

FamilyCare

HEALTH PLANS



2010

Prior Authorization

Questions? Please call us at 866-798-CARE (2273) TTY: 800-735-2900
For more information, please visit www.FamilyCareHealthPlans.org



**Family Care Basic
Prior Authorization Criteria
ACNE**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Tretinoin® is covered for members who meet the following criteria:

- A. Documented ineffectiveness to topical benzoyl peroxide products and topical antibiotics

NON COVERAGE

Tretinoin® is NOT covered for members with the following criteria:

- A. Using for facial wrinkles or other cosmetic indications

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
ACTONEL**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Actonel ® is covered for members who meet the following criteria:

- A. Documented ineffectiveness, intolerance, or contraindication to alendronate

COVERAGE DURATION

Plan Year.



**Family Care Basic
Prior Authorization Criteria
ADAGEN**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Adagen® is covered for members who meet the following criteria:

- A. Patient has ineffectiveness from or is not a suitable candidate for bone marrow transplantation

NON-COVERAGE

Adagen® is NOT covered for members who meet the following criteria:

- A. Diagnosis of severe thrombocytopenia

PRESCRIBER RESTRICTIONS

Endocrinologist

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
AFINITOR**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Afinitor® is covered for members who meet the following criteria:

- A. Patient must have previous trial and failure with one of the following:
 - a. Sutent
 - b. Nexavar

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Documentation of previous trial/failure of Sutent or Nexavar

AGE RESTRICTIONS

Patient must be 18 years of age or older

PRESCRIBER RESTRICTIONS

Oncologist

COVERAGE DURATION

Plan Year



Family Care Basic Prior Authorization Criteria

ALDURAZYME

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Aldurazyme® is covered for members who meet the following criteria:

- A. If the patient has previously received at least 26 weeks of Aldurazyme® therapy, they must show an improvement in lung function (forced vital capacity [FVC]) from when therapy was started

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Documentation showing patient has at least two of the listed moderate-to-severe symptoms.
 - a. Impaired vision
 - b. Recurrent otitis media
 - c. Recurrent sinopulmonary infections
 - d. Impaired hearing
 - e. Upper airway obstruction
 - f. Malaise and reduced endurance
 - g. Corneal clouding
 - h. Macrocephaly
 - i. Reduced joint range of motion
 - j. Progressively course facial features
 - k. Umbilical and inguinal hernias
 - l. Carpal tunnel syndrome
 - m. Delayed or regressed mental development
 - n. Hepatosplenomegaly
 - o. Cardiac abnormalities and valvular disease
 - p. Communicating hydrocephalus
 - q. Spinal cord compression
 - r. Sleep apnea
 - s. Short stature
 - t. Reduced pulmonary function
 - u. Bone deformities
- B. AND Chart notes documenting diagnosis confirmed by alpha-iduronidase activity or enzymatic assay

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
AMITIZA**

COVERED USES

FDA approved indications:

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

NON-COVERAGE

Amitiza® is NOT covered for members who meet the following criteria:

- A. Presence of a mechanical gastrointestinal obstruction

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
BANZEL**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Banzel® is covered for members who meet the following criteria:

- A. Documented ineffectiveness or intolerance to two or more of the following medications:
 - a) Felbamate (Felbatol),
 - b) Lamotrigine (Lamictal),
 - c) Topiramate (Topamax)

AGE RESTRICTIONS

Coverage for 4 years and older

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
BONIVA**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Boniva® is covered for members who meet the following criteria

- A. Documented ineffectiveness, intolerance, or contraindications to alendronate AND Actonel

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
BUPHENYL**

COVERED USES

FDA approved indications:

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

REQUIRED MEDICAL INFORMATION

Chart notes documenting diagnosis of

- A. Argininosuccinic acid synthetase deficiency or
- B. Carbamoylphosphate synthetase deficiency or
- C. Ornithine transcarbamylase deficiency

PRESCRIBER RESTRICTIONS

Endocrinologist

COVERAGE DURATION

Plan Year

**Family Care Basic
Prior Authorization Criteria****BYETTA****COVERED USES**

FDA approved indications:

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

COVERAGE POLICY

Byetta® is covered for members who meet the following criteria:

- A. Current drug therapy includes or there is a contraindication to metformin or a sulfonylurea
- B. AND current drug therapy includes or there is a contraindication to a thiazolidinedione.

REQUIRED MEDICAL INFORMATION

- A. Chart notes indicating inability to achieve adequate glycemic control (HbA1c less than 7.0) on metformin or a sulfonylurea and a thiazolidinedione.
- B. Lab results including HbA1c greater than 7.0

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
CAPASTAT**

COVERED USES

FDA approved indications:

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

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Culture and Sensitivity report showing susceptibility of bacteria to Capastat

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
CELEBREX**

COVERED USES

FDA approved indications:

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

REQUIRED MEDICAL INFORMATION

For Doses of 50mg to 400mg per day:

- A. Documented history of NSAID-induced GI adverse effects requiring discontinuation of the NSAID AND addition of a proton pump inhibitor or misoprostol.

For Doses greater than 400mg/day

- A. A documented diagnosis of familial adenomatous polyposis.

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
CHORIONIC GONADOTROPIN**

COVERED USES

FDA approved indications:

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

NON-COVERAGE

Chorionic Gonadotropin® is NOT covered for members who meet the following criteria:

- A. Patient is Female OR
- B. Treatment of obesity OR
- C. Presence of precocious puberty OR
- D. Prostatic carcinoma or other androgen dependant neoplasm

COVERAGE DURATION

Plan Year



Family Care Basic Prior Authorization Criteria

EMEND

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Emend® is covered for members who meet the following criteria:

- A. IF BvD Criteria indicates that coverage should be through Medicare Part D:
 - a. Emend must be administered in combination with a 5HT3 antagonist AND corticosteroid AND
 - b. The patient is receiving moderately or highly emetogenic chemotherapy or
- B. Part B will be billed if the medication is being used for cancer treatment and as full replacement of intravenous administration within 48 hours of cancer treatment if the prescriber states: As a full therapeutic replacement for an intravenous anti-emetic drug as part of a cancer chemotherapeutic regimen.

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
EMSAM**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Emsam® is covered for members who meet the following criteria:

- A. Prior treatment trials including maximum tolerated dose of at least ONE drug from TWO of the following THREE therapeutic classes:
 - a. SSRI (Celexa, Lexapro, Prozac, Zoloft, Paxil), and
 - b. SNRI (Effexor, Cymbalta), and
 - c. MISC (Wellbutrin, Remeron, Nefazodone)

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
ENBREL**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Enbrel® is covered for members who meet the following criteria:

- A. For Rheumatoid arthritis OR juvenile idiopathic arthritis:
 - a. Ineffectiveness or contraindication to an 8 week treatment course with methotrexate.
- B. FOR plaque psoriasis documented ineffective, intolerance, or contraindication for 60 days of two of the following treatments:
 - a. Topical steroids,
 - b. Phototherapy or Photochemotherapy,
 - c. Cyclosporine,
 - d. Methotrexate,
 - e. Acitretin.

REQUIRED MEDICAL INFORMATION

- C. For chronic plaque psoriasis chart notes documenting
 - a. Significant functional disability OR
 - b. At least 10% body surface area involvement.
- D. For rheumatoid arthritis
 - a. Chart notes documenting diagnosis made with Amer. College of Rheumatology.
- E. Classification. Chart notes documenting
 - a. Psoriatic arthritis or
 - b. Ankylosing spondylitis.

PRESCRIBER RESTRICTIONS

Rheumatologist or Dermatologist

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
ERAXIS**

COVERED USES

FDA approved indications:

All FDA approved indications not otherwise excluded from Part D

COVERAGE POLICY

Eraxis® is covered for members who meet the following criteria:

- A. BvD criteria indicated that coverage should be through Medicare Part D.
- B. Documented trial with fluconazole was ineffective or not tolerated.

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
FANAPT**

COVERED USES

FDA approved indications:

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

REQUIRED MEDICAL INFORMATION

Chart notes documenting the following:

- A. Previous use of two or more antipsychotics have been ineffective or contraindicated

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
FORTEO**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Forteo® is covered for members who meet the following criteria:

- A. History of ineffectiveness to 2 years of treatment with bisphosphonate therapy, including alendronate, risedronate, Boniva or Reclast.

NON-COVERAGE

Forteo® is NOT covered for members who meet the following criteria:

- A. Over 24 months of previous Forteo therapy.

REQUIRED MEDICAL INFORMATION

Chart notes documenting osteoporosis with at least two of the following fracture risk factors:

- B. T-Score less than or equal to -2.5
- C. Prior fragility fracture (counts as two risk factors)
- D. Age greater than or equal to 70
- E. Family history (1st degree relative)

COVERAGE DURATION

Plan year



**Family Care Basic
Prior Authorization Criteria
FOSAMAX**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Fosamax® is covered for members who meet the following criteria:

- A. Documented ineffectiveness, intolerance, or contraindication to Alendronate

COVERAGE DURATION

Plan Year



Family Care Basic Prior Authorization Criteria

GONADOTROPIN-RELEASING HORMONE ANALOGS

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Gonadotropin-Releasing Hormone Analogs are covered for members who meet the following criteria:

- A. BvD criteria indicates that coverage should be through Medicare Part D
- B. If being used for metastatic breast cancer in a pre-menopausal women the disease has progressed or recurred after a 3 month trial of tamoxifen.
- C. If the diagnosis is advanced prostate cancer, orchiectomy or estrogen therapy are documented as unacceptable.
- D. If the diagnosis is endometriosis the patient has completed documented ineffective trial of at least two of the following: oral contraceptives, medroxyprogesterone, and Danazol

REQUIRED MEDICAL INFORMATION

Chart notes required if being used to suppress onset of puberty where adolescent meets medical necessity for growth hormone supplementation and is not within target growth range (within 1 standard deviation of mean height for age and sex)

COVERAGE DURATION

Plan year



**Family Care Basic
Prior Authorization Criteria
GROWTH HORMONES**

COVERED USES

FDA approved indications:

All FDA approved indications not otherwise excluded from Part D

COVERAGE POLICY

Chart notes lab result documenting the following:

A. Pediatric Criteria:

- a. Pediatric growth hormone deficiency by pre-treatment, 2 growth hormone (GH) stimulation tests less than 10 mcg/ml OR pre-treatment, at least one GH stimulation test less than 15 mcg/ml, AND IGF-I and IGF-BP3 levels below normal for bone age and sex.
- b. OR pre-treatment, one GH stimulation test less than 10 mcg/ml AND disease or condition affecting pituitary function (tumor, surgery, radiation, etc).
- c. OR multiple pituitary hormone deficiencies:
 - i. at least 2 in addition to GHD –
 1. Cortisol
 2. thyroid
 3. ACTH
 4. FSH/LH
 5. testosterone/estrogen.
- d. OR neonatal hypoglycemia:
 - i. AGHD (low GH levels are detected during hypoglycemia).
- e. Open Growth Plates:
 - i. Initial bone age and demo of open growth plates (until max bone age met, whichever is shorter)
 1. Males up to 16 0/12 years
 2. Females, up to 14 0/12 years.
- f. Short Stature / Growth failure:
 - i. Height less than 2 SD below mean for age and sex
 - ii. OR height velocity greater than 1 SD below mean for age and sex
 - iii. OR Decrease in height greater than 0.5 SD in 1 year (if 2 yrs or older) for age and sex
 - iv. OR Requires weekly dialysis or chronic renal insufficiency (GFR less than 75ml/min /1.73 m²)

B. Adult criteria:

- a. Pre-treatment, at least one GH stimulation test less than 5 mcg/ml (radioimmunoassay) or less than 2.5 mcg/ml if measured by immunoradiometric assay (Clonidine not acceptable) AND At least one known cause for pituitary disease or condition affecting pituitary fxn, including:
 - i. pituitary tumor
 - ii. surgical damage
 - iii. hypothalamic disease
 - iv. irradiation
 - v. trauma
 - vi. Or infiltrative diseases



Family Care Basic Prior Authorization Criteria

- b. AND Other pituitary hormone deficiencies being supplemented:
 - i. Cortisol
 - ii. Thyroid
 - iii. ACTH
 - iv. FSH/LH
 - v. testosterone/estrogen
- c. AND One or more of the following additional risk factors/abnormalities present:
 - i. Reduced bone mineral density greater than 1 SD below mean, by WHO criteria
 - ii. OR High risk lipid profile (total cholesterol greater than 240mg/dL, or LDL greater than 190mg/dL)
 - iii. OR At least 2 pituitary hormone deficiencies other than GH inc:
 - 1. TSH
 - 2. ACTH
 - 3. gonadotropins
 - 4. or ADH**

NON-COVERAGE

Growth Hormones are NOT covered for members who meet the following criteria:

- A. Pediatric: growth plates closed

PRESCRIBER RESTRICTIONS

Endocrinologist

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
HUMIRA**

COVERED USES

FDA approved indications:

All FDA approved indications not otherwise excluded from Part D

COVERAGE POLICY

Humira® is covered for members who meet the following criteria:

- A. For Rheumatoid arthritis OR juvenile idiopathic arthritis:
 - a. Ineffectiveness or contraindication to an 8 week treatment course with methotrexate.
- B. FOR plaque psoriasis
 - a. Documented ineffective, intolerance, or contraindication for 60 days of two of the following treatments:
 - i. Topical steroids,
 - ii. Phototherapy or photochemotherapy,
 - iii. Cyclosporine,
 - iv. Methotrexate,
 - v. Acitretin.
- C. FOR Crohns disease:
 - a. Documented ineffectiveness of two of the following:
 - i. Mesalamine-containing product
 - ii. Sulfasalazine
 - iii. Systemic corticosteroids,
 - iv. Oral immunomodulator (azathioprine, mercaptopurine, cyclosporine, OR methotrexate)

REQUIRED MEDICAL INFORMATION

- A. For chronic plaque psoriasis
 - 1. Chart notes documenting significant functional disability OR at least 10% body surface area involvement.
- B. For ankylosing spondylitis or psoriatic arthritis
 - 1. Chart notes documenting diagnosis of ankylosing spondylitis or psoriatic arthritis.
- C. For Chrons disease
 - 1. Chart notes documenting as Fistulizing Crohns disease.

PRESCRIBER RESTRICTIONS

Rheumatologist, Dermatologist, Gastroenterologist

COVERAGE DURATION

Plan year



**Family Care Basic
Prior Authorization Criteria
INTERFERONS/RIBAVIRIN**

COVERED USES

FDA approved indications:

All FDA approved indications not otherwise excluded from Part D

COVERAGE POLICY

Interferons/Ribavirins are covered for members who meet the following criteria:

- A. For chronic hepatitis C, genotype 1 and 4,
 - a. Assess response at 12 weeks. Discontinue if a 2 log drop has not been achieved
 - b. OR continue therapy for up to 48 weeks total if 2 log drop has been achieved.
- B. For chronic hepatitis C, genotype 2 or 3,
 - a. Allow 24 weeks of therapy.
- C. For chronic hepatitis B, chronic hepatitis C with AIDS, OR chronic hepatitis C
 - a. As monotherapy allow 48 weeks therapy.

From labeling: "There are no safety and efficacy data on treatment of chronic HCV or HBV for longer than 48 weeks. For patients with HCV, consider discontinuing therapy after 12 to 24 weeks of therapy if the patient has failed to demonstrate an early virologic response, defined as undetectable HCV ribonucleic acid (RNA) or at least a 2 log₁₀ reduction from baseline in HCV RNA titer by 12 weeks of therapy"

NON-COVERAGE

Interferons/Ribavirins are NOT covered for members who meet the following criteria:

- A. Patient has received previous treatment with a pegylated interferon.

REQUIRED MEDICAL INFORMATION

Chart notes indicating a detectable HCV RNA levels of higher than 50 IU/ml at start of therapy.

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
INVEGA**

COVERED USES

FDA approved indications:

All FDA approved indications not otherwise excluded from Part D

COVERAGE POLICY

Invega® is covered for members who meet the following criteria:

- A. For diagnosis of schizophrenia:
 - a. Documented one month of two or more of the following alternatives were ineffective or not tolerated:
 - i. Risperidone,
 - ii. Clozapine,
 - iii. Seroquel,
 - iv. Seroquel XR,
 - v. Zyprexa,
 - vi. Zyprexa Zydis,
 - vii. Abilify
 - viii. Geodon.
- B. For the diagnosis of schizoaffective disorder:
 - a. approve

NON-COVERAGE

Invega® is NOT covered for members who meet the following criteria:

- A. Concomitant therapy with Risperidone

PRESCRIBER RESTRICTIONS

Psychiatrist

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
LOTRONEX**

COVERED USES

FDA approved indications:

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

NON-COVERAGE

Lotronex® is NOT covered for members who meet the following criteria:

- A. Male (Female use only)

REQUIRED MEDICAL INFORMATION

Chart notes documenting diagnosis of irritable bowel syndrome with primary symptom of diarrhea

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
LYRICA**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Lyrica® is covered for members who meet the following criteria:

- A. For seizures disorders, must be used as adjunctive therapy

REQUIRED MEDICAL INFORMATION

Chart notes indicating the diagnosis of diabetic neuropathy, post-herpetic neuralgia or fibromyalgia.

- A. For post-herpetic neuralgia
 - a. 1 month trial of gabapentin was ineffective or is not tolerated or contraindicated.
- B. For diabetic neuropathy and fibromyalgia ,
 - a. 1 month of duloxetine was ineffective or is not tolerated or is contraindicated.

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
NEXAVAR**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Nexavar® is covered for members who meet the following criteria:

- A. Chart notes demonstrate that patient has received previous Nexavar® therapy, and has evidence of clinical improvement from the pretreatment report
- B. AND/OR the patient has stable disease (tumor size within 25% of baseline).

NON-COVERAGE

Nexavar® is NOT covered for members who meet the following criteria:

- A. Combination therapy with interferon Alfa or interleukin-2

REQUIRED MEDICAL INFORMATION

Chart notes documenting

- A. Diagnosis of hepatocellular carcinoma that is NOT surgically resectable
- B. OR diagnosis of advanced renal cell carcinoma.

PRESCRIBER RESTRICTIONS

Oncologist or Nephrologist

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
ORFADIN**

COVERED USES

FDA approved indications:

All FDA approved indications not otherwise excluded from Part D

REQUIRED MEDICAL INFORMATION

Chart notes indicating

- A. Documentation that patient is compliant on a protein-restricted diet low in phenylalanine
- B. Lab reports demonstrating baseline LFTs are WNL

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
OXYCONTIN**

COVERED USES

FDA approved indications:

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

REQUIRED MEDICAL INFORMATION

Patient shows ineffectiveness or contraindications to Morphine Sulfate SR AND Methadone

COVERAGE DURATION

6 months



**Family Care Basic
Prior Authorization Criteria
PASER**

COVERED USES

FDA approved indications:

All FDA approved indications not otherwise excluded from Part D

COVERAGE POLICY

Paser® is covered for members who meet the following criteria:

- A. Patient is diagnosed with bacteria that are susceptible to Paser.
- B. Patient has culture and sensitivity report that shows susceptibility of bacteria to Paser.

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Culture and Sensitivity report showing susceptibility of bacteria to Paser

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
PROVIGIL**

COVERED USES

FDA approved indications:

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

NON-COVERAGE

Provigil® is NOT covered for members who meet the following criteria:

- A. Combination with medications used for insomnia

REQUIRED MEDICAL INFORMATION

Chart Notes including:

- A. Diagnosis of excessive daytime sleepiness associated with narcolepsy: confirmation by sleep study.
- B. For shift work sleep disorder: documentation from employer of work schedule including night shift.
- C. For treatment of excessive sleepiness due to obstructive sleep apnea/hypopnea syndrome: patient is utilizing and compliant with a nasal continuous positive airway pressure (CPAP) or bi-level positive airway pressure (BIPAP) for 1 month and the CPAP/BIPAP is continued in combination with Provigil

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
RANEXA**

COVERED USES

FDA approved indications:

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

REQUIRED MEDICAL INFORMATION

Chart notes indicating diagnosis of chronic angina

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
REVATIO**

COVERED USES

FDA approved indications:

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

NON-COVERAGE

Revatio® is NOT covered for members who meet the following criteria:

- A. Concurrent use of an organic nitrates (i.e. isosorbide mononitrate, isosorbide dinitrate, nitroglycerin)

REQUIRED MEDICAL INFORMATION

Chart notes documenting diagnosis of pulmonary arterial hypertension (PAH)

COVERAGE DURATION

Plan Year

**Family Care Basic
Prior Authorization Criteria****REVLIMID****COVERED USES**

FDA approved indications:

All FDA approved indications not otherwise excluded from Part D

COVERAGE POLICY

Revlimid® is covered for members who meet the following criteria:

- A. For diagnosis of multiple myeloma:
 - a. documented ineffectiveness of one of the following:
 - i. Melphalan,
 - ii. Carmustine,
 - iii. Cyclophosphamide,
 - iv. Doxorubicin,
 - v. Doxorubicin liposomal,
 - vi. Bortezomib,
 - vii. Zoledronic Acid,
 - viii. Thalidomide.
 - b. AND if the patient has received previous Revlimid® therapy, a delay or no disease progression must be documented
- B. For diagnosis of transfusion-dependent anemia
 - a. patient has received 2 or more units of red blood cells within 8 weeks
 - b. AND if the patient has received previous Revlimid® therapy, stabilization of anemia is documented by having experienced one of the following:
 - i. A 50% reduction in blood transfusions.
 - ii. An increase in hemoglobin of at least 1g/dL over baseline.
 - iii. The absence of the pretreatment cytogenetic abnormality or
 - iv. A reduction in the number of abnormal cells of at least 50%.

REQUIRED MEDICAL INFORMATION

Chart notes documenting

- A. Diagnosis of multiple myeloma or myelodysplastic syndrome.
- B. For multiple myeloma therapy will be in combination with dexamethasone

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
RILUTEK**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Rilutek® is covered for members who meet the following criteria:

- A. No more than 50 mg every 12 hours

REQUIRED MEDICAL INFORMATION

Chart notes indicating diagnosis of amyotrophic lateral sclerosis

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
ROMIDEPSIN**

COVERED USES

All FDA covered uses

COVERAGE POLICY

Romidepsin is covered for members who meet the following criteria:

- A. Documentation supporting at least one previous systemic therapy for confirmed cutaneous T-Cell lymphoma was inadequate

PRESCRIBER RESTRICTIONS

Oncologist

COVERAGE DURATION

Plan year



**Family Care Basic
Prior Authorization Criteria
SABRIL**

COVERED USES

FDA approved indications:

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

REQUIRED MEDICAL INFORMATION

Documentation of infantile spasms for whom the potential benefits outweigh the potential risk of vision loss

PRESCRIBER RESTRICTIONS

Registered with Share 1-888-45-SHARE

COVERAGE DURATION

Plan year



**Family Care Basic
Prior Authorization Criteria
SAPHRIS**

COVERED USES

FDA approved indications:

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

REQUIRED MEDICAL INFORMATION

Documentation of

- A. Diagnosis of schizophrenia or bipolar disorder
- B. AND Inadequate response to:
 - a. Risperidone,
 - b. Clozapine,
 - c. Zyprexa,
 - d. Seroquel,
 - e. Geodon
 - f. Abilify.

COVERAGE DURATION

Plan year



**Family Care Basic
Prior Authorization Criteria
SEROMYCIN**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Seromycin® is covered for members who meet the following criteria:

- A. Patient is diagnosed with bacteria that are susceptible to Seromycin.
- B. Patient has culture and sensitivity report that shows susceptibility of bacteria to Seromycin.

NON-COVERAGE

Seromycin is NOT covered for members who meet the following criteria:

- A. Patient has a seizure disorder
- B. Patient has history of major depression, anxiety, or psychosis

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Culture and Sensitivity report showing susceptibility of bacteria to Seromycin
- B. Documentation of absence of seizure disorder
- C. Documentation of absence of major depression, anxiety, or psychosis

AGE RESTRICTIONS

Patient must be 18 years old or older

COVERAGE DURATION

14 Days



**Family Care Basic
Prior Authorization Criteria
SMOKING CESSATION**

COVERED USES

FDA approved indications:

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

REQUIRED MEDICAL INFORMATION

Patient must be registered in the Free and Clear comprehensive behavioral smoking cessation program.

- A. OTC Gum and Patches are NOT Covered

COVERAGE DURATION

3 months



**Family Care Basic
Prior Authorization Criteria
SPRYCEL**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Sprycel® is covered for members who meet the following criteria:

- A. Previous use of Gleevac was ineffective or not tolerated

REQUIRED MEDICAL INFORMATION

Chart notes including:

- a. Diagnosis of Chronic myelogenous leukemia (CML) or Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL).

PRESCRIBER RESTRICTIONS

Hematologist or Oncologist

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
SUCRAID**

COVERED USES

FDA approved indications:

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

REQUIRED MEDICAL INFORMATION

Chart notes including results of genetic testing showing a sucrase deficiency

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
SUPRAX**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Suprax® is covered for members who meet the following criteria:

- A. Patient is diagnosed with bacteria that are susceptible to Suprax.
- B. Patient has culture and sensitivity report that shows susceptibility of bacteria to Suprax.
- C. For all diagnoses except gonorrhea:
 - a. Previous trial/failure to at least one first- or second-generation cephalosporin

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Culture and Sensitivity report showing susceptibility of bacteria to Suprax

COVERAGE DURATION

14 Days



**Family Care Basic
Prior Authorization Criteria
SUSTENNA**

COVERED USES

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

COVERAGE POLICY

Invega Sustenna is covered for members who meet the following criteria:

- A. The patient has a history of non compliance or refuses to utilize oral medications.
- B. The patient must have history of ONE of the following:
 - a. Three test doses of oral Risperdal
 - b. Three test doses of oral Invega
 - c. Previous use of Invega Sustenna
- C. If the patient is increasing the dose of Invega Sustenna they must have a history of two prior injections.

NON COVERAGE

Invega Sustenna is not covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications: torsades de pointes, dementia or breast-feeding.
- B. If the patient is taking any of the following: Astemizole, Bepridil, Chlorpromazine, Cisapride, Droperidol, Grepafloxacin, Halofantrine, Levomethadyl, Mesoridazine, Nilotinib, Pimozide, Probuco, Sertindole, Sparfloxacin, Terfenadine, Thioridazine.

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Documentation showing the patient is non compliant and or refuses to utilize oral medication.
- B. Documentation showing that the patient has received at least ONE of the following:
 - a. Three test doses of oral Risperdal
 - b. Three test doses of oral Invega
 - c. Previous use of Invega Sustenna
- C. Documentation showing that the patient has received 2 injections prior to any increase to their current dosage

PRESCRIBER RESTRICTIONS

Psychiatrist

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
SUTENT**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Sutent® is covered for members who meet the following criteria:

- A. If the patient has had previous Sutent® therapy, must have documentation there has been no evidence of disease progression since initiating Sutent® therapy.

NON-COVERAGE

Sutent® is NOT covered for members who meet the following criteria:

- A. Combination therapy with interferon alpha or interleukin-2.

REQUIRED MEDICAL INFORMATION

- A. For gastrointestinal stromal tumor (GIST):
 - a. Chart notes indicating the GIST is unresectable and/or metastatic malignant and
 - b. Chart notes indicating disease progression while on Gleevac or intolerance to Gleevec.
- B. For metastatic renal cell carcinoma:
 - a. Chart notes indicating the carcinoma is surgically unresectable

PRESCRIBER RESTRICTIONS

Gastroenterologist, Oncologist or Nephrologist

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
SYMLIN**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Symlin® is covered for members who meet the following criteria:

- A. Patient will continue use of insulin while receiving Symlin.
- B. AND if the pt has had previous Symlin® treatment, he/she must show a reduction in their HbA1c since initiating Symlin® treatment.

REQUIRED MEDICAL INFORMATION

Chart notes including HbA1c greater than 7.0 while receiving insulin therapy

PRESCRIBER RESTRICTIONS

Endocrinologist

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
TARCEVA**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Tarceva® is covered for members who meet the following criteria:

- A. If the patient has received previous Tarceva® therapy, the provider has evidence of clinical improvement from the pretreatment report by showing no increase in tumor size and/or progression of disease.

NON-COVERAGE

Tarceva® is NOT covered for members who meet the following criteria:

- A. Pregnant Female

REQUIRED MEDICAL INFORMATION

Chart notes including:

- A. Negative pregnancy test and documenting that patient has no plans to become pregnant and has been educated on the potential risks of Tarceva therapy during pregnancy.
- B. For non-small cell lung cancer:
 - a. Chart notes indicating the cancer is locally advanced or metastatic (Stage 3 or 4). and
 - b. Chart notes indicating disease progression after completion of or unacceptable toxicity to at least one of the following chemotherapy regimens:
 - i. Platinum-based (e.g. carboplatin, Paroplatin, cisplatin, Platinol, oxaliplatin, or Eloxatin),
 - ii. Taxoid-based regimen (e.g. paclitaxel, Taxol, Onxol, Abraxane, docetaxel, or Taxotere). and
 - c. Chart notes indicate patient will not receive Tarceva in combination with any other chemotherapeutic agents.
- C. For pancreatic cancer
 - a. Chart notes indicating the cancer is surgically unresectable. and
 - b. Chart notes indicating the cancer is locally advanced or metastatic (Stage 3 or 4) and
 - c. Chart notes that patient will receive combination therapy with gemcitabine.

PRESCRIBER RESTRICTIONS

Oncologist or Nephrologist

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
TASIGNA**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Tasigna® is covered for members who meet the following criteria:

- A. Chart notes indicating ineffectiveness or intolerance to prior therapy that included imatinib

COVERAGE DURATION

Plan Year

**Family Care Basic
Prior Authorization Criteria****TRECTOR****COVERED USES**

FDA approved indications:

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

COVERAGE POLICY

Trector® is covered for members who meet the following criteria:

- A. Patient is diagnosed with bacteria that are susceptible to Trector.
- B. Patient has culture and sensitivity report that shows susceptibility of bacteria to Trector.

NON-COVERAGE

Trector® is NOT covered for members who meet the following criteria:

- A. Patients with hepatic encephalopathy

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Culture and Sensitivity report showing susceptibility of bacteria to Trector
- B. Documentation showing patient does NOT have encephalopathy

COVERAGE DURATION

Plan Year

**Family Care Basic
Prior Authorization Criteria****TYZEKA****COVERED USES**

FDA approved indications:

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

COVERAGE POLICY

Tyzeka ® is covered for members who meet the following criteria:

- A. The patient has received previous Tyzeka® treatment,
- B. There is documented clinical improvement shown by a drop in viral load or reduction in the patient's liver aminotransferases.
- C. AND the patient is not receiving duplicate therapy that includes Hepsera®, Baraclude®, Epivir®, Intron A® and/or Infergen®.

NON-COVERAGE

Tyzeka ® is NOT covered for members who meet the following criteria:

- A. Combination therapy with Hepsera®, Baraclude®, Epivir®, Intron A® and/or Infergen®.

REQUIRED MEDICAL INFORMATION

Lab results:

- A. Hepatitis B Viral load greater than 100,000 copies per mL
- B. LFT results demonstrating elevated ALT and AST that are two times the upper limit of normal

PRESCRIBER RESTRICTIONS

Infectious Disease or Gastroenterologist

COVERAGE DURATION

Plan Year

**Family Care Basic
Prior Authorization Criteria****VFEND****COVERED USES**

FDA approved indications:

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

COVERAGE POLICY

Vfend® is covered for members who meet the following criteria:

- A. Ineffectiveness or intolerance to at least one other antifungal therapy.
- B. For Candida infections must have ineffectiveness or intolerance to fluconazole

REQUIRED MEDICAL INFORMATION

Lab results: Culture and sensitivity results demonstrating susceptibility to voriconazole

COVERAGE DURATION

Plan Year

**Family Care Basic
Prior Authorization Criteria****VIMPAT****COVERED USES**

FDA approved indications:

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

COVERAGE POLICY

Vimpat ® is covered for members who meet the following criteria:

- A. Currently taking another formulary anticonvulsant such as:
 - a. Carbamazepine,
 - b. Divalproex,
 - c. Gabapentin,
 - d. Lamotrigine,
 - e. Levetiracetam,
 - f. Oxcarbazepine,
 - g. Phenytoin,
 - h. Pregabalin,
 - i. Tiagabine,
 - j. Topiramate,
 - k. Valproic acid,
 - l. Zonisamide

REQUIRED MEDICAL INFORMATION

Chart notes indicating Vimpat will be used as adjunctive therapy

AGE RESTRICTIONS

Covered for 17 years and older

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
XYREM**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Xyrem® is covered for members who meet the following criteria:

- A. Diagnosis of narcolepsy with cataplexy may be approved.
- B. For narcolepsy without cataplexy:
 - a. Previous use of Provigil and an amphetamine have been ineffective, not tolerated or is contraindicated.

REQUIRED MEDICAL INFORMATION

Chart notes indicating:

- A. The diagnosis of excessive daytime sleepiness from narcolepsy as confirmed with a sleep study with symptoms that limit the ability to perform normal daily activities.
- B. OR the diagnosis is documented as cataplexy in patients with narcolepsy as confirmed with a sleep study.

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
ZAVESCA**

COVERED USES

FDA approved indications:

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

COVERAGE POLICY

Zavesca® is covered for members who meet the following criteria:

- A. Documented ineffectiveness or contraindication to enzyme replacement therapy (Ceredase, Cerezyme)
- B. If the patient has previously received 24 months of Zavesca® therapy,
 - a. they must show a decrease in liver and spleen volume
 - b. and/or increases in platelet count
 - c. and/or increases in hemoglobin concentration.

REQUIRED MEDICAL INFORMATION

Lab results including:

- a. Hemoglobin concentration greater than 9 g/dL OR
- b. Platelet count greater than $50 \times 10^9/L$

COVERAGE DURATION

Plan Year



**Family Care Basic
Prior Authorization Criteria
ZYVOX**

COVERED USES

FDA approved indications:

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

REQUIRED MEDICAL INFORMATION

Chart notes indication one of the following:

- A. Patient has a severe allergy to beta lactamase inhibitors AND/OR other susceptible antibiotics AND Culture and sensitivity documenting infection susceptible to linezolid OR
- B. Documentation of ineffectiveness or been intolerant to treatment with other antibiotics that the organism is susceptible OR
- C. Culture and sensitivity results indicating Vancomycin-Resistant Enterococcus faecium infection OR
- D. Culture and sensitivity results indicating MRSA and patient has failed or is intolerant to Vancomycin

PRESCRIBER RESTRICTIONS

Infectious Disease

COVERAGE DURATION

28 days



**Family Care Basic
Prior Authorization Criteria**

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