



Care N Care
Prior Authorization Criteria
ACETYLCYSTEINE

COVERAGE POLICY

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.



Care N Care
Prior Authorization Criteria
ADAGEN

COVERED USES

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

COVERAGE POLICY

Adagen is covered for members who meet the following criteria:

- A. Documented diagnosis of Adenosine Deaminase (ADA) deficiency
- B. AND patient has failed bone marrow transplantation or is not a suitable candidate for bone marrow transplantation
- C. AND is being used for direct replacement for deficient enzyme (no benefit achieved in patients with immunodeficiency due to other causes)

NON COVERAGE

Adagen is NOT covered for members with the following criteria:

- A. Patient has diagnosis of severe thrombocytopenia
- B. Patient with bone marrow transplantation

REQUIRED MEDICAL INFORMATION

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

- A. Documentation showing patient has failed bone marrow transplantation or is not a suitable candidate for bone marrow transplantation.

PRESCRIBER RESTRICTIONS

Endocrinologist

COVERAGE DURATION

Plan Year



**Care N Care
Prior Authorization Criteria
AFINITOR**

COVERED USES

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

COVERAGE POLICY

- 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



Care N Care
Prior Authorization Criteria
AVONEX

COVERED USES

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

COVERAGE POLICY

Avonex is covered for members who meet the following criteria:

- A. The diagnosis is documented as Relapsing-Remitting Multiple Sclerosis.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation showing the diagnosis is Relapsing-Remitting Multiple Sclerosis. (Avonex does not have the indication for primary progressive, secondary progressive or progressive relapsing)

PRESCRIBER RESTRICTIONS

Neurologist

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
AZATHIOPRINE

COVERAGE POLICY

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.



Care N Care
Prior Authorization Criteria
BYETTA

COVERED USES

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

COVERAGE POLICY

Byetta is covered for members who meet the following criteria:

- A. The patient is diagnosed as having type-2 diabetes.
- B. AND the patient has an HbA1c level greater than 7.
- C. AND the patients current drug therapy includes metformin (eg. Metformin, Avandia, or ActoPlus Met) and therapy has been escalated to the highest tolerated dose, (Please verify that the patient has received metformin therapy by reviewing the patients drug history). OR if the patient is unable to take metformin due to clinical contraindications they can substitute the metformin requirement with a maximum tolerated dose of a sulfonylurea (chlorpropamide, tolazamide, glipizide, glimepiride, or glyburide).
- D. AND the patient's current drug therapy includes a thiazolidinedione (eg. Avandia, Avandia, Actos or ActoPlus Met) and therapy has been escalated to the highest tolerated dose. (Please verify that the patient has received thiazolidinedione therapy by reviewing the patient's drug history).
- E. AND the patient has a creatinine clearance of greater than 30 ml/minute or normal kidney function.
- F. AND if the patient has received previous Byetta therapy, the physician must show a documented reduction in the patients HbA1c since initiating Byetta therapy.

NON COVERAGE

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

- A. If the patient has any of the following contraindications: Colitis, cresol hypersensitivity, Crohn's disease, diabetic ketoacidosis, gastroparesis, GI bleeding, GI disease, GI obstruction, GI perforation, hypoglycemia, ileus, inflammatory bowel disease, pseudomembranous colitis, renal failure, ulcerative colitis.
- B. If the patient is taking Gatifloxacin.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation showing the patient has type-2 diabetes.
- B. Documentation showing the patient has an HbA1c level greater than 7.
- C. Documentation showing the patient's current drug therapy includes metformin (eg. Metformin, Avandia, or ActoPlus Met) and therapy has been escalated to the highest tolerated dose, or if the patient is unable to take metformin due to clinical contraindications they can substitute the metformin requirement with a maximum tolerated dose of a sulfonylurea.
- D. Documentation showing the patient's current drug therapy includes a thiazolidinedione (eg. Avandia, Avandia, Actos or ActoPlus Met) and therapy has been escalated to the highest tolerated dose.
- E. Documentation showing the patient has a creatinine clearance of greater than 30 ml/minute or normal kidney function.



Care N Care
Prior Authorization Criteria
BYETTA
(Continued)

- F. If the patient has received previous Byetta therapy, the physician must show a documented reduction in the patient's HbA1c since initiating Byetta therapy.

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
CELLCEPT

COVERED USES

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

COVERAGE POLICY

Cellcept is covered for members who meet the following criteria:

- A. AND diagnosis is documented as the prophylaxis of organ rejection in a patient receiving or received an organ transplant.
- B. AND the transplant was NOT covered by Medicare Part A/B. (Please verify the payer of the transplant. If Medicare paid for the transplant, Cellcept is covered by Medicare Part A/B).

NON COVERAGE

Cellcept is NOT covered for members with the following criteria:

- A. If the patient is pregnant.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation that if the patient is female and of childbearing years, she is not pregnant.
- B. Documentation showing diagnosis for the prophylaxis of organ rejection in a patient receiving or who has received an organ transplant.
- C. Documentation showing the transplant was NOT covered by Medicare Part A/B.

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
CEREZYME

COVERED USES

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

COVERAGE POLICY

Cerezyme is covered for members who meet the following criteria:

- A. Diagnosis is documented as mild-to-moderate type-1 Gaucher disease.
- B. AND diagnosis has been confirmed by bone marrow histology, DNA testing or measurement of b-glucocerebrosidase enzyme activity less than 30%.
- C. AND the patient has at least one of the following conditions: Anemia, thrombocytopenia, bone disease, hepatomegaly or splenomegaly.
- D. AND if the patient has previously received 24 months of Cerezyme therapy, they must show a decrease in liver and spleen volume and/or increases in platelet count and/or increases in hemoglobin concentration since starting therapy.

NON COVERAGE

Cerezyme is NOT covered for members with the following criteria:

- A. If the patient is taking Miglustat.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation showing diagnosis as mild-to-moderate type-1 Gaucher disease.
- B. Documentation that diagnosis has been confirmed by bone marrow histology, DNA testing or measurement of b-glucocerebrosidase enzyme activity less than 30%.
- C. Documentation showing the patient has at least one of the following conditions: Anemia, thrombocytopenia, bone disease, hepatomegaly or splenomegaly.
- D. Documentation if the patient has previously received 24 months of Cerezyme therapy, they must show a decrease in liver and spleen volume and/or increases in platelet count and/or increases in hemoglobin concentration since starting therapy.

PRESCRIBER RESTRICTIONS

Endocrinologist

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
COPAXONE

COVERED USES

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

COVERAGE POLICY

Copaxone is covered for members who meet the following criteria:

- A. AND the diagnosis is documented as Relapsing-Remitting Multiple Sclerosis. (Copaxone does not have the indication for primary progressive, secondary progressive or progressive relapsing multiple sclerosis).
- B. AND the patient has a history of at least two focal neurological deficits (e.g., loss of vision, double vision, localized numbness, localized weakness, walking gait abnormalities, slurred speech, tingling) in which the second deficit followed after the resolution of the first deficit.
- C. AND the patient will NOT be receiving Copaxone therapy in combination with interferon-beta therapy (e.g., Rebif, Avonex, or Betaseron) or mitoxantrone. (Please verify that the patient is not on duplicate therapy by reviewing the patients drug history or chart).
- D. AND if the patient has received previous Copaxone therapy, the provider can document a decrease in the frequency of clinical relapses OR slowing in the progression of the disease OR the patient has remained stable OR lesions on MRI have diminished after initiating therapy.

NON COVERAGE

Copaxone is NOT covered for members with the following criteria:

- A. If the patient has hypersensitivity to mannitol.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation showing diagnosis as Relapsing-Remitting Multiple Sclerosis. (Copaxone does not have the indication for primary progressive, secondary progressive or progressive relapsing multiple sclerosis).
- B. Documentation showing the patient has a history of at least two focal neurological deficits (e.g., loss of vision, double vision, localized numbness, localized weakness, walking gait abnormalities, slurred speech, tingling) in which the second deficit followed after the resolution of the first deficit.
- C. Documentation that the patient will NOT be receiving Copaxone therapy in combination with interferon-beta therapy (e.g., Rebif, Avonex, or Betaseron) or mitoxantrone.
- D. Documentation if the patient has received previous Copaxone therapy, the provider can document a decrease in the frequency of clinical relapses OR slowing in the progression of the disease OR the patient has remained stable OR lesions on MRI have diminished after initiating therapy.

PRESCRIBER RESTRICTIONS

Neurologist

COVERAGE DURATION

Plan Year



**Care N Care
Prior Authorization Criteria
CYKLOKAPRON**

COVERED USES

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

COVERAGE POLICY

Cyklokapron is covered for members who meet the following criteria:

- A. Patient is diagnosed with an FDA approved indication.
- B. AND the patient meets B vs. D determination that requires Medicare Part D payment

NON COVERAGE

Cyklokapron is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications: Renal insufficiency, subarachnoid hemorrhage, acquired defective color vision, active intravascular clotting processes or Thromboembolic disease.
- B. If the patient is taking/receiving any of the following: Anti-inhibitor coagulant complex, Chlorpromazine, clotting factors: disseminated intravascular coagulation, Estrogens, Thrombolytic agents or Tretinoin.

COVERAGE DURATION

1 month



Care N Care
Prior Authorization Criteria
CYTARABINE

COVERED USES

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

COVERAGE POLICY

Cytarabine is covered for members who meet the following criteria:

- A. Patient is diagnosed with an FDA approved indication.
- B. AND the patient meets B vs. D determination that requires Medicare Part D payment

NON COVERAGE

Cytarabine is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications: Benzyl alcohol hypersensitivity or breast feeding.
- B. If the patient is receiving live vaccines

PRESCRIBER RESTRICTIONS

Oncologist

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
CYTOXAN

COVERAGE POLICY

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.



Care N Care
Prior Authorization Criteria
DACOGEN

COVERED USES

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

COVERAGE POLICY

Dacogen is covered for members who meet the following criteria:

- A. Patient is diagnosed with Myelodysplastic Syndrome
- B. AND B vs. D criteria is met to ensure coverage should be through Medicare Part D

NON COVERAGE

Dacogen is NOT covered for members with the following criteria:

- A. If the patient is receiving live vaccines
- B. Patient is pregnant

PRESCRIBER RESTRICTIONS

Oncologist

COVERAGE DURATION

24 weeks



Care N Care
Prior Authorization Criteria
EPIDUO

COVERED USES

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

COVERAGE POLICY

Epiduo is covered for members who meet the following criteria:

- A. Patient must be diagnosed with acne
- B. Patient must have previous trial/failure of at least TWO of the following:
 - a. Tretinoin
 - b. Erythromycin (topical)
 - c. Doxycycline (oral)
 - d. Minocycline (oral)

REQUIRED MEDICAL INFORMATION

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

- A. Documentation of diagnosis 2
- B. Documentation of previous trial/failure of at least two of the following:
 - a. Tretinoin
 - b. Erythromycin (topical)
 - c. Doxycycline (oral)
 - d. Minocycline (oral)

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
ERAXIS

COVERED USES

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

COVERAGE POLICY

Eraxis is covered for members who meet the following criteria:

- A. The diagnosis is documented as candidemia or another Candida infection
- B. AND the patient has completed a documented trial and failure of Fluconazole B
- C. AND verification of all B vs. D criteria indicate coverage by Part D

REQUIRED MEDICAL INFORMATION

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

- A. Documentation of previous trial/failure of Fluconazole

AGE RESTRICTIONS

Patient must be 2 years of age or greater

PRESCRIBER RESTRICTIONS

Infectious Disease

COVERAGE DURATION

6 Months



Care N Care
Prior Authorization Criteria
ERYTHROPOIESIS STIMULATING AGENTS

COVERED USES

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

COVERAGE POLICY

Erythropoiesis is covered for members who meet the following criteria:

- A. Lab values have been completed within 30 days of the request.
- B. AND the patient's hemoglobin is less than or equal to 11 g/dL OR hematocrit Less than or equal to 33%.
- C. AND/OR the patient has received Erythropoiesis within the last 12 weeks and the patient's hemoglobin is less than 12 g/dL OR hematocrit less than 36%.
- D. AND the patient's transferrin saturation is at least 20%.
- E. AND the patient's ferritin level is at least 100 ng/mL.
- F. AND if the patient has previously received Erythropoiesis therapy, the patient has experienced an increase in hemoglobin or hematocrit since the initial Erythropoiesis treatment and therapy is needed to maintain the patient's current hemoglobin or hematocrit level.
- G. AND the diagnosis is documented as treatment for a surgery patient who is at high risk for perioperative blood loss.
 - a. AND the patient is receiving iron supplementation.
 - b. AND surgery is within 30 days of request.
- H. OR the diagnosis is documented as the treatment of anemia associated with chronic renal failure.
 - a. AND the patient is NOT on dialysis.
 - b. AND/OR the patient has received previous Erythropoiesis therapy within the last 12 weeks.
- I. OR the diagnosis is documented as treatment of anemia in an HIV-infected patient.
 - a. AND it is the initial request for Erythropoiesis (Patient has not received Erythropoiesis therapy for at least 12 weeks):
 - b. AND the patient is on anti-retroviral therapy.
 - c. OR the patient has received previous Erythropoiesis therapy within the last 12 weeks.
 - d. AND the patient is on anti-retroviral therapy.
 - e. AND the patient's serum Erythropoiesis level was less than or equal to 500 mUnits/mL at the time therapy was initiated.
- J. OR the diagnosis is documented as treatment of anemia in cancer patients on chemotherapy.
 - a. AND it is the initial request for Erythropoiesis (Patient has not received Erythropoiesis therapy for at least 12 weeks):
 - b. AND the patient has a non-myeloid malignancy.
 - c. AND the patient is receiving a chemotherapy regimen to treat the non-myeloid malignancy.
 - d. AND the patient's serum Erythropoiesis level is Less than or equal to 200 mUnits/mL.

ERYTHROPOIESIS STIMULATING AGENTS



Care N Care
Prior Authorization Criteria
(Continued)

- e. OR the patient has received previous Erythropoiesis therapy within the last 12 weeks.
- f. AND the patient has a non-myeloid malignancy.
- g. AND the patient is receiving a chemotherapy regimen to treat the non-myeloid malignancy.
- h. AND the patient's serum Erythropoiesis level was less than or equal to 200 mUnits/mL at the time therapy was initiated.
- K. OR the diagnosis is documented as anemia secondary to myelodysplasia.
 - a. AND it is the initial request for Erythropoiesis (Patient has not received EPO therapy for at least 12 weeks):
 - b. AND the patient's serum Erythropoiesis level is less than or equal to 500 mUnits/mL.
 - c. OR the patient has received previous Erythropoiesis therapy within the last 12 weeks.
 - d. AND the patient's serum Erythropoiesis level was less than or equal to 500 mUnits/mL at the time therapy was initiated.

NON COVERAGE

Erythropoiesis is not covered for members who meet the following criteria:

- A. If the patient has any of the following contraindication, albumin hypersensitivity, benzyl alcohol hypersensitivity, hamster protein hypersensitivity, uncontrolled hypertension, red cell aplasia, hemoglobin concentration greater than 12 g/dl, surgery prophylaxis or if the patient is receiving Darbepoetin Alfa.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation showing transferrin levels within the last 30 days of at least 20%
- B. Documentation showing ferritin levels within the last 30 days of at least 100 ng/ml
- C. Documentation showing hemoglobin within the last 30 days below 10 g/dL OR documentation showing hematocrit within the last 30 days below 33%
- D. If the diagnosis is anemia due to renal failure:
 - a. Documentation showing patient is NOT on dialysis

COVERAGE DURATION

12 weeks



Care N Care
Prior Authorization Criteria
ETHYOL

COVERED USES

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

COVERAGE POLICY

Amifostine is covered for members who meet the following criteria:

- A. Patient is being treated for FDA indication.
- B. AND B vs. D criteria indicates coverage should be through Medicare Part D

NON COVERAGE

Amifostine is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications: dehydration, exfoliative dermatitis, hypotension or mannitol hypersensitivity.

PRESCRIBER RESTRICTIONS

Oncologist

COVERAGE DURATION

6 months



Care N Care
Prior Authorization Criteria
EXJADE

COVERED USES

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

COVERAGE POLICY

Exjade is covered for members who meet the following criteria:

- A. Patient has a diagnosis of transfusion-dependent anemia (β -thalassemia, sickle cell disease, Diamond-Blackfan anemia, or myelodysplastic syndrome) and chronic iron overload due to blood transfusions, evidenced by serum ferritin 1,000-8,000ng/mL.
- B. Patient failed Desferal therapy due to compliance or is unable to use it (documentation of noncompliance, adverse effects, and/or contraindications).

NON COVERAGE

Exjade is NOT covered for members with the following criteria

- A. If the patient is taking/receiving any of the following: Deferoxamine, Iron Dextran, Iron Salts, Iron Sucrose, Polysaccharide-Iron Complex or Sodium Ferric Gluconate Complex.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation of ferreting levels within the last 60 days of at least 1000 ng/MI
- B. Documentation of previous trial/failure of Desferal therapy

PRESCRIBER RESTRICTIONS

Hematologist

COVERAGE DURATION

3 months



**Care N Care
Prior Authorization Criteria
FABRAZYME**

COVERED USES

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

COVERAGE POLICY

Fabrazyme is covered for members who meet the following criteria:

- A. Diagnosis is documented as a patient with Fabry disease.
- B. AND the diagnosis has been confirmed with an enzyme assay measuring a deficient activity of alpha-galactosidase enzyme.

NON COVERAGE

Fabrazyme is NOT covered for members with the following criteria:

- A. Known hypersensitivity to mannitol.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation of alpha-galactosidase enzyme deficiency

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
FORTEO

COVERED USES

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

COVERAGE POLICY

Forteo is covered for members who meet the following criteria:

- A. Patient has NOT been diagnosed with Pagets disease nor has high levels of alkaline phosphatase.
- B. AND the patient does NOT have pre-existing hypercalcemia, skeletal malignancies, or prior radiation therapy involving the skeleton.
- C. AND diagnosis is documented as postmenopausal women with osteoporosis or a man with primary or hypgonadal osteoporosis.
- D. AND the patient has at least two of the following fracture risk fractures:
 - a. T score Less than or equal to - 2.5.
 - b. Prior fragility fracture (Counts as two risk fractures).
 - c. Family history (1st degree relative).
- E. AND the patient has failed to have an adequate response to treatment with a bisphosphonate therapy (Fosamax, alendronate, Actonel, risedronate, Boniva and/or Reclast) for at least 1 year. (Please verify that the patient has received bisphosphonate therapy by reviewing the patient's drug history or patients chart).
- F. AND patient has NOT had accumulative Forteo therapy for more than 24 months (Lifetime therapy).
- G. AND evidence of diagnosis, risk fractures, and tried bisphosphonate therapy is documented in patients chart notes provided by prescribing provider.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation of normal alkaline phosphate levels
- B. Documentation showing the patient has at least two of the following risk fractures:
 - a. T score Less than or equal to - 2.5.
 - b. Prior fragility fracture (Counts as two risk fractures).
 - c. Family history (1st degree relative).
- C. Documentation of previous trial/failure with at least one year therapy with a bisphosphonate
- D. Documentation showing previous Forteo therapy (or lack of previous trial)

AGE RESTRICTIONS

Patient is 70 years or older (50 if female)

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
HEPATITIS C

COVERED USES

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

COVERAGE POLICY

Treatment will be approved when any of the following indication(s) exists:

- A. Chronic Hepatitis C Virus (HCV), Genotype 1 or 4
 - a. Recent lab reports documenting elevated HCV RNA are required, along with genotype.
 - b. Request is initiated by a GI or infectious disease specialist.
 - c. Initial authorization will be given for 12 weeks. At 12 weeks, an early viral response (EVR) must be documented via repeat HCV RNA assay. (EVR during the first 12 weeks is predictive of the patient's viral response³).
 - d. For patients with a greater than 2log reduction in viral load, therapy may be continued up to a total of 48 weeks treatment.
 - e. For patients who fail to achieve a 2log reduction, treatment should be discontinued. These patients have a less than 2% chance of achieving an SVR with continued therapy^{3, 4}.
- B. Chronic Hepatitis C Virus (HCV), Genotype 2, 3, 5, or 6
 - a. Recent lab reports documenting elevated HCV RNA are required, along with genotype.
 - b. Request is initiated by a GI or infectious disease specialist.
 - c. Initial authorization will be given for 12 weeks. At 12 weeks, an early viral response (EVR) must be documented via repeat HCV RNA assay. (EVR during the first 12 weeks is predictive of the patient's viral response³).
 - d. For patients with a greater than 2log reduction in viral load, therapy may be continued up to a total of 24 weeks treatment.
 - e. For patients who fail to achieve a 2log reduction, treatment should be discontinued. These patients have a less than 2% chance of achieving an SVR with continued therapy^{3, 4}.
- C. Retreatment (not approvable)
Re-treatment of non-responders to standard interferon-ribavirin combinations is not generally indicated, and therefore will not be approved. Only 15-20% of nonresponders achieve an SVR upon re-treatment. Response rates are even poorer for those with Genotype 1. 2. For patients who have relapsed after combination treatment, re-treatment is generally not indicated and is currently being studied. Upon re-treatment, most of these patients relapse as well
- D. OR the indication is documented as chronic hepatitis B
 - a. AND the patient has evidence of a positive HBsAg (+ or -) serological marker for greater than 6 months
 - b. OR evidence by a liver biopsy showing chronic hepatitis
 - c. AND the patient has a Hepatitis B viral load greater than 100,000 copies per ml AND the patient has elevations in liver aminotransferases (ALT or AST) that are two (2) times greater than normal



Care N Care
Prior Authorization Criteria
HEPATITIS C
(Continued)

- d. AND the patient is not receiving duplicate therapy that includes PegIntron, Intron-A, Hepsera, Tyzeka, and Epivir AND if the patient has received previous Pegasys treatment, there is documented clinical improvement shown by a drop in viral load or reduction in the patients liver aminotransferases

NON COVERAGE POLICY

Hepatitis C medications will not be covered if the patient meets any of the following
Contraindications and Cautions:

- A. Current psychosis or a history of psychosis.
- B. Severe depression
- C. Severe thrombocytopenia
- D. Decompensated cirrhosis.
- E. Pregnancy, or unwillingness to use effective contraception
- F. Renal insufficiency
- G. Severe heart disease.
- H. Current infection

REQUIRED MEDICAL INFORMATION

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

- A. Documentation of diagnosis
- B. If patient is diagnosed with Hepatitis C:
 - a. Documentation showing Hepatitis C genotype
 - b. Documentation showing baseline HCV RNA levels that are dated within the last 90 days
- C. If request is for treatment for Hepatitis C beyond initial 12 weeks:
 - a. Documentation of Early Viral Response (EVR) showing at least a 2 log reduction from baseline HCV RNA levels
- D. If request is for Hepatitis B:
 - a. Documentation of positive HBsAg OR liver biopsy showing chronic hepatitis
 - b. Documentation of Hepatitis B viral load greater than 100000 copies/ML
 - c. Documentation of elevated liver enzymes showing AST greater than 69 units/L AND ALT greater than 71 units/L

PRESCRIBER RESTRICTIONS

Infectious Disease and Gastroenterology

COVERAGE DURATION

12 weeks



Care N Care
Prior Authorization Criteria
HEPSERA

COVERED USES

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

COVERAGE POLICY

Hepsera is covered for members who meet the following criteria:

- A. AND the patient has been diagnosed with chronic hepatitis B.
- B. AND the patient has evidence of a positive HBsAg (+ or -) serological marker for greater than 6 months OR evidence by a liver biopsy showing chronic hepatitis. (Please verify that the patient has a HBsAg serological marker for greater than 6 months or a positive liver biopsy by reviewing the patients drug history or chart).
- C. AND the patient has a Hepatitis B viral load greater than 100,000 copies per ml.
- D. AND the patient has elevations in liver aminotransferases (ALT or AST) that are two (2) times greater than normal.
- E. AND the patient has been tested for HIV. (Hepsera therapy can cause HIV resistance in untreated HIV infection).
- F. AND if the patient has received previous Hepsera treatment, there is documented clinical improvement shown by a drop in viral load or reduction in the patients liver aminotransferases. (Please verify patients chart notes to verify drop in viral load or reduction in liver aminotransferases from their starting level).
- G. AND the patient is not receiving duplicate therapy that includes Baraclude, Tyzeka, Epivir, Intron A and/or Infergen. (Please verify that the patient does not have duplicate therapy by reviewing the patient's drug history or chart).
- H. AND evidence of diagnosis, serological markers, liver biopsy, viral load, and liver aminotransferases is documented in patients chart.

NON COVERAGE

Hepsera is NOT covered for members with the following criteria:

- A. If the patient has any of the following conditions: hepatic disease, human immunodeficiency virus (HIV) or renal impairment.
- B. If the patient is taking/receiving Emtricitabine; Tenofovir, Tenofovir or PMPA.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation of positive HBsAg OR liver biopsy showing chronic hepatitis
- B. Documentation of Hepatitis B viral load greater than 100000 copies/MI
- C. Documentation of elevated liver enzymes showing AST greater than 69 units/L AND ALT greater than 71 units/L

AGE RESTRICTIONS

Patient is age 12 years or older.

PRESCRIBER RESTRICTIONS

Gastroenterologist or Infectious Disease

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
HUMIRA

COVERED USES

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

COVERAGE POLICY

Humira is covered for members who meet the following criteria:

- A. The patient will NOT receive combination therapy with other biologic and/or retinoid therapy. (Eg. Enbrel, Remicade, Kineret, Orenzia, Soriatane Tysabri, Raptiva and Rituxan).
- B. AND if the patient has received previous Humira therapy, the provider must show an improvement in clinical symptoms.
- C. AND if the diagnosis is documented as moderate to severe active rheumatoid arthritis.
 - a. AND the patient has at least four (4) of the following symptoms:
 - i. Morning stiffness.
 - ii. Arthritis of three (3) or more joint areas.
 - iii. Arthritis of hand joints.
 - iv. Symmetric arthritis.
 - v. Rheumatoid nodules.
 - vi. Serum rheumatoid factor.
 - vii. Radiographic changes.
 - b. AND the patient has had at least an 8-week maximum tolerated dose trial and failure to at least two of the following:
 - i. Methotrexate
 - ii. Cyclosporine
 - iii. Azathioprine
 - iv. Penicillamine
 - v. Sulfasalazine
 - vi. Leflunomide
 - vii. gold products
 - viii. hydroxychloroquine.
- D. OR the diagnosis is juvenile rheumatoid arthritis.
 - a. AND the patient has had at least a 6-week duration of persistent arthritis in one or more joints.
 - b. AND the patient has had at least an 8-week maximum tolerated dose trial and failure to at least two of the following:
 - i. Methotrexate
 - ii. Cyclosporine
 - iii. Azathioprine
 - iv. Penicillamine
 - v. Sulfasalazine
 - vi. Leflunomide
 - vii. gold products
 - viii. hydroxychloroquine.
- E. OR the diagnosis is documented as psoriatic arthritis.
 - a. AND the patient has at least one of the following symptoms:



Care N Care
Prior Authorization Criteria
HUMIRA
(Continued)

- i. Three (3) or more swollen joints.
 - ii. Three (3) or more tender joints.
 - b. AND the patient has had at least an 8-week maximum tolerated dose trial and failure to at least two of the following:
 - i. Methotrexate
 - ii. Cyclosporine
 - iii. Azathioprine
 - iv. Penicillamine
 - v. Sulfasalazine
 - vi. Leflunomide
 - vii. gold products
 - viii. hydroxychloroquine.
- F. OR the diagnosis is documented as active ankylosing spondylitis.
 - a. AND the patient has tried and failed at least a 60-day trial of at least two NSAID drugs.
- G. OR the diagnosis is documented as chronic moderate to severe plaque psoriasis.
 - a. AND the patient has had the disease for 1 year or greater.
 - b. AND the involvement of plaque psoriasis is 10% or greater of the patient's total body surface area (BSA)
 - c. OR if the BSA is less than 10%, the plaque psoriasis must involve areas that will prevent the patient from performing crucial daily functions such as walking (eg. feet).
 - d. AND the patient has tried and failed at least a 60-day trial of two (2) of the following:
 - i. High potency topical steroid treatment
 - ii. Calcipotriene,
 - iii. Phototherapy
 - iv. Retinoids (Soriatane)
 - v. Methotrexate
 - vi. Cyclosporine.
- H. OR the diagnosis is documented as Crohn's Disease:
 - a. AND the patient has tried, failed and/or had an inadequate response to a 60-day trial of at least two Crohn's disease conventional therapies that may include the following:
 - i. Sulfasalazine
 - ii. Balsalazide
 - iii. Mesalamine
 - iv. Asacol
 - v. Canasa
 - vi. Lialda
 - vii. Pentasa
 - viii. Rowasa
 - ix. Azathioprine

Care N Care
Prior Authorization Criteria
HUMIRA
(Continued)

- x. Cyclosporine
- xi. Methotrexate
- xii. Mercaptopurine
- xiii. Purinethol.

NON COVERAGE

Humira is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications: infection, influenza or sepsis.
- B. If the patient is taking/receiving any of the following Abatacept, Anakinra, Etanercept, Infliximab or Riloncept.

REQUIRED MEDICAL INFORMATION

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

- A. If the patient has previously received Humira therapy, documentation showing improvement in clinical symptoms
- B. If the diagnosis is Rheumatoid Arthritis, Juvenile Rheumatoid Arthritis, or Psoriatic Arthritis:
 - a. Documentation of the patient showing at least 4 symptoms
 - b. OR documentation of patient experiencing at least 6-weeks of persistent arthritis in one or more joints
 - c. OR documentation the patient has three swollen joints or three tender joints
 - d. AND documentation of previous trial/failure of an 8-week trial or more of at least two of the following agents:
 - i. Methotrexate
 - ii. Cyclosporine (Neoral), (Sandimmune), (Gengraf)
 - iii. Azathioprine (Imuran)
 - iv. Penicillamine (Cuprimine), (Depen)
 - v. Sulfasalazine (Azulfidine)
 - vi. Leflunomide (Arava)
 - vii. Gold sodium thiomalate (Aurolate)
 - viii. Aurothioglucose (Solganal)
 - ix. Auranofin (Ridaura)
 - x. Hydroxychloroquine (Plaquenil)
- C. If the diagnosis is Ankylosing Spondylitis:
 - a. Documentation of previous 60-day trial of at least two NSAIDs
- D. If the diagnosis is Plaque Psoriasis:
 - a. Documentation patient has had disease for at least 1 year
 - b. Documentation showing affected area is greater than 10% of body surface area OR an area that will affect crucial daily function (i.e. feet)
 - c. Documentation of previous 60-day trial to at least two of the following:
 - i. High potency topical steroid treatment
 - ii. Calcipotriene (Dovonex)
 - iii. Phototherapy
 - iv. Retinoids (Soriatane)



Care N Care
Prior Authorization Criteria
HUMIRA
(Continued)

- v. Methotrexate
- vi. Cyclosporine
- E. If the diagnosis is Crohn's Disease:
 - a. Documentation of previous 60-day trial to at least two of the following:
 - i. Sulfasalazine (Azulfidine)
 - ii. Balsalazide (Colazal)
 - iii. Mesalamine (Asacol), (Canasa), (Lialda), (Pentasa), (Rowasa)
 - iv. Azathioprine (Imuran)
 - v. Cyclosporine (Neoral), (Sandimmune), (Gengraf)
 - vi. Methotrexate
 - vii. Mercaptopurine (Purinethol)

AGE RESTRICTIONS

- A. For Juvenile Rheumatoid Arthritis the age of the patient is 17 years old or less.
- B. For chronic moderate to severe plaque psoriasis the patient's age is 18 years old or older.

PRESCRIBER RESTRICTIONS

Rheumatologist, Dermatologist and Gastroenterology

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
INCRELEX

COVERED USES

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

COVERAGE POLICY

Increlex is covered for members who meet the following criteria:

- A. The patient is not being treated with chronic anti-inflammatory steroids.
- B. AND the diagnosis is documented as the treatment of growth failure in a child with severe primary IGF-1 deficiency or with growth hormone gene deletion who have developed neutralizing antibodies to growth hormone.
- C. AND the patient has a basal IGF-1 standard deviation score Less than or equal to -3 based on lab reference for age and sex. (Please verify the IGF-1 level in the patient s chart notes and ensure the test was performed within 3 months of the initial request).
- D. AND the patient has a normal or elevated growth hormone level that has been confirmed with at least one growth hormone stimulation test. (Please verify the stimulation test result in the patient s chart notes).
- E. AND the patient has severe growth retardation with a height standard deviation (SDS) score more than 3 SDS below the mean for chronological age and sex and their target height based on mid-parental height calculation. (Please verify the SDS score in the patient s chart notes).
- F. AND all indications of secondary IGF-1 have been ruled out such as growth hormone deficiency, hypothyroidism and malnutrition.
- G. AND the patient is not taking or has no plans to receive growth hormone therapy in combination with Increlex therapy. (Please review the patient s drug history or drug chart to verify that the patient will not be receiving growth hormone therapy (e.g. Humatrope, Genotropin, Norditropin, Serostim, Nutropin, Saizen, Tev-Tropin, Zorbtive).
- H. AND if the patient has received previous mescasermin therapy, the patient must meet all of the following criteria:
 - a. There has been an increase in height velocity Greater than 2.5 cm total growth in one year of therapy
 - b. There is no evidence of epiphyseal closure.
 - c. The patient has NOT met their expected final adult height or targeted height based on mid-parental height calculation or their current absolute height is Less than or equal to 25th percentile (defined as 68 inches in males and 63 inches in females).

NON COVERAGE

Increlex is not covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications: benzyl alcohol hypersensitivity, epiphyseal closure, intravenous administration, neonates or neoplastic disease.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation showing patient's epiphyses are NOT closed
- B. Documentation showing patient has NO active malignancy



Care N Care
Prior Authorization Criteria
INCRELEX
(Continued)

- C. Documentation of IGF-1 standard deviation score of less than -2.9 based on lab reference for age and sex
- D. If requesting retreatment:
- E. Documentation of an increase in height velocity greater than 2.5 cm total growth in one year
- F. Documentation patient has NOT met final expected adult height based on mid-parental height calculation

AGE RESTRICTIONS

Between 2 years old and 20 years old

PRESCRIBER RESTRICTIONS

Endocrinologist

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
IXEMPRA

COVERED USES

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

COVERAGE POLICY

Ixempra is covered for members who meet the following criteria:

- A. Verify B vs. D criteria per CMS guidelines
 - a. Incident to a physician s service
- B. AND the patient is diagnosed with metastatic or locally advanced breast cancer
- C. AND the patient has previous trial and failure on a taxane
- D. AND the patient has previous failure to anthracyclines or further therapy is contraindicated
- E. AND treatment with Ixempra follows 1 (ONE) of the following:
 - a. Patient has previous trial and failure using capecitabine OR combination therapy with Ixempra.

NON COVERAGE

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

- A. If the patient has any of the following contraindications: breast-feeding, hepatic disease, neutrophil count less than 1500 cells/mm(3) or platelet count less than 100,000 cells/mm(3).
- B. If the patient is taking/receiving any of the following: Disulfiram, Metronidazole, St. John's Wort, Hypericum perforatum or Grapefruit juice.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation of diagnosis
- B. Documentation of previous trial/failure with an anthracycline AND a taxane
- C. Documentation of previous trial/failure with Capecitabine OR documentation of combination therapy of Ixempra with Capecitabine and written medical summary is provided that shows dosing strategy.

PRESCRIBER RESTRICTIONS

Oncologist

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
KETEK

COVERED USES

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

COVERAGE POLICY

Ketek is covered for members who meet the following criteria:

- A. The patient is diagnosed with community-acquired pneumonia
- B. AND the patient has had previous failed therapy on BOTH of the following:
 - a. Azithromycin
 - b. Fluoroquinolone

NON COVERAGE

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

- A. If the patient has any of the following contraindications: macrolide hypersensitivity, history of macrolide induced hepatitis/jaundice, myasthenia gravis, QT prolongation, torsade de pointes.
- B. If the patient is taking/receiving any of the following: Astemizole, Atorvastatin, Bepridil, Cisapride, Class IA antiarrhythmics, Class III antiarrhythmics, Droperidol, Ergot Alkaloids, Grepafloxacin, Levomethadyl, Lovastatin, Pimozide, ProbucoI, Red Yeast Rice, Rifampin, Simvastatin, Sirolimus, Terfenadine or Ziprasidone.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation of diagnosis
- B. Documentation of previous trial/failure on Azithromycin AND a Fluoroquinolone. (including length of therapy of both agents)

COVERAGE DURATION

10 days



Care N Care
Prior Authorization Criteria
MESNEX

COVERED USES

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

COVERAGE POLICY

Mesnex is covered for members who meet the following criteria:

- A. Patient is diagnosed with an FDA approved indication.
- B. AND patient is being administered with ifosfamide or cyclophosphamide
- C. AND B vs. D criteria indicates that coverage should be through Medicare Part D

REQUIRED MEDICAL INFORMATION

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

- A. Documentation that the patient is being administered with ifosfamide or cyclophosphamide

PRESCRIBER RESTRICTIONS

Oncologist

COVERAGE DURATION

3 months



Care N Care
Prior Authorization Criteria
MORPHINE

COVERAGE POLICY

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.



Care N Care
Prior Authorization Criteria
MYOZYME

COVERED USES

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

COVERAGE POLICY

Myozyme is covered for members who meet the following criteria:

- A. Diagnosis is documented as infantile-onset Pompe disease (glycogen storage disease type II, GSD II, glycogenosis type II, acid maltase deficiency disease).
- B. AND diagnosis has been confirmed by an enzymatic assay showing a deficiency in acid alpha glucosidase.
- C. AND the patient is NOT receiving treatment at home. (Myozyme therapy would be paid by Medicare Part B).
- D. AND/OR if the patient is in a hospital or long term care facility (LTC) or skilled nursing facility (SNF) and the payer of the stay is NOT Medicare Part A. (Medicare Part A can pay for the first 110 days and Myozyme therapy would be paid by Medicare Part B. Please verify payer).
 - a. AND the medication is NOT being administered using an IMPLANTABLE PUMP. (Please verify the delivery method of the medication. Administration through an implantable pump is covered under Medicare Part B.)
 - b. AND approval can be allowed for up to one year.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation that the diagnosis of Pompe Disease has been confirmed by an enzymatic assay showing a deficiency in acid alpha glucosidase

PRESCRIBER RESTRICTIONS

Endocrinology

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
NEUTREXIN

COVERED USES

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

COVERAGE POLICY

Neutrexin is covered for members who meet the following criteria:

- A. Verification of B vs. D criteria per CMS guidelines
 - a. Incident to a physician s service
- B. AND the patient is diagnosed with moderate to severe pneumocystis pneumonia (PCP)
- C. AND the patient is immunocompromised (including HIV and oncology patients)
- D. AND the patient has previous trial/failure or contraindication to sulfamethoxazole/trimethoprim AND pentamidine
- E. AND the patient is concurrently taking leucovorin with treatment

NON COVERAGE

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

- A. If the patient has any of the following contraindications: breast-feeding, bone marrow suppression, hepatic disease or renal impairment.
- B. If the patient is taking/receiving any of the following: Methotrexate or live vaccines.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation that the patient is immunocompromised
- B. Documentation that the patient has completed a trial and failure of sulfamethoxazole/trimethoprim and pentamidine
- C. Documentation that the patient is concurrently taking leucovorin

PRESCRIBER RESTRICTIONS

Infectious Disease

COVERAGE DURATION

21 days



Care N Care
Prior Authorization Criteria
NOVANTRONE

COVERED USES

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

COVERAGE POLICY

Novantrone is covered for members who meet the following criteria:

- A. For Acute myelogenous leukemia:
 - a. Documented diagnosis of acute myelogenous leukemia.
- B. For Multiple Sclerosis:
 - a. Diagnosis documented as secondary (chronic) progressive, progressive relapsing, or worsening relapsing-remitting multiple sclerosis
- C. For Prostate Cancer:
 - a. Diagnosis is documented as prostate cancer

NON COVERAGE

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

- A. If the patient has any of the following contraindications: breast-feeding, intraarterial administration, intramuscular administration, intrathecal administration, subcutaneous administration, neutropenia.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation of diagnosis.

PRESCRIBER RESTRICTIONS

Neurologist or Oncologist

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
ORTHOCLONE

COVERED USES

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

COVERAGE POLICY

Orthoclone is covered for members who meet the following criteria:

- A. Patient is being treated for Heart, Lung, or Kidney transplant
- B. AND has been unresponsive to high dose steroids
- C. AND is suffering Acute rejection
- D. AND patient is free of hypervolemia
- E. AND B vs. D criteria is determined that coverage should be through Medicare Part D

NON COVERAGE

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

- A. If the patient has any of the following contraindications: anti-mouse antibody titers more than 1:1000, hypervolemia, heart failure, murine protein hypersensitivity, uncontrolled hypertension, seizures, pregnancy or breast-feeding.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation verifying the patient has been unresponsive to high dose steroids
- B. Documentation verifying the patient is suffering from acute rejection
- C. Documentation verifying the patient is free of hypervolemia

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
OXSORALEN

COVERED USES

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

COVERAGE POLICY

Oxsoralen is covered for members who meet the following criteria:

- A. Patient must be diagnosed with T-cell lymphoma OR psoriasis OR vitiligo.
- B. AND if the diagnosis is psoriasis the patient must have previous trial/failure or contraindication to ALL of the following:
 - a. At least 1 topical steroid
 - b. Dovonex.

NON COVERAGE

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

- A. If the patient has any of the following contraindications: albinism, aphakia, melanoma, porphyria, skin photosensitivity disorder, systemic lupus erythematosus (SLE), xeroderma pigmentosum or current skin burns.

REQUIRED MEDICAL INFORMATION

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

- A. If the diagnosis is psoriasis, documentation verifying the patient has completed a trial and failure or is adverse to at least 1 topical steroid AND Dovonex

PRESCRIBER RESTRICTIONS

Dermatologist and Oncologist

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
OXYCODONE

COVERED USES

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

COVERAGE POLICY

OxyContin is covered for members who meet the following criteria:

- A. Patient has no history of substance abuse.
- B. AND diagnosis is documented as chronic severe pain.
- C. AND the patient's pain management is being administered solely by the requesting provider's office. (Verification can be made by reviewing the patient's drug history. Please verify that the patient has only received pain medication from the one requesting provider in the last 6 weeks).
- D. AND the patient has had an adequate trial and pain is still unmanageable with at least one of the following medications: codeine, hydromorphone, meperidine, methadone, morphine, oxycodone, and/or hydrocodone.
- E. AND the patient has had an adequate trial to a morphine controlled release medication (MS Contin, morphine SR and/or Kadian) and pain is still unmanageable.
- F. AND evidence of diagnosis and previous failed opioid therapy is documented in patient's chart notes provided by prescribing provider.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation of previous trial/failure of at least one of the following monotherapies: codeine, hydromorphone, meperidine, morphine (IR), oxycodone, hydrocodone.
- B. Documentation of previous trial/failure of at least one of the following: morphine sulfate extended-release, methadone, Kadian, Avinza

COVERAGE DURATION

Plan Year



**Care N Care
Prior Authorization Criteria
PROTOPIC**

COVERED USES

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

COVERAGE POLICY

Protopic is covered for members who meet the following criteria:

- A. Patient must be immunocompetent
- B. AND the patient must have previous trial/failure to at least one topical steroid
- C. AND the patient must have previous trial/failure to at least a 6 week trial of Elidel.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation that patient is immunocompetent
- B. Documentation of previous trial/failure to a topical steroid.
- C. Documentation of previous trial/failure of Elidel.

AGE RESTRICTIONS

Patient must be 2 years old or older

PRESCRIBER RESTRICTIONS

Dermatologist

COVERAGE DURATION

2 months



Care N Care
Prior Authorization Criteria
PULMOZYME

COVERED USES

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

COVERAGE POLICY

Pulmozyme is covered for members who meet the following criteria:

- A. The patient is a cystic fibrosis patient and medication is being used to improve pulmonary function and/or reduce the frequency of respiratory infections.
- B. AND the patient will be using one of the following nebulizers: Hudston T UP-draft II, Marquest Acorn II, PARI LC Jet+, Pari BABY, Durable Sidestream. (Safety and efficacy have only been shown with these nebulizers).
- C. AND the patient will be using one of the following compressors: Pulmo-Aide, PARI PRONEB, Mobilair, Porta-Neb. (Safety and efficacy have only been shown with these compressors).
- D. AND the patient is being treated in a hospital or long-term care facility (LTC) or a skilled-nursing facility (SNF).
 - a. AND the payer of the stay is NOT Medicare Part A. ((Medicare Part A can pay for the first 110 days and Pulmozyme would be paid by Medicare Part B. Please verify payer).
- E. AND/OR the patient is being treated at home.
 - a. THEN Pulmozyme is NOT covered. (Patients using a medication with a nebulizer are covered under Medicare Part B).
- F. AND if the patient has previously received Pulmozyme, he/she must show an improvement in pulmonary function and/or reduction in the frequency of respiratory infections since initiating therapy.

PRESCRIBER RESTRICTIONS

Pulmonologist

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
RAPAMUNE

COVERED USES

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

COVERAGE POLICY

Rapamune is covered for members who meet the following criteria:

- A. Diagnosis is documented as the prophylaxis of organ rejection in a patient receiving or received an organ transplant.
- B. AND the transplant was NOT covered by Medicare Part A. (Please verify the payer of the transplant. If Medicare paid for the transplant, Rapamune is covered by Medicare Part B).
- C. OR the indication is documented as an indication listed in compendia. The prior authorization request should be reviewed by a prior authorization pharmacist. Pharmacist should review the drug study for:
 - a. A study can be found.
 - b. The study shows clinical improvement with treatment.
 - c. If there are first line treatments, the patient must have tried and failed. (e.g. Psoriasis patients should have tried and failed methotrexate).
 - d. The patient meets the criteria of the study.
 - e. The study has clinical validity (e.g. blinded, substantial population).
 - f. The studys population meets the patients demographics.
 - g. The patients disease status is not terminal and therapy will provide benefit.
 - h. The patient will not receive duplicate therapy.
 - i. Authorization period or re-treatment is within timeframe of study.

NON COVERAGE

Rapamune is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications: breast-feeding or infection.
- B. If the patient is taking/receiving any of the following: Clarithromycin, Erythromycin, Itraconazole, Ketoconazole, Posaconazole, Rifabutin, Rifampin, Telithromycin, Voriconazole or Grapefruit juice.

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
REBIF

COVERED USES

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

COVERAGE POLICY

Rebif is covered for members who meet the following criteria:

- A. The diagnosis is documented as Relapsing-Remitting Multiple Sclerosis.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation showing the diagnosis is Relapsing-Remitting Multiple Sclerosis. (Rebif does not have the indication for primary progressive, secondary progressive or progressive relapsing)

PRESCRIBER RESTRICTIONS

Neurologist

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
RELISTOR

COVERED USES

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

COVERAGE POLICY

Relistor is covered for members who meet the following criteria:

- A. A.B vs D determination per CMS guidelines
- B. B.Patient must have previous trial/failure on BOTH of the following:
 - a. Polyethylene Glycol
 - b. Amitiza

NON COVERAGE

Relistor is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications: GI obstruction.

REQUIRED MEDICAL INFORMATION

The following chart notes/laboratory reports are required:

- A. Documentation verifying the patient has completed a trial and failure of both Polyethylene Glycol and Amitiza

COVERAGE DURATION

4 Months



Care N Care
Prior Authorization Criteria
ROTATEQ

COVERED USES

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

COVERAGE POLICY

RotaTeq is covered for members who meet the following criteria:

- A. Must be used for prophylaxis against rotavirus infection
- B. AND the patient must be between 6-12 weeks old upon first dose
- C. AND the patient will receive all three doses before 32 weeks of age
- D. AND request is for 3 doses (or less if patient has already received 1-2 doses)

NON COVERAGE

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

- A. A.If the medication is given by parenteral administration.
- B. If the patient is taking/receiving any of the following: Adalimumab, Anakinra, Antineoplastic Agents, Etanercept, Immunosuppressives or Infliximab.

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
SANCUSO

COVERED USES

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

COVERAGE POLICY

Sancuso is covered for members who meet the following criteria:

- A. Patient must have previous trial/failure on oral Ondansetron OR Granisetron

NON COVERAGE

Sancuso is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications: benzyl alcohol hypersensitivity, neonates.
- B. If the patient is taking/receiving any of the following: apomorphine.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation showing that the patient has had a previous trial/failure to oral Ondansetron or Granisetron.

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
STRIANT

COVERED USES

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

COVERAGE POLICY

Striant is covered for members who meet the following criteria:

- A. The diagnosis is documented as hypogonadism
- B. AND the patient's total testosterone is less than 280 ng/dL OR free testosterone is less than 44 pg/mL

NON COVERAGE

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

- A. The patient is using for erectile dysfunction
- B. The patient is a female

REQUIRED MEDICAL INFORMATION

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

- A. Documentation of diagnosis
- B. Documentation showing total testosterone of less than 280 ng/dL OR a free testosterone less than 44 pg/mL

AGE RESTRICTIONS

Patient must be 18 years of age or greater

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
SUTENT

COVERED USES

- 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 is female and of childbearing years, she is NOT pregnant, has NO plans for pregnancy and has been educated on the potential dangers of Sutent therapy in pregnancy.
- B. AND the patient does NOT have clinical manifestations of congestive heart failure (CHF).
- C. AND the patient will NOT be treated with interferon alfa (Roferon-A, Pegasys, Intron-A, Peg-Intron) or interleukin-2 (Proleukin) therapy in combination with Sutent treatment. (Please verify the patient's drug history or patient chart to verify that the patient is not on interferon alfa or interleukin-2 therapy).
- D. AND the diagnosis is documented as treatment for gastrointestinal stromal tumor (GIST).
 - a. AND GIST is unresectable and/or metastatic malignant.
 - b. AND the patient has experienced disease progression while trying or intolerant to Gleevec drug regimen. (Please verify the patient's drug history or chart to verify a trial of Gleevec).
 - c. AND if the patient has received previous Sutent therapy, he/she has no evidence of disease progression (tumor growth) since initiating Sutent therapy.
- E. AND/OR the diagnosis is documented as metastatic (advanced) renal cell carcinoma.
 - a. AND the carcinoma is surgically unresectable.
 - b. AND if the patient has had previous Sutent therapy, he/she has no evidence of disease progression since initiating Sutent therapy.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation showing that the patient will NOT be treated with interferon alfa (Roferon-A, Pegasys, Intron-A, Peg-Intron) or interleukin-2 (Proleukin) therapy in combination with Sutent treatment.
- B. Documentation showing that the GIST is unresectable and/or metastatic malignant.
- C. Documentation showing that the patient has experienced disease progression while trying or intolerant to at least a 30-day Gleevec drug regimen.
- D. Documentation showing that if the patient has received previous Sutent therapy, he/she has no evidence of disease progression (tumor growth) since initiating Sutent therapy.

PRESCRIBER RESTRICTIONS

Oncologist

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
SYMLIN

COVERED USES

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

COVERAGE POLICY

Symlin is covered for members who meet the following criteria:

- A. AND the patient's HbA1c is greater than 7% but lower than 9%.
- B. AND the patient has NOT had recurrent severe hypoglycemia during the past 6 months.
- C. AND the patient will NOT be taking Symlin in combination with any of the following medications that may alter gastrointestinal motility:
 - a. Metoclopramide
 - b. Reglan
 - c. Dexpanthenol
 - d. Zelnorm
 - e. Erythromycin
 - f. Cisapride
 - g. Propulsid
 - h. Clarithromycin
 - i. Biaxin
 - j. Ranitidine
 - k. Zantac
 - l. Nizatidine
 - m. Axid
 - n. Neostigmine
 - o. Lidocaine
 - p. Amitiza.
- D. AND the patient is NOT currently receiving a Byetta drug regimen.
- E. AND the diagnosis is documented as diabetes type-1.
 - a. AND the patient has tried and failed at least a 3-month optimization of insulin therapy that includes a trial and failure to short acting insulin. (e.g. Humulin R, Novolin R, Humulin 70/30, Humulin 50/50, Humalog, Novolog, Apidra and Exubra).
 - b. AND the patient will continue the use of short-acting insulin during treatment with Symlin.
 - c. AND if the patient has had previous Symlin therapy, he/she must show a reduction in their HbA1c since initiating Symlin therapy.
- F. AND/OR the diagnosis is documented as diabetes type-2.
 - a. AND the patient has tried and failed at least a three-month optimization of insulin therapy that includes a trial and failure to BOTH short and long-acting insulin.
 - i. Short acting insulin: (e.g. Humulin R, Novolin R, Humulin 70/30, Humulin 50/50, Humalog, Novolog, Apidra and Exubra).
 - ii. Long acting insulin: (e.g. NPH, Humulin N, Novolin N, Humulin 70/30, Humulin 50/50, Lente, Humulin L, Humulin U, Humalog 75/30, Lantus, Levenir).
 - b. AND the patient will continue the use of short-acting insulin during treatment with Symlin.
 - c. AND if the patient has had previous Symlin therapy, he/she must show a reduction in their HbA1c since initiating Symlin therapy.

NON COVERAGE

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

- A. If the patient has any of the following contraindications: cresol hypersensitivity, gastroparesis or hypoglycemia unawareness.



Care N Care
Prior Authorization Criteria
SYMLIN
(Continued)

REQUIRED MEDICAL INFORMATION

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

- A. Documentation showing that the patient does not have gastroparesis.
- B. Documentation showing an HbA1c between 7% and 9%. Lab values must be within the last 3 months.
- C. Documentation showing that the patient has not had recurrent severe hypoglycemia during the past 6 months.
- D. Documentation showing that the patient will NOT be taking Symlin in combination with any of the following medications that may alter gastrointestinal motility: metoclopramide, Reglan, dexpanthenol, Zelnorm, erythromycin, cisapride, Propulsid, clarithromycin, Biaxin, ranitidine, Zantac, nizatidine, Axid, neostigmine, lidocaine or Amitiza.
- E. Documentation showing that the patient is NOT currently receiving a Byetta drug regimen.
- F. For Type 1 Diabetes:
 - a. Documentation showing the patient has tried and failed at least a three-month optimization of insulin therapy that includes a trial and failure to short acting insulin and which short acting insulin will be used during treatment with Symlin.
- G. For Type 2 Diabetes:
 - a. Documentation showing the patient has tried and failed at least a three-month optimization of insulin therapy that includes a trial and failure to BOTH short and long-acting insulin and which short acting insulin will be used during treatment with Symlin.
- H. If the patient has had previous Symlin therapy: Documentation showing that he/she has a reduction in their HbA1c since initiating Symlin therapy. Lab values must be within the last 3 months.

AGE RESTRICTIONS

The patient is over the age of 2 years old.

PRESCRIBER RESTRICTIONS

Endocrinologist

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
TARCEVA

COVERED USES

- 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 is female and of childbearing years, she is NOT pregnant, has NO plans for pregnancy and has been educated on the potential dangers of Tarceva therapy in pregnancy.
- B. AND the diagnosis is documented as treatment for non-small cell lung cancer.
 - a. AND the cancer is locally advanced or metastatic (Stage 3 or Stage 4).
 - b. AND the patient's disease has progressed after completing or had unacceptable toxicity to at least one of the following chemotherapy regimens:
 - i. Platinum-based regimen: (e.g. carboplatin, Paroplatin, cisplatin, Platinol, oxaliplatin, or Eloxatin)
 - ii. Taxoid-based regimen: (e.g. paclitaxel, Taxol, Onxol, Abraxane, docetaxel, or Taxotere).
 - c. AND Tarceva therapy will NOT be used in combination with any other chemotherapy agent. (Please verify that the patient is not receiving additional chemotherapy by reviewing the patient's drug history or chart.)
 - d. AND 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.
- C. AND/OR the diagnosis is documented as pancreatic cancer.
 - a. AND the cancer is surgically unresectable.
 - b. AND the cancer is locally advanced or metastatic (Stage 3 or Stage 4).
 - c. AND the patient will and/or has received Tarceva therapy in combination with gemcitabine (Gemzar) on a 4 and/or 8 week cycle.
 - d. AND if the patient has had 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.

REQUIRED MEDICAL INFORMATION

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

- A. If the patient is female and of childbearing years, documentation showing she is NOT pregnant, has NO plans for pregnancy and has been educated on the potential dangers of Tarceva therapy in pregnancy
- B. For non-small cell lung cancer: Documentation showing the cancer is locally advanced or metastatic (Stage 3 or Stage 4).
 - a. Documentation showing the patient's disease has progressed after completing or had unacceptable toxicity to at least one of the following chemotherapy regimens:
 - i. Platinum-based regimen: (e.g. carboplatin, Paroplatin, cisplatin, Platinol, oxaliplatin, or Eloxatin)
 - ii. Taxoid-based regimen: (e.g. paclitaxel, Taxol, Onxol, Abraxane, docetaxel, or Taxotere).



Care N Care
Prior Authorization Criteria
TARCEVA
(Continued)

- C. For pancreatic cancer: Documentation showing that the cancer is surgically unresectable. AND the cancer is locally advanced or metastatic (Stage 3 or Stage 4).
 - a. Documentation showing the patient will and/or has received Tarceva therapy in combination with gemcitabine (Gemzar) on a 4 and/or 8 week cycle
- D. If the patient has had previous Tarceva therapy, documentation showing the provider has evidence of clinical improvement from the pretreatment report by showing no increase in tumor size and/or progression of disease

PRESCRIBER RESTRICTIONS

Oncologist or nephrologist

COVERAGE DURATION

6 months



Care N Care
Prior Authorization Criteria
TAZORAC

COVERED USES

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

COVERAGE POLICY

Tazorac is covered for members who meet the following criteria:

- A. Patient must have previous trial/failure to at least one topical steroid OR to a topical antibiotic.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation of diagnosis.
- B. Documentation of previous trial/failure to a topical steroid OR a topical antibiotic.

AGE RESTRICTIONS

Patient must be 12 years old or older

PRESCRIBER RESTRICTIONS

Dermatologist

COVERAGE DURATION

12 weeks



Care N Care
Prior Authorization Criteria
TRIMETHOBENZAMIDE

COVERED USES

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

COVERAGE POLICY

Trimethobenzamide is covered for members who meet the following criteria:

- A. The medication is NOT a Part B medication per CMS guidelines
- B. The patient has previously tried and failed BOTH Promethazine and Prochlorperazine

REQUIRED MEDICAL INFORMATION

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

- A. Documentation of previous trial/failure to Prochlorperazine AND Promethazine.

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
VFEND

COVERED USES

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

COVERAGE POLICY

Vfend is covered for members who meet the following criteria:

- A. The patient is diagnosed with invasive aspergillosis
- B. AND the patient has had previous trial and failure or contraindication to itraconazole *If aspergillosis infection is extrapulmonary no previous trial is required
- C. OR the patient is diagnosed with candidiasis
- D. AND the patient has previous trial and failure or contraindication to BOTH fluconazole and itraconazole
- E. OR the patient is diagnosed with furariosis or Scedosporium sp.
- F. AND Vfend is being used as salvage therapy due to failure of other therapies

NON COVERAGE

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

- A. If the patient is taking/receiving any of the following: Astemizole, Atorvastatin, Barbiturates, Carbamazepine, Cisapride, Ergot Alkaloids, Pimozide, Quinidine, Ranolazine, Red Yeast Rice, Rifabutin, Rifampin, Rifapentine, Ritonavir, Sirolimus, St. John's Wort, Hypericum perforatum, Terfenadine or Vinca alkaloids.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation showing the patient's trial/failure to itraconazole for aspergillosis.
- B. Documentation showing the patient's trial/failure to fluconazole and itraconazole for candidiasis.
- C. Documentation of diagnosis for furariosis or Scedosporium sp.

PRESCRIBER RESTRICTIONS

Infectious Disease

COVERAGE DURATION

1 month



Care N Care
Prior Authorization Criteria
XENAZINE

COVERED USES

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

COVERAGE POLICY

Xenazine is covered for members who meet the following criteria:

- A. A. Patient must be diagnosed with Huntington's chorea
- B. B. Patient must have previous trial/failure of Haloperidol

NON COVERAGE

Xenazine is NOT covered for members with the following criteria:

- A. A. If the patient has any of the following contraindications: hepatic disease, torsade de pointes, depression or suicidal ideation.
- B. If the patient is taking/receiving any of the following: Monoamine oxidase inhibitors (MAOIs), Reserpine or has been less than 20 days of Reserpine discontinuation.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation showing that the patient is diagnosed with Huntington's chorea.
- B. Documentation showing trial/failure of Haloperidol.

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
XOLAIR

COVERED USES

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

COVERAGE POLICY

Xolair is covered for members who meet the following criteria:

- A. The patient is NOT a current smoker.
- B. AND the diagnosis is documented as moderate-to-severe persistent asthma and there is evidence of reversible disease (20% or greater improvement in peak expiratory flow [PEF] with a short acting bronchodilator challenge). (Please verify the patients chart notes for diagnosis).
- C. AND the patient has experienced at least two asthma exacerbations per month within the last 3 months.
- D. AND the patient has tested positive to a perennial aeroallergen skin test. (Please verify the patients chart notes for a positive aeroallergen skin test).
- E. AND the patient's baseline IgE is between 30 and 700 IU/ mL. (Please verify IgE level in the patients chart notes).
- F. AND the patient has been compliant and maintained on standard inhaled corticosteroid therapy for at least 6-months and still remains inadequately controlled. (Please verify the patients chart notes or drug history to verify their use of an inhaled corticosteroid [e.g. QVAR, Pulmicort, AeroBid, Flovent, Azmacort, Asmanex]).
- G. AND the patient has had a 3-month trial and failure to a leukotriene therapy that can include Singulair or Accolate. (Please verify the use of a leukotriene by reviewing the patients chart notes or drug history).
- H. AND the patient has had a 3-month trial and failure or intolerant to a long acting beta agonist agent that can include Symbicort, Foradil, Serevent, or Advair.
- I. AND if the patient has received prior treatment with Xolair, " The patient must experience a reduction in symptoms and improvement in their FEV1 or PEF before initiation of re-treatment.

NON COVERAGE

Xolair is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications: hamster protein hypersensitivity or omalizumab hypersensitivity.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation of the patient's peak expiratory flow [PEF] before and after bronchodilator challenge.
- B. Documentation showing that the patient has tested positive to a perennial aeroallergen skin test.
- C. Documentation showing that the patient's baseline IgE is between 30 and 700 IU/ mL.
- D. Documentation showing that the patient has been compliant and maintained on standard inhaled corticosteroid therapy for at least 6-months and still remains inadequately controlled.



Care N Care
Prior Authorization Criteria
XOLAIR
(Continued)

- E. Documentation showing that the patient has had a 3-month trial and failure or intolerant to a long acting beta agonist agent that can include Symbicort, Foradil, Serevent, or Advair.
- F. Documentation showing that the patient has experienced a reduction in symptoms and improvement in their FEV1 or PEF before initiation of re-treatment.

AGE RESTRICTIONS

Patient is age 12 years or older

PRESCRIBER RESTRICTIONS

Pulmonologist, allergist, or immunologist

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
ZAVESCA

COVERED USES

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

COVERAGE POLICY

Zavesca is covered for members who meet the following criteria:

- A. Diagnosis is documented as mild-to-moderate type-1 Gaucher disease.
- B. AND diagnosis has been confirmed by bone marrow histology, DNA testing or measurement of b-glucocerebrosidase enzyme activity less than 30%.
- C. AND the patient has a hemoglobin concentration above 9 g/dL or a platelet count above 50 x10⁹/L or active bone disease. (Zavesca has not been evaluated in patients with severe disease).
- D. AND the patient has tried and failed enzyme replacement therapy (e.g. Ceredase, Cerezyme) or is not a therapeutic option (e.g. allergy, hypersensitivity). (Please verify trial in the patient s drug history or chart).
- E. AND if the patient is female and of childbearing years, she is NOT pregnant, has NO plans for pregnancy, is on a form of contraception or has NO ability to conceive and has been educated on the potential dangers of Zavesca therapy.
- F. AND if the patient has previously received 24 months of Zavesca therapy, they must show a decrease in liver and spleen volume and/or increases in platelet count and/or increases in hemoglobin concentration.

NON COVERAGE

Zavesca is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications: pregnancy, labor, obstetric delivery or renal failure.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation showing that the diagnosis has been confirmed by bone marrow histology, DNA testing or measurement of b-glucocerebrosidase enzyme activity less than 30%.
- B. Documentation showing that the patient has a hemoglobin concentration above 9 g/dL or a platelet count above 50 x10⁹/L or active bone disease.
- C. Documentation showing that the patient has tried and failed enzyme replacement therapy.
- D. If the patient is female and of childbearing years, documentation showing that she is NOT pregnant, has NO plans for pregnancy, is on a form of contraception or has NO ability to conceive and has been educated on the potential dangers of Zavesca therapy.
- E. If the patient has previously received 24 months of Zavesca therapy, documentation showing that they show a decrease in liver and spleen volume and/or increases in platelet count and/or increases in hemoglobin concentration.

AGE RESTRICTIONS

18 years or older

**PRESCRIBER
RESTRICTIONS**
Endocrinologist

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
ZENAPAX

COVERED USES

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

COVERAGE POLICY

Zenapax is covered for members who meet the following criteria:

- A. Zenapax is being prescribed for Kidney transplantation prophylaxis
- B. AND B vs. D criteria is determined that coverage should be through Medicare Part D.

NON COVERAGE

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

- A. If the patient has any of the following contraindications: murine protein hypersensitivity or infection.

AGE RESTRICTIONS

Patient is age greater than 11 months

COVERAGE DURATION

10 weeks



Care N Care
Prior Authorization Criteria
ZYMAR

COVERED USES

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

COVERAGE POLICY

Zymar is covered for members who meet the following criteria:

- A. The documented diagnosis is bacterial conjunctivitis
- B. AND the patient has previous trial/failure to at least one of the following: ophthalmic gentamicin OR neomycin-polymyxin combination product
- C. OR the patient is using Zymar for prophylaxis associated with cataract surgery.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation of diagnosis
- B. If the diagnosis is bacterial conjunctivitis:
 - a. Documentation of previous trial/failure to Gentamicin OR neomycin-polymyxin combination product

AGE RESTRICTIONS

Patient must be 1 year old or older

COVERAGE DURATION

7 days



Care N Care
Prior Authorization Criteria
ZYVOX

COVERED USES

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

COVERAGE POLICY

Zyvox is covered for patients who meet the following criteria:

- A. Therapy is NOT being used for prophylaxis therapy
- B. AND The infection is NOT a decubitus ulcer. (Zyvox has not been studied in the therapy of decubitus ulcers).
- C. AND chart notes, lab values and susceptibility results that document that the pathogen is susceptible to Zyvox, other meds that the organism is susceptible to have been tried, the infection is a covered indication listed below, and the organism is a covered pathogen also listed below:
- D. Infection caused by Vanco-Resistant Enterococcus faecium. nosocomial pneumonia infection caused by Staph aureus (MTH-susceptible and MTH-resistant strains) or S. pneumoniae (including multi-drug resistant strains [MDRSP]).
- E. AND the susceptibility report shows that the pathogen is not susceptible to any other antibiotics
- F. Complicated skin and skin structure infections, including diabetic foot infections, without concomitant osteomyelitis, caused by Staph aureus (MTH-susceptible and MTH-resistant strains) OR S. pyogenes OR S. agalactiae.
- G. AND the susceptibility report shows that the pathogen is not susceptible to any other antibiotics AND the patient does NOT have osteomyelitis.
- H. Uncomplicated skin and skin structure infections caused by MTH-susceptible only -Staph aureus AND the pathogen is MTH-susceptible only
- I. AND the susceptibility report shows that the pathogen is not susceptible to any other antibiotics
- J. OR the medical doctor can show a documented trial and failure or intolerance to the listed susceptible antibiotics
- K. OR a first time Zyvox request to treat uncomplicated skin and skin structure infections caused by S. pyogenes.
- L. OR a first time Zyvox request to treat community-acquired pneumonia caused by S. pneumoniae (including multi-drug resistant strains [MDRS]), including cases with concurrent bacteremia.
- M. AND the susceptibility report shows that the pathogen is not susceptible to any other antibiotics
- N. OR a first time Zyvox request to treat community-acquired pneumonia caused by Staph aureus (MTH-susceptible strains only).
- O. AND the pathogen is MTH-susceptible.
- P. AND the susceptibility report shows that the pathogen is NOT susceptible to any other antibiotics



Care N Care
Prior Authorization Criteria
ZYVOX
(Continued)

NON COVERAGE

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

- A. If the patient has pheochromocytoma.
- B. If the patient is taking/receiving any of the following: Furazolidone, Green Tea, Monoamine oxidase inhibitors (MAOIs) or Procarbazine.

REQUIRED MEDICAL INFORMATION

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

- A. Documentation showing lab values and susceptibility results that document that the pathogen is susceptible to Zyvox
- B. Documentation showing that other medications that the organism is susceptible to have been tried, the infection is a covered indication, and the organism is a covered pathogen:

COVERAGE DURATION

Plan Year



Care N Care
Prior Authorization Criteria
INDEX

A		MORPHINE	35
ACETYLCYSTEINE.....	1	MYOZYME	36
ADAGEN.....	2	N	
AFINITOR	3	NEUTREXIN	37
AVONEX.....	4	NOVANTRONE	38
AZATHIOPRINE	5	O	
B		ORTHOCLONE	39
BYETTA.....	6	OXSORALEN	40
C		OXYCODONE	41
CELLCEPT.....	8	P	
CEREZYME.....	9	PROTOPIC	42
COPAXONE.....	10	PULMOZYME	43
CYKLOKAPRON	11	R	
CYTARABINE	12	RAPAMUNE	44
CYTOXAN	13	REBIF	45
D		RELISTOR	46
DACOGEN	14	ROTATEQ	47
E		S	
EPIDUO	15	SANCUSO	48
ERAXIS.....	16	STRIANT	49
ERYTHROPOIESIS STIMULATING AGENTS	17	SUTENT	50
ETHYOL.....	19	SYMLIN	51
EXJADE.....	20	T	
F		TARCEVA	53
FABRAZYME	21	TAZORAC	55
FORTEO	22	TRIMETHOBENZAMIDE	56
H		V	
HEPATITIS C.....	23	VFEND	57
HEPSERA	25	X	
HUMIRA.....	26	XENAZINE	58
I		XOLAIR	59
INCRELEX	30	Z	
IXEMPRA	32	ZAVESCA	61
K		ZENAPAX	62
KETEK.....	33	ZYMAR	63
M		ZYVOX	64
MESNEX.....	34		