



2010 Prior Authorization Guidelines

Note: Prior authorization requirements are listed to provide members with information to discuss treatment options with their physicians or health care prescribers.

Drug(s)	Approval Criteria	Required Medical Criteria	Coverage Duration
ACCUNEB NEBULIZER SOLN.	Authorization required only to validate Part B versus Part D coverage	No Part B coverage	Ongoing if no Part B coverage
ALBUTEROL NEBULIZER SOLN.	Authorization required only to validate Part B versus Part D coverage	No Part B coverage	Ongoing if no Part B coverage
AMBIEN	Ambien (brand) is approved for all FDA-approved uses not otherwise excluded by Part D, in patients who have demonstrated a prior trial and failure of generic zolpidem.	Evidence of trials of two generic alternatives.	Approved one year
AMEVIVE	Amevive is approved for the treatment of plaque psoriasis and all FDA-approved indications not otherwise excluded by Part D where patient has demonstrated a trial and failure and adherent use of disease-modifying anti-rheumatic drugs or immunosuppressants or topical therapy, one trial of which must be within 3 months prior to request.	Evidence of a trial and failure of two DMARDs or immunosuppressants including methotrexate and cyclosporine and topical treatment including high-potency corticosteroids and Dovonex.	Approved at six month intervals.
ARANESP	Aranesp is approved for treatment of anemia in end stage renal disease and cancer to maintain hemoglobin levels between 10 and 12 grams per deciliter and for all other FDA-approved uses not otherwise excluded by Part D.	Three months of hemoglobin monitoring and dosage titration to maintain hemoglobin levels within the range of 10 to 12.	Approved for one year.
BOTOX	Botox is approved for all FDA-approved uses not otherwise excluded by Part D.	A prior authorization request for FDA-approved and labeled indications.	Approved for six months.
BYETTA	Byetta is approved for the treatment of Diabetes type 2 in patients whose HbA1c is greater than 7, after prior adherent use of standard first-line therapy including both metformin with a sulfonylurea and metformin with a thiazolidinedione, unless contraindicated.	A prior authorization request with current HbA1c reading greater than 7 and evidence of adherent use of standard first-line therapy as defined under criteria.	Approved for one year.
CELLCEPT	Authorization required only to validate Part B versus Part D coverage	Non-Medicare approved transplant.	Ongoing if non-Medicare approved transplant
COREG	Coreg (brand) is approved for all FDA-approved uses not otherwise excluded by Part D, when a patient has demonstrated a prior trial and failure on generic carvedilol.	Evidence of a trial on and adherent use of generic carvedilol.	Approved for one year.
CROMOLYN NEBULIZER	Authorization required only to validate Part B versus Part D coverage	No Part B coverage	Ongoing if no Part B coverage
ELIDEL	Elidel is approved for the treatment of atopic dermatitis where patient has demonstrated adherent use of medium to high potency corticosteroids in the prior 90 days.	Evidence of adherent use to topical steroids as defined under criteria	Approved for one year.
ENBREL	Enbrel is approved for the treatment of rheumatoid arthritis, juvenile idiopathic arthritis, psoriatic arthritis, plaque psoriasis and ankylosing spondylitis in patients who have evidenced a trial and failure and adherent use of at least two oral disease-modifying anti-rheumatic drugs or immunosuppressants, unless contraindicated, one trial of which must be within 3 months prior to request.	Evidence of a trial and failure and adherent use of at least two oral disease-modifying anti-rheumatic drugs or immunosuppressants, unless contraindicated, one trial of which must be within 3 months prior to request. The treatment must be ordered by a rheumatologist or dermatologist as appropriate to the diagnosis.	Approved for six months.
FENTANYL LOLLIPOPS	Fentanyl Citrate Transmucosal is approved for the treatment of patients with breakthrough cancer pain.	Diagnosis of cancer and use of long-acting pain medications at maximized dosing.	Approved for six months.
FORTEO	Forteo is approved for the treatment of osteoporosis and all FDA-approved indications not otherwise excluded by Part D where patient has demonstrated a trial and failure or intolerance to oral bisphosphonates.	Evidence of adherent trial and failure of oral bisphosphonates unless contraindicated.	Approve for one year.
FOSAMAX	Fosamax (brand) is approved for the treatment of all FDA-approved uses not otherwise excluded by Part D, in patients who have demonstrated a prior trial and failure of generic alendronate.	Evidence of a trial on and adherent use of generic alendronate.	Approved for one year.
GENGRAF	Authorization required only to validate Part B versus Part D coverage	Non-Medicare approved transplant	Ongoing if non-Medicare approved transplant

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GENOTROPIN	Growth hormone is approved for the treatment of growth hormone deficiency for all FDA-approved uses not otherwise excluded by Part D.	Submission of information showing a diagnosis listed under criteria, severe short stature with height more than 2 standard deviations below the mean for chronological age, bone age delay at least one year behind chronological age documented by x-ray, a growth hormone stimulation test reading of less than 10 µg/L and a growth velocity less than normal for patient's age.	Approved for six months.
HUMATROPE	Growth hormone is approved for the treatment of growth hormone deficiency for all FDA-approved uses not otherwise excluded by Part D.	Submission of information showing a diagnosis listed under criteria, severe short stature with height more than 2 standard deviations below the mean for chronological age, bone age delay at least one year behind chronological age documented by x-ray, a growth hormone stimulation test reading of less than 10 µg/L and a growth velocity less than normal for patient's age.	Approved for six months.
HUMIRA	Treatment for rheumatoid arthritis, juvenile idiopathic arthritis, Crohn's disease, psoriatic arthritis, plaque psoriasis or ankylosing spondylitis where patient has evidenced a trial and failure and adherent use of at least two oral disease-modifying anti-rheumatic drugs or immunosuppressants, unless contraindicated, one trial of which must be within 3 months prior to request.	Evidence of a trial and failure and adherent use of at least two oral disease-modifying anti-rheumatic drugs or immunosuppressants, unless contraindicated, one trial of which must be within 3 months prior to request. The treatment must be ordered by a rheumatologist, gastroenterologist or dermatologist as appropriate to the diagnosis.	Approved for six months.
INFERGEN	Infergen is approved for the treatment of Hepatitis C for patients who have relapsed or were non-responders to prior interferon monotherapy. Treatment must be ordered by a gastroenterologist.	Submission of baseline viral load and documentation of prior treatment with interferon. Submission of 12 week labs showing a viral load decrease of at least a 2 log from baseline	Approved for 48 weeks.
INTAL NEBULIZER SOLN.	Authorization required only to validate Part B versus Part D coverage	No Part B coverage	Ongoing if no Part B coverage
JANUVIA	Januvia is approved for the treatment of Diabetes type 2 in patients whose HbA1c is greater than 7, after prior adherent use of standard first-line therapy including both metformin with a sulfonylurea and metformin with a thiazolidinedione, unless contraindicated.	A prior authorization request with current HbA1c reading greater than 7 and evidence of adherent use of standard first-line therapy as defined under criteria.	Approved for one year.
KINERET	Treatment for rheumatoid arthritis in patients who have evidenced trial and failure and adherent use of at least two oral disease-modifying anti-rheumatic drugs or immunosuppressants, unless contraindicated, one trial of which must be within 3 months prior to request.	Evidence of a trial and failure and adherent use of at least two oral disease-modifying anti-rheumatic drugs or immunosuppressants, unless contraindicated, one trial of which must be within 3 months prior to request. The treatment must be ordered by a rheumatologist.	Approved for six months.
LIDODERM PATCHES	Lidoderm Patches are approved for all FDA-approved uses not otherwise excluded by Part D		Approved for six months.
METAPROTERENOL NEBULIZER SOLN.	Authorization required only to validate Part B versus Part D coverage	No Part B coverage	Ongoing if no Part B coverage
MYOBLOC	Myobloc is approved for all FDA-approved uses not otherwise excluded by Part D.	A prior authorization request for FDA approved and labeled indications.	Approved for six months.
NEORAL	Authorization required only to validate Part B versus Part D coverage	Non-Medicare approved transplant	Ongoing if non-Medicare approved transplant
NORDITROPIN	Growth hormone is approved for the treatment of growth hormone deficiency for all FDA-approved uses not otherwise excluded by Part D.	Submission of information showing a diagnosis listed under criteria, severe short stature with height more than 2 standard deviations below the mean for chronological age, bone age delay at least one year behind chronological age documented by x-ray, a growth hormone stimulation test reading of less than 10 µg/L and a growth velocity less than normal for patient's age.	Approved for six months.
NORVASC	Norvasc (brand) is approved for all FDA-approved uses not otherwise excluded by Part D, in patients who have demonstrated a prior trial and failure of generic amlodipine.	Evidence of a trial on and adherent use of generic amlodipine.	Approved one year

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NUTROPIN, NUTROPIN AQ	Growth hormone is approved for the treatment of growth hormone deficiency for all FDA-approved uses not otherwise excluded by Part D.	Submission of information showing a diagnosis listed under criteria, severe short stature with height more than 2 standard deviations below the mean for chronological age, bone age delay at least one year behind chronological age documented by x-ray, a growth hormone stimulation test reading of less than 10 µg/L and a growth velocity less than normal for patient's age.	Approved for six months.
ORTHOCLONE OKT3	Authorization required only to validate Part B versus Part D coverage	Non-Medicare approved transplant	Ongoing if non-Medicare approved transplant
PEGASYS	Pegasys is approved for the treatment of hepatitis C for treatment naïve patients with compensated liver disease and for patients diagnosed with hepatitis B. Treatment must be ordered by a gastroenterologist	Baseline viral load and submission of 12 week lab values showing a viral load decrease of at least a 2 log from baseline	24 weeks for genotypes 2 and 3 or 48 weeks for genotypes 1 and 4.
PEG-INTRON	Peg-Intron is approved for the treatment of hepatitis C for treatment naïve patients with compensated liver disease and for patients diagnosed with hepatitis B. Treatment must be ordered by a gastroenterologist.	Baseline viral load and submission of 12 week lab values showing a viral load decrease of at least a 2 log from baseline	24 weeks for genotypes 2 and 3 or 48 weeks for genotypes 1 and 4.
PROCRIT	Procrit is approved for treatment of anemia in end stage renal disease and cancer to maintain hemoglobin levels between 10 and 12 grams per deciliter and for all other FDA-approved uses not otherwise excluded by Part D.	Three months of hemoglobin monitoring and dosage titration to maintain hemoglobin levels within the range of 10 to 12.	Approved for one year.
PROGRAF	Authorization required only to validate Part B versus Part D coverage	Non-Medicare approved transplant	Ongoing if non-Medicare approved transplant
PROTOPIC	Protopic is approved for the treatment of atopic dermatitis where patient has demonstrated adherent use of medium to high potency corticosteroids in the prior 90 days.	Evidence of adherent use to topical steroids as defined under criteria	Approved for one year.
PROVIGIL	Provigil is approved for the treatment of narcolepsy, obstructive sleep apnea/hypopnea syndrome, shift work sleep disorder. and all FDA-approved indications not otherwise excluded by Part D	Evidence supporting one of the listed diagnoses listed under criteria	Approved for one year.
RAPAMUNE	Authorization required only to validate Part B versus Part D coverage	Non-Medicare approved transplant	Ongoing if non-Medicare approved transplant
REMICADE	Treatment for rheumatoid arthritis, Crohn's disease, ulcerative colitis, psoriatic arthritis, plaque psoriasis or ankylosing spondylitis where patient has evidenced trial and failure and adherent use of at least two oral disease-modifying anti-rheumatic drugs or immunosuppressants, unless contraindicated, one trial of which must be within 3 months prior to request.	Evidence of a trial and failure and adherent use of at least two oral disease-modifying anti-rheumatic drugs or immunosuppressants, unless contraindicated, one trial of which must be within 3 months prior to request. The treatment must be ordered by a rheumatologist, gastroenterologist or dermatologist as appropriate to the diagnosis.	Approved for six months.
SAIZEN	Treatment for growth hormone deficiency evidenced by growth hormone stimulation test results, bone age measurement and growth velocity as appropriate to age.	Submission of information showing a diagnosis listed under criteria, severe short stature with height more than 2 standard deviations below the mean for chronological age, bone age delay at least one year behind chronological age documented by x-ray, a growth hormone stimulation test reading of less than 10 µg/L and a growth velocity less than normal for patient's age.	Approved for six months.
SANDIMMUNE	Authorization required only to validate Part B versus Part D coverage	Non-Medicare approved transplant	Ongoing if non-Medicare approved transplant
SEROSTIM	Serostim is approved for the treatment of all FDA-approved uses not otherwise excluded by Part D.	Diagnosis appropriate to FDA labeled indications.	Approved for six months.
SIMULECT	Authorization required only to validate Part B versus Part D coverage	Non-Medicare approved transplant	Ongoing if non-Medicare approved transplant
SOMAVERT	Somavert is approved for the treatment of acromegaly.	Confirmed diagnosis of acromegaly inadequate response to surgery and/or radiation therapy and bromocriptine	Approved for six months.

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SYMLIN	Symlin is approved for the treatment of Diabetes types 1 or 2 in patients whose HbA1c is greater than 7, after prior adherent use of standard first-line therapy.	Diabetes type 1 patients: HbA1c reading and adherent use to short acting and basal insulins. Diabetes type 2 patients: HbA1c reading and evidence of prior adherent use of standard first-line therapy including both metformin with a sulfonylurea and metformin with a thiazolidinedione, unless contraindicated.	Approved for one year.
TEV-TROPIN	Growth hormone is approved for the treatment of growth hormone deficiency for all FDA-approved uses not otherwise excluded by Part D.	Submission of information showing a diagnosis listed under criteria, severe short stature with height more than 2 standard deviations below the mean for chronological age, bone age delay at least one year behind chronological age documented by x-ray, a growth hormone stimulation test reading of less than 10 µg/L and a growth velocity less than normal for patient's age.	Approved for six months.
THYMOGLOBULIN	Authorization required only to validate Part B versus Part D coverage	Non-Medicare approved transplant	Ongoing if non-Medicare approved transplant
XOLAIR	Xolair is approved for the treatment of allergic asthma and all FDA-approved indications not otherwise excluded by Part D, where patient has demonstrated adherent use of combined therapy with inhaled corticosteroids, long acting beta agonists and a leukotriene modifier in the 90 days prior to the request	Prescription history evidence of adherence to inhaled corticosteroids along with long-acting beta agonists and a leukotriene modifier for at least 3 months prior to request. Submission of IgE serum levels between 30 and 700 IU per milliliter.	Approved for six months.
XOPENEX NEBULIZER SOLN	Authorization required only to validate Part B versus Part D coverage	No Part B coverage	Ongoing if no Part B coverage
ZENAPAX	Authorization required only to validate Part B versus Part D coverage	Non-Medicare approved transplant	
ZOFRAN	Zofran (brand) is approved for all FDA-approved uses not otherwise excluded by Part D, when a patient has demonstrated a prior trial and failure on generic ondansetron.	Evidence of a trial on and adherent use of generic ondansetron.	Approved for six months.
ZORBIVE	Zorbive is approved for the treatment of short-bowel syndrome in patients receiving specialized nutritional support.	Evidence of the diagnosis listed under criteria	Approved for six months.