixivan and Invirase. In patients with liver disease. .

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

RELISTOR

Affected Drugs

RELISTOR®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Documented history of opioid-induced constipation. Documented history of one of the following primary diagnoses: incurable cancer, end-stage COPD [Chronic Obstructive Pulmonary Disease], emphysema, cardiovascular disease, heart failure, Alzheimer's disease, Alzheimer's dementia, HIV, AIDS, or any other advanced illness that requires a palliative opioid therapy. .

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

The use of at least one formulary laxative: lactulose, generlac or polyethylene glycol 3350 for the current condition is required prior to the initiation of Relistor. .

REMICADE

Affected Drugs

REMICADE®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Remicade is furnished “incident to” a physician service.

Required Medical Information

In patients with moderately to severely active Rheumatoid Arthritis, the concurrent use of methotrexate with Remicade.

Age Restrictions

N/A

Prescriber Restrictions

Rheumatologist, Gastroenterologist, Dermatologist.

Coverage Duration

12 Months.

Other Criteria

In patients with moderately to severely active Rheumatoid Arthritis, the documented use of at least 1 DMARD [Disease-modifying antirheumatic drug] is required for the current condition prior to the initiation of Remicade. In patients with Psoriatic Arthritis, the documented use of methotrexate is required for the current condition prior to the initiation of Remicade. In patients with Ankylosing Spondylitis, the documented use of at least 2 NSAIDs [Non-steroidal anti-inflammatory drugs] is required for the current condition prior to the initiation of Remicade. In patients with Plaque Psoriasis, the documented use of phototherapy or systemic therapy is required if a patient is a candidate for phototherapy or systemic therapy prior to the initiation of Remicade. In patients with moderately to severely active Crohn's disease or Ulcerative Colitis (UC), the documented use of conventional therapy agents: aminosalicylates, corticosteroids or immunomodulators is required prior to the initiation of Remicade. For all FDA-approved indications, except for the treatment of UC [Ulcerative colitis], the documented use of Humira for at least 3 months is required prior to the use of Remicade. Part D coverage if dispensed by a pharmacy (If a pharmacy furnishes this drug to a member

who is in a Medicare Part A stay: Hospital or Skilled Nursing Facility, the drug will not be covered under Part D). .

REVATIO

Affected Drugs

REVATIO®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Current use of nitrates if potential risks outweigh the potential benefits.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

RITUXAN

Affected Drugs

RITUXAN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Rituxan is furnished "incident to" a physician service.

Required Medical Information

In patients with Non Hodgkin's Lymphoma, expression of CD20 positive B-cells must be confirmed by histologic testing. In patients with moderately-to severely-active Rheumatoid Arthritis, concurrent use of Rituxan with methotrexate is required. CBC, platelet count for any FDA-approved diagnosis. .

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist, Rheumatoid Arthritis Specialist.

Coverage Duration

12 Months.

Other Criteria

In patients with moderately-to severely-active Rheumatoid Arthritis, the documented use of at least one TNF [Tumor necrosis factor] antagonist or contraindications to TNF [Tumor necrosis factor] antagonists are required prior to the initiation of Rituxan. Part D coverage if dispensed by a pharmacy for administration under the supervision of a Healthcare Professional who is experienced in the use of Rituxan therapy and will monitor the patient for the infusion reactions. (If a pharmacy furnishes this drug to a member who is in a Medicare Part A stay: Hospital or Skilled Nursing Facility, the drug will not be covered under Part D). .

SIMPONI

Affected Drugs

SIMPONI®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

The concurrent administration of the following drugs: Kineret or Orencia with Simponi.

Required Medical Information

In patients with moderately to severely active Rheumatoid Arthritis, the concurrent use of methotrexate with Simponi. .

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

In patients who don't have contraindications to Humira, the documented use of Humira for at least three months is required prior to the initiation of Simponi. In patients with moderately to severely active Rheumatoid Arthritis, the documented use of at least one Disease-Modifying Anti-Rheumatic Drug is required for the current condition prior to the initiation of Simponi. In patients with active Psoriatic Arthritis, the documented use of methotrexate is required for the current condition prior to the initiation of Simponi. In patients with active Ankylosing Spondylitis, the documented use of at least 2 NSAIDs [Non-steroidal anti-inflammatory drugs] is required for the current condition prior to the initiation of Simponi. .

SOMAVERT

Affected Drugs

SOMAVERT®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

The patient has not tried and failed surgery and/or radiation therapy within the past 6 months if the patient is a candidate for these therapies.

Required Medical Information

The patient is not responsive or intolerant to octreotide or IGF-1 level is greater than 900ng/ml.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

SORIATANE CK

Affected Drugs

SORIATANE CK®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

The documented three month trial of formulary topical corticosteroids for the current condition prior to the initiation of Soriatane CK.

SPRYCEL

Affected Drugs

SPRYCEL®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of BCR-ABL positive chronic, accelerated, or myeloid or lymphoid blast phase chronic myeloid leukemia or diagnosis of Philadelphia chromosome positive acute lymphoblastic leukemia. .

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

The documented use of Gleevec is required prior to the initiation of Sprycel.

STRATTERA

Affected Drugs

STRATTERA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

The documented use of methylphenidate and dextroamphetamine is required prior to the initiation of Strattera (A trial of methylphenidate and dextroamphetamine is not required if patient has a history of stimulant drug abuse and dependence or other contraindications to methylphenidate and dextroamphetamine).

SUTENT

Affected Drugs

SUTENT®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist.

Coverage Duration

12 Months.

Other Criteria

In patients with gastrointestinal stromal tumors (GIST), the documented use of Gleevec is required prior to the initiation of Sutent. .

SYMLIN

Affected Drugs

SYMLIN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

The patient is currently not using insulin. The patient has a poor compliance with the current oral hypoglycemic agents or insulin regimen and with self-blood glucose monitoring. The patient's current hemoglobin A1C is 9 or greater. The patient has a history of a recurrent severe hypoglycemia requiring assistance in the last 6 months. The patient has a diagnosis of gastroparesis. The patient is currently taking metoclopramide.

Required Medical Information

Hemoglobin A1C.

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Endocrinologist.

Coverage Duration

12 Months.

Other Criteria

N/A

SYMLINPEN

Affected Drugs

SYMLINPEN 120®
SYMLINPEN 60®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

The patient is currently not using insulin. The patient has a poor compliance with the current oral hypoglycemic agents or insulin regimen and with self-blood glucose monitoring. The patient's current hemoglobin A1C is 9 or greater. The patient has a history of a recurrent severe hypoglycemia requiring assistance in the last 6 months. The patient has a diagnosis of gastroparesis. The patient is currently taking metoclopramide.

Required Medical Information

Hemoglobin A1C.

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Endocrinologist.

Coverage Duration

12 Months.

Other Criteria

N/A

TARGRETIN

Affected Drugs

TARGRETIN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

In patients requesting oral Targretin, Liver function tests: ALT/AST, Fasting lipid panel, WBC, thyroid function tests. .

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist or Dermatologist.

Coverage Duration

12 Months.

Other Criteria

The patient was prescribed at least one systemic or topical therapy for the current condition prior to the initiation of Targretin.

TASIGNA

Affected Drugs

TASIGNA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

The patient is not resistant to prior therapy with Gleevec. The patient's QTc interval 480 msec or greater. The patient's baseline potassium and magnesium levels are not within normal limits. Concurrent use of strong CYP3A4 Inhibitors or drugs that prolong QT interval. Hepatic impairment defined as the following: ALT/ST are greater than 2. 5 (or greater than 5, if related to disease) times the upper limit of the normal range and/ or total bilirubin greater than 1. 5 times the upper normal limit of the normal range. .

Required Medical Information

Documented history of resistance to Gleevec that is defined as one of the following: failure to achieve a complete hematologic response by 3 months, failure to achieve a cytogenic response by 6 months or major cytogenic response by 12 months, progression of disease after a previous cytogenic or hematologic response. Baseline ECG. Baseline Potassium and Magnesium levels. Hepatic Function tests: ALT/AST, total bilirubin. .

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist.

Coverage Duration

12 Months.

Other Criteria

A trial of Gleevec is not required if patient is intolerant to Gleevec.

THALOMID

Affected Drugs

THALOMID®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

In patients with Multiple Myeloma, the concurrent use of Thalomid with dexamethasone.

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist, Hematologist or Dermatologist. .

Coverage Duration

12 Months.

Other Criteria

Thalomid must be prescribed by a physician registered with System for Thalomid Education and Prescribing Safety Program.

THIOGUANINE

Affected Drugs

THIOGUANINE®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist.

Coverage Duration

12 Months.

Other Criteria

N/A

TRISENOX

Affected Drugs

TRISENOX®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Trisenox is furnished "incident to" a physician service.

Required Medical Information

Presence of the t(15, 17) translocation or PML/RAR-alpha gene expression. Documented history of retinoid and anthracycline chemotherapy use. The patient's baseline ECG and electrolytes (potassium, calcium, and magnesium) are within normal limits. .

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist.

Coverage Duration

12 Months.

Other Criteria

The patient is refractory to (or have relapsed from) retinoid and anthracycline chemotherapy. Part D coverage if dispensed by a pharmacy for administration under the supervision of a physician who is experienced in the management of patients with acute leukemia. (If a pharmacy furnishes this drug to a member who is in a Medicare Part A stay: Hospital or Skilled Nursing Facility, the drug will not be covered under Part D).

TYKERB

Affected Drugs

TYKERB®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

The patient's tumor does not overexpress Human Epidermal Receptor Type 2 (HER2).

Required Medical Information

Laboratory testing based on the new HER2 Testing Guidelines from the College of American Pathologists (CAP) and the American Society of Clinical Oncology (ASCO) that confirms HER2 overexpression. Testing for hormone receptor positive metastatic breast cancer in postmenopausal women who will be prescribed Tykerb with Femara (letrozole). The patient's baseline LVEF is equal or greater than 50% The patient's baseline potassium and magnesium levels are within normal limits.

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist.

Coverage Duration

12 Months.

Other Criteria

The documented use of anthracycline, taxane, and Herceptin is required prior to the initiation of Tykerb with advanced or metastatic breast cancer who will receive Tykerb in combination with Xeloda (capecitabine). These criteria do not apply for the other indication: in postmenopausal women with hormone receptor positive metastatic breast cancer who will receive Tykerb in combination with Femara (letrozole).

VELCADE

Affected Drugs

VELCADE®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Velcade is furnished "incident to" a physician service.

Required Medical Information

Documented history of at least one prior therapy use for the current condition.

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist.

Coverage Duration

12 Months.

Other Criteria

Part D coverage if dispensed by a pharmacy for administration under the supervision of a Healthcare Professional who is experienced in the use of antineoplastic therapy. (If a pharmacy furnishes this drug to a member who is in a Medicare Part A stay: Hospital or Skilled Nursing Facility, the drug will not be covered under Part D). .

VOTRIENT

Affected Drugs

VOTRIENT®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Pre-existing severe hepatic impairment (total bilirubin greater than 3 times upper limit of normal). In members who experienced and were hospitalized for cerebral hemorrhage or clinically significant GI hemorrhage in the past 6 months. In members who experienced Arterial Thrombotic Events: Myocardial Infarction, ischemic stroke, or Transient Ischemic Attack in the previous 6 months. .

Required Medical Information

Baseline serum liver tests: AST, ALT, bilirubin, EKG, electrolytes (e. g. , calcium, magnesium, potassium), thyroid function tests, urinalysis.

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist.

Coverage Duration

12 Months.

Other Criteria

N/A

ZAVESCA

Affected Drugs

ZAVESCA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

The patient who doesn't have contraindications to Enzyme Replacement Therapy, such as allergy, hypersensitivity, or poor venous access. .

Required Medical Information

The diagnosis must be confirmed by laboratory or Genetic testing. Documented intolerance to Enzyme Replacement Therapy, such as allergy, hypersensitivity, or poor venous access. . .

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

ZOLINZA

Affected Drugs

ZOLINZA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist.

Coverage Duration

12 Months.

Other Criteria

The documented use of at least one systemic therapies for the current condition: Targretin oral or CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or Intron-A or methotrexate is required prior to the initiation of Zolinza. .