CareFirst
The CareFirst BlueCross BlueShield family of health care plans

Medications Requiring Pre-Authorization

BRAND NAME DRUG(S)	PRE-AUTH GROUP DESCRIPTION	COVERED USES	EXCLUSION CRITERIA	MEDICAL CRITERIA	PRESCRIBER RESTRICTION	COVERAGE DURATION
ABRAXANE	ONCOLOGY	Breast Cancer, Non-small cell lung cancer, Pancreatic adenocarcinoma, Melanoma, Epithelial Ovarian Cancer	Baseline absolute neutrophil count < 1,500 cells/mm3 prior to initiation of Abraxane therapy	**1. Breast cancer** a. Authorization may be granted as a single agent for recurrent or metastatic (Stage IV) disease and who meet ANY of the following criteria: i. Human epidermal growth factor receptor 2 (HER2)-negative, hormone receptor-positive disease with visceral crisis ii. HER2-negative and hormone receptor-negative disease iii. HER2-negative and hormone receptor-positive disease that is refractory to endocrine therapy iv. Progressive disease with no clinical benefit after three sequential endocrine therapy regimens v. Progressive disease with symptomatic visceral disease **2. Non-Small Cell Lung Cancer** a. Authorization may be granted for ECOG performance status (PS) 0-2 in combination with carboplatin as first-line therapy for any of the following: mediastinal lymph node recurrence, metastatic (Stage IV) disease, or treatment with palliative intent. **3. Pancreatic Adenocarcinoma** a. Authorization may be granted for ECOG PS 0-1 in combination with gemcitabine for locally advanced unresectable or metastatic disease. **4. Melanoma** a. Authorization may be granted as a single agent and who meet ANY of the following criteria: i. Unresectable stage IIIb in-transit metastases ii. Stage IV disease iii. Recurrent, unresectable disease **5. Epithelial Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer** a. Authorization may be granted as a single agent and who meet ANY of the following criteria: i. Member has		12 months

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				persistent disease ii. Member has recurrence and Abraxane will not be used for immediate treatment of biochemical relapse		
ABSTRAL, ACTIQ, FENTANYL CITRATE, FENTORA, LAZANDA, ONSOLIS, SUBSYS	FENTANYL CITRATE	All FDA-approved indications		Must meet the following criteria: 1) For Breakthrough cancer pain. and 2) Tolerant to other opioid therapy.	Oncologist must prescribe Fentanyl Citrate.	12 Months
ACTEMRA	ARTHRITIS	All FDA-approved indications		Must meet the following criteria: 1)Diagnosis of moderate to severe active Rheumatoid Arthritis (RA) 2) Trial and failure or inadequate response to at least one or more DMARDs such as Methotrexate, Imuran, Ridaura, Plaquenil, Cuprimine, Azulfidine or Arava. 3) Use of FDA approved dosing 4) If patient is receiving a different TNF blocking agent, therapy must be discontinued prior to initiating new TNF agent Actemra 5) Trial and failure or inadequate response to one preferred agent, Humira or Enbrel along with Cimzia. 6) For all above diagnosis, must be must FDA approved dosage guidelines.	Rheumatologist has recommended Actemra.	12 Months
ACTIMMUNE	INFECTIOUS DISEASE	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of one of the following: a) Chronic granulomatous disease b) Malignant osteoporosis c) Atopic dermatitis d) Cutaneous T-cell Lymphoma i) Mycosis fungoides ii) Sezary syndrome 2) Use of topical medications or phytotherapy		
ADAGEN	LYSOSOMAL STORAGE DISORDERS	Adenosine deaminase deficiency (ADA) in patients with SCID in patients who are not suitable candidates/failed BMT	Severe thrombocytopenia	Must meet the following criteria: 1) Must have SCID 2) Must have ADA deficiency 3) Must have failed or not be a suitable candidate for BMT		24 months

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ADAPELENE,ATRALIN, AVITA, TAZORAC, DIFFERIN, EPIDUO, RETIN-A, RETIN-A MICRO, TRETINOIN, TRETIN-X, VELTIN, ZIANA	TOPICAL RETINOIDS	All FDA-approved indications not otherwise excluded from benefit plan	1. Cosmetic reasons	Must meet the following criteria: 1) Diagnosis of acne vulgaris OR 2) Diagnosis of psoriasis (tazorac only).		12 Months
ADCIRCA	PULMONARY HYPERTENSION	Pulmonary Arterial Hypertension	Patients taking nitrates	Must meet the following criteria: Diagnosis of Pulmonary Hypertension.		24 Months
ADEMPAS	PULMONARY HYPERTENSION	All FDA-approved indications	Patients taking Nitrates, Pregnancy, PDE Inhibitors	Must meet the following criteria: 1) Recurrent or persistent CTEPH after Pulmonary Endarterectomy WITHOUT nitrate/amyl nitrate/PDE inhibitor 2) Diagnosis of PAH		24 Months
ADVATE	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		Must meet the following criteria: Hemophilia A		
AFINITOR	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: Renal Cell Carcinoma: 1) Diagnosis of advanced renal cell carcinoma. 2) Trial and failure of either Sunitinib (Sutent) or Sorafenib (Nexavar) or Pazopanib (Votrient). Brain Tumor: 1) Diagnosis of SEGA (subependymal giant cell astrocytoma) associated with tuberous sclerosis for which surgical resection is not a treatment option. Pancreatic Neuroendocrine Tumor: 1) Diagnosis of PNET (progressive neuroendocrine tumors) of pancreatic origin that is unresectable, locally advanced or metastatic. Angiomyolipoma and Tuberous Sclerosis Complex: 1) Diagnosis of angiomyolipoma and tuberous sclerosis complex (TSC) that doesn't require immediate surgery. Breast Cancer: 1) diagnosis of breast cancer in postmenopausal women with advanced hormone receptor-positive, HER2-negative breast cancer (advanced HR+ BC) in combination with exemestane after failure of treatment with letrozole or anastrozole.	Oncologist has recommended Afinitor.	12 Months

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ALDURAZYME	HURLER & HURLER-SCHEIE, AND MODERATE-TO-SEVERE SCHEIE	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Hurler, Hurler-Scheie, or Moderate to severe Scheie syndrome.		
ALIMTA	ONCOLOGY	All FDA-approved indications	Squamous Cell NSCLC	1. **Bladder Cancer, Primary Carcinoma of the Urethra, Upper GU Tract Tumors, or Urothelial Carcinoma of the Prostate** Authorization may be granted for use as single-agent, second-line therapy for metastatic disease. **2. Malignant Pleural Mesothelioma (MPM)** Authorization may be granted for ANY of the following: a. Clinical Stage I-III disease and epithelial or mixed histology, for use as one of the following: i. Induction chemotherapy for medically operable disease, in combination with cisplatin ii. Treatment of unresectable/medically inoperable (ie, patient is not a candidate for surgery) disease, as a single agent or in combination with cisplatin/carboplatin iii. Treatment of resected disease in members who were not treated with induction chemotherapy, as a single agent or in combination with cisplatin/carboplatin b. Treatment of Stage IV disease, as a single agent or in combination with cisplatin/carboplatin c. Treatment of sarcomatoid tumors, as a single agent or in combination with cisplatin/carboplatin d. Second-line chemotherapy as a single agent **3. Non-Small Cell Lung Cancer (Non-Squamous)** **3.1 Neoadjuvant or Adjuvant Therapy (Stage I-III)** Authorization may be granted for ANY of the following: a. Preoperative concurrent chemoradiation in combination with cisplatin/carboplatin for Stage I-III disease b. Neoadjuvant or induction chemotherapy in combination with cisplatin for Stage I-III disease c. Initial treatment as definitive concurrent chemoradiation in combination with cisplatin/carboplatin for i. Medically inoperable Stage I-II disease, or ii. Stage IIIA (including N2 or unresectable N0-1), or iii. Stage IIIB disease d. Adjuvant chemotherapy in combination with cisplatin for i. Stage IB disease that is either margin-positive or high-risk and margin-negative, or		6-12 Months

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				ii. Stage II or III disease e. Adjuvant concurrent chemoradiation in combination with cisplatin/carboplatin for resected Stage II-III disease with margin-positive tumors f. Concurrent chemoradiation in combination with cisplatin/carboplatin for locoregional recurrence in the mediastinal lymph nodes or for superior vena cava obstruction **3.2 Chemotherapy for Recurrent or Metastatic (Stage IV) Disease or Palliative Therapy** Authorization may be granted for mediastinal lymph node recurrence or metastatic (Stage IV) disease, or for palliative therapy, and ANY of the following criteria are met: a. First-line treatment in combination with cisplatin/carboplatin in members with Eastern Cooperative Oncology Group (ECOG) Performance Status (PS) 0-2 b. First-line treatment as single agent in members with ECOG PS 0-2 c. First-line treatment in cisplatin- or carboplatin-based regimens in combination with bevacizumab for members with ECOG PS 0-1 and no history of recent hemoptysis d. Continuation maintenance therapy as a single agent or in combination with bevacizumab in members who achieved tumor response or stable disease following first-line chemotherapy (if Alimta or Alimta and bevacizumab were used as first-line treatment above) e. Second-line treatment for progression as a single agent in members with ECOG PS 0-2 and negative or unknown EGFR mutation status if not already given f. Third-line treatment for progressive disease as a single agent in members with ECOG PS 0-2 if not already given and erlotinib or crizotinib were used as first- or second-line therapy **4. Ovarian Cancer (Epithelial)/Fallopian Tube Cancer/Primary Peritoneal Cancer** Authorization may be granted as single-agent therapy for either of the following: a. Persistent disease b. Recurrence and Alimta will not be used for immediate treatment of biochemical relapse		

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				5. Primary CNS Lymphoma Authorization may be granted as a single-agent therapy for members with progressive or recurrent disease who have previously received either of the following: a. Whole brain radiation therapy, or b. Methotrexate (MTX)-based chemotherapy without radiation therapy (Alimta may be used in combination with radiation in patients who had a short response or no response to a MTX-based regimen) **6. Thymoma and Thymic Carcinoma** Authorization may be granted for locally advanced unresectable disease and Alimta is used as a single-agent, second-line therapy following radiation therapy.		
ALPHANATE	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		Must meet the following criteria: Diagnosis of Hemophilia A, or von Willebrand Syndrome		
ALPHANINE SD	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		Must meet the following criteria: Hemophilia B		
ALPROLIX	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		Must meet the following criteria: Hemophilia B		
AMPYRA	MS AGENTS	All FDA-approved indications	1. Hx of Seizures, 2. Moderate or severe renal impairment (CrCl equal to or less than 50ml per min).	Must meet the following criteria: Initial Therapy for Multiple Sclerosis (MS): 1) Diagnosis of MS and 2) EDSS score between 4.5-6.5 Reauthorization for MS: 1) After 16 weeks of therapy, documentation that patient has demonstrated at least 10% improvement in timed walking speed. and 2) Dose is 10mg twice daily.	Neurologist must prescribe Ampyra.	Initial 16 weeks, renewal 12 Months.

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APOKYN	PARKINSON'S DISEASE	All FDA-approved indications	Concurrent use of 5-HT3 antagonists (Zofran, Anzemet, Kytril)	Must meet the following criteria: 1) Treatment of hypomobility "off" episodes with advanced Parkinson disease.		
ARALAST NP	ALPHA-1 ANTITRYPSIN DEFICIENCY	All FDA-approved indications	IgA deficiency with antibodies against IgA due to risk of severe hypersensitivity	Must meet the following criteria: 1) Diagnosis of ATT deficiency 2) Emphysema		
ARANESP, PROCRIT, EPOGEN	ERYTHROPOIETIN AGENTS	All FDA-approved indications		Must meet the following criteria: Treatment of anemia related to one of the following: Anemia due to Chronic Kidney Disease (Aranesp-Epogen-Procrit): 1) Hgb less than 10 gm per dl and 2) Trial of Procrit first if requesting Aranesp Anemia due to Chemotherapy/Cancer (Aranesp-Procrit): 1) Diagnosis of anemia due to chemotherapy for non-myeloid malignancy and 2) Verification that the anemia is due to treatment with concomitant administration of chemotherapy and 3) Verification that the patient will be receiving chemotherapy for more than 2 months and 4) Hgb less than 10 gm per dl. and 5) Trial of Procrit first if requesting Aranesp. Anemia due to HIV related to Zidovudine therapy (Procrit): 1) Serum erythropoietin level is equal to or less than 500mU per ml and 2) Verification that patient is receiving a dose of Zidovudine equal to or less than 4200mg per week. Reduction of Allogenic Blood Transfusion in surgery (Procrit): 1) Verification that patient is at high risk for transfusions with significant, anticipated blood loss and hemoglobin greater than 10 but less than or equal to 13 g/dl. Renewal Criteria for patients who have been receiving Procrit, Epogen or Aranesp: 1) Dosage should have been adjusted if Hgb has increased more than 1.0g/dl in any 2 week period and 2) Current Hgb should be less than 11g/dl for anemia due to CKD or less than 12g/dl for anemia due to AZT in HIV patient or cancer patient on chemotherapy.		4 months
ARCALYST	CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of CAPS, including FDAS (Familial cold auto-inflammatory syndrome) and MWS (Muckle-Wells Syndrome).		24 Months

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AUBAGIO AVONEX ADMINISTRATION PACK, AVONEX, BETASERON, COPAXONE, EXTAVIA, GILENYA, REBIF, TECFIDERA	MS AGENTS	All FDA-approved indications		Must meet the following criteria: 1) Confirmed diagnosis of Multiple Sclerosis. and 2) If requesting either Aubagio, Avonex, Betaseron, Extavia Gilenya, or Tecfidera, must provide documentation of trial and failure of both Rebif and Copaxone (preferred agents) or documentation of prior use of non-preferred drug for at least six months.		12 Months
AVASTIN	ONCOLOGY	All FDA-approved indications		**1. Breast Cancer** Authorizations may be granted for Avastin in combination with paclitaxel. **2. Cervical Cancer** Authorizations may be granted for: a. Avastin used in combination with ONE of the following: i. cisplatin AND paclitaxel ii. topotecan AND paclitaxel b. Member has persistent, recurrent, or metastatic disease **3. CNS Cancer** Authorizations may be granted for ANY of the following CNS tumor types: a. glioblastoma b. anaplastic glioma c. adult intracranial ependymoma (excludes subependymoma and myxopapillary) **4. Colorectal Cancer** Authorizations may be granted for Avastin in combination with a fluoropyrimidine OR irinotecan-based regimen **5. Endometrial Cancer** Authorizations may be granted for Avastin as a single agent and who have progressed on prior cytotoxic chemotherapy **6. Fallopian Tube Cancer** **7. NSCLC** Authorizations may be granted ALL of the following criteria: a. The histologic subtype is non-squamous b. Avastin is used as ONE of the following: i. in combination with platinum-based chemotherapy ii. as a single agent for maintenance therapy		24 months

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				iii. in combination with pemetrexed for maintenance therapy **8. Ovarian Cancer** Authorizations may be granted ANY of the following ovarian tumor types: a. epithelial ovarian tumor b. ovarian stromal tumor c. ovarian carcinosarcoma (malignant mixed Mullerian tumor) **9. Primary Peritoneal Cancer** . **10. Renal Cell Carcinoma** **11. Soft tissue sarcoma** Authorizations may be granted for ANY of the following soft tissue sarcoma subtypes: a. angiosarcoma b. solitary fibrous tumor c. hemangiopericytoma **12. Ophthalmic-related disorders** Authorizations may be granted ANY of the following retinal disorders: a. CNV associated with high (pathologic) myopia, ocular histoplasmosis syndrome, angioid streaks, inflammatory conditions, or idiopathic b. wet AMD including polypoidal choroidopathy and retinal angiomatous proliferation subtypes of AMD c. macular edema due to retinal vein occlusion d. diabetic macular edema e. ocular neovascularization (choroidal, retinal, iris) associated with proliferative diabetic retinopathy f. neovascular glaucoma, as adjunct g. retinopathy of prematurity.		
AZACITIDINE	ONCOLOGY	All FDA-approved indications		Must meet the following criteria: 1) Myelodysplastic syndrome (MDS) 2) Acute Myeloid Leukemia (AML)		
BEBULIN VH	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		Must meet the following criteria: Hemophilia B		

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BENEFIX	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		Must meet the following criteria: Hemophilia B		
BENLYSTA	SYSTEMIC LUPUS ERYTHEMATOSUS	All FDA-approved indications		Must meet the following Criteria: 1) Diagnosis of SLE		6-24 Months
BERINERT	HERIDATORY ANGIOEDEMA	All FDA-approved indications		Must meet the following Criteria: Treatment of abdominal, facial, or laryngeal attacks of HAE		
BOSULIF	ORAL ONCOLOGY	All FDA-approved indications		Must meet following criteria: Diagnosis of chronic, accelerated or blast phase Ph+ chronic myeloid leukemia (CML) that has been resistant or intolerant to prior therapy including Gleevec.	Oncologist has recommended Bosulif.	12 Months
BOTULINUM TOXINS BOTOX, DYSPORT, MYOBLOC, XEOMIN	BOTULINUM TOXINS	Overactive bladder, Urinary Incontinence, Migraine Prophylaxis, Upper Limb Spasticity, Cervical Dystonia, Severe Primary Hyperhidrosis, Strabismus, Blepharospasm.		Must meet the following criteria: Must have approved diagnosis and Disease State Specific Criteria. Over Active Bladder/Urinary incontinence: Intolerance to Anticholinergic medications Chronic Migraine Prophylaxis: Use of preventative therapies		Up t 24 Months depending upon indication
BRAVELLE	INFERTILITY	All FDA-approved indications		Coverage is based on member's benefit.		
BUPHENYL, PHENYLBUTYRATE SODIUM	UREA CYCLE DISORDER	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Urea Cycle Disorder a) Diagnosis confirmed by enzymatic, biochemical or genetic testing 2) Failed dietary protein restriction and/or amino acid supplementation 3) Use in combination with dietary protein restriction		
CAPRELSA	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: Thyroid Cancer: Diagnosis of symptomatic or progressive medullary thyroid cancer that is unresectable locally advanced or metastatic.	Oncologist has recommended Caprelsa.	12 Months

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CARBAGLU	UREA CYCLE DISORDER	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of one of the following: a) N-acetylglutamate synthase deficiency (NAGS) b) Methylmalonic academia c) Propionic academia 2) Diagnosis confirmed by enzymatic, biochemical or genetic testing		
CAYSTON	CYSTIC FIBROSIS	All FDA-approved indications		1) Diagnosis of one of the following: a) Cystic fibrosis 2) Diagnosis confirmed by enzymatic, biochemical or genetic testing 3) Pseudomonas aeruginosa present in airway culture		
CERDELGA	GAUCHER DISEASE	All FDA-approved indications	CYP2D6 indeterminate & ultra-rapid metabolizers The use of a strong or moderate CYP2D6 inhibitor concomitantly with a strong or moderate CYP3A inhibitor in CYP2D6 extensive metabolizers and in CYP2D6 intermediate metabolizers The use of a strong CYP3A inhibitor in CYP2D6 intermediate metabolizers and in CYP2D6 poor metabolizers	Must meet the following criteria: Diagnosis of Gaucher disease and CYP2D6 metabolism status		

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CEREZYME	GAUCHER DISEASE	All FDA-approved indications		Must meet the following criteria: Type 1 Gaucher disease resulting in one or more of the following: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly		
CETROTIDE	INFERTILITY	All FDA-approved indications		Coverage is based on member's benefit.		
CHORIONIC GONADOTROPIN, NOVAREL, PREGNYL	INFERTILITY	All FDA-approved indications		Coverage is based on member's benefit.		
CIMZIA	ARTHRITIS/ CROHN'S	All FDA-approved indications		Must meet the following criteria: Rheumatoid Arthritis (RA): 1) Diagnosis of moderate to severe active RA and 2) Trial and failure or inadequate response to at least one or more DMARDs and 3) A 3 month trial and failure of both Enbrel and Humira and 4) If patient is receiving a different TNF blocking agent, therapy must be discontinued and 5) Must be FDA approved dosing. Crohn's Disease: 1) Diagnosis of Crohn's disease and 2) Trial and failure or inadequate response to at least one or more conventional therapies such as 5-ASA, systemic corticosteroids, or immunosuppressants and 3) A 3 month trial and failure of Humira and 4) If patient is receiving a different TNF blocking agent, therapy must be discontinued and 5) Must be FDA approved dosing.	Rheumatologist must recommend therapy for RA. Gastroenterologis t must recommended therapy for Crohn's disease.	12 Months
CINRYZE	HEREDITARY ANGIOEDEMA	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of HAE		
COMETRIQ	ORAL ONCOLOGY	All FDA-approved indications		Meets the following criteria: 1) Diagnosis of progressive, metastatic medullary thyroid cancer.	Oncologist has recommended Cometriq.	12 Months
CORIFACT	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		Meets the following criteria: 1) Acquired Factor XIII Deficiency 2) Congenital Factor XIII Deficiency		
COSENTYX	PSORIASIS	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Plaque Psoriasis 2) Trial of TNF-alpha agents 3) Trial of Phytotherapy 4) Screening for TB		

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CYSTAGON, PROCYSBI	NEPHROGENIC CYSTINOSIS	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Cystinosis		
CYSTARAN	OCCULAR CYSTINOSIS	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Cystinosis		
CYTOGAM	CMV IMMUNE GLOBULIN	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Pregnant woman with CMV infection in pregnancy 2) Diagnosis of CMV pneumonitis 3) Prevention of CMV disease in a patient undergoing solid organ transplant		Up to 12 Months
DIABETIC TEST STRIPS		All FDA-approved indications		Must meet the following criteria: 1) Patient has a diagnosis of diabetes. 2) Patient has tried preferred strips, One Touch Ultra, One Touch Verio, or SureStep Pro or 3) Patient is currently on Accu-chek, Medtronic or, OmniPod pump or is currently using an insulinX meter.		12 Months
DOCEFREZ	ONCOLOGY	All FDA-approved indications		**1. Bladder Cancer, Primary Carcinoma of the Urethra, Upper GU Tract Tumors, Urothelial Carcinoma of the Prostate** **1.1 Bladder Cancer** a. Authorization may be granted for docetaxel as single-agent therapy and the following criteria are met: i. Recurrent or metastatic disease as second-line treatment, and ii. Docetaxel has not been used as a first-line therapy **1.2 Primary Carcinoma of Non-prostatic Urethra (Squamous Cell Carcinoma)** a. Authorization may be granted docetaxel as single-agent therapy for ANY of the following: i. Primary treatment for clinical stage T3-4, cN1-2 disease or any T with palpable lymph nodes and cN1-2 ii. Primary treatment of metastatic disease iii. Recurrent clinical stage T2 disease iv. Second-line treatment of recurrent or metastatic disease if not used as first-line therapy **2. Bone Cancer** **2.1 Ewing's Sarcoma** a. Authorization may be granted for docetaxel in combination with gemcitabine with or without vincristine (and growth factor support) for ANY of the following:		Up to 12 Months

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				i. Relapse, with or without radiation therapy (RT) ii. Progressive disease following primary treatment iii. Metastatic disease as second-line therapy **2.2 Osteosarcoma** a. Authorization may be granted for docetaxel in combination with gemcitabine (and growth factor support) as second-line therapy for relapsed/refractory or metastatic disease. **3. Breast Cancer** **3.1 Preoperative/Neoadjuvant Therapy for Stage IIA, IIB, IIIA or Locally Advanced Disease (Stage IIIA-C)** a. Authorization may be granted for docetaxel for preoperative/neoadjuvant systemic therapyin the any of the following regimens: i. For human epidermal growth factor receptor 2 (HER2)-negative tumors 1) In combination with cyclophosphamide (TC regimen) or with doxorubicin and cyclophosphamide (TAC regimen) 2) As a single agent following AC (doxorubicin and cyclophosphamide) or following FEC/CEF (fluorouracil, epirubicin, and cyclophosphamide) ii. For HER2-positive tumors 1) In combination with carboplatin and trastuzumab (TCH regimen) (with or without pertuzumab) 2) In combination with trastuzumab following AC (with or without pertuzumab) 3) In combination with trastuzumab and pertuzumab following AC or prior to/following FEC/CEF **3.2 Adjuvant Therapy for Stage I, IIA, IIB, IIIA or Locally Advanced Disease (Stage IIIA-C)** a. Authorization may be granted docetaxel for adjuvant systemic therapy in any of the following regimens: i. For HER2-negative tumors 1) In combination with cyclophosphamide (TC regimen) or with doxorubicin and cyclophosphamide (TAC regimen) 2) As a single agent following AC (doxorubicin and cyclophosphamide) or following FEC/CEF (fluorouracil, epirubicin, and cyclophosphamide) ii. For HER2-positive tumors 1) In combination with carboplatin and trastuzumab (TCH regimen) 2) In TCH regimen with pertuzumab if pertuzumab was		

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				not used as neoadjuvant therapy 3) In combination with trastuzumab following AC 4) In combination with trastuzumab and pertuzumab following AC or prior to/following FEC/CEF if pertuzumab was not used as neoadjuvant therapy **3.3 Recurrent or Metastatic (Stage IV) Disease** a. Authorization may be granted for docetaxel for recurrent or metastatic disease and the following criteria are met: i. For HER2-negative tumors 1) Docetaxel is used as a single agent or in combination with capecitabine and member has ANY of the following: a) Hormone receptor (HR)-positive disease with visceral crisis b) HR-negative disease c) HR-positive disease that is refractory to endocrine therapy d) Progressive disease with no clinical benefit after three consecutive endocrine therapy regimens e) Progressive symptomatic visceral disease ii. For HER2-positive tumors 1) Docetaxel is used in combination with trastuzumab as first-line therapy or as therapy for trastuzumab-exposed disease and member has ANY of the following: a) HR-positive disease with visceral crisis b) Progressive disease with no clinical benefit after three consecutive endocrine therapy regimens c) Progressive symptomatic visceral disease 2) Docetaxel is used in combination with trastuzumab and pertuzumab as first-line therapy or for one line of therapy beyond first-line therapy in patients previously treated with chemotherapy and trastuzumab in the absence of pertuzumab and member has ANY of the following: a) HR-negative disease b) HR-positive disease that is refractory endocrine therapy c) Progressive symptomatic visceral disease **4. Esophageal and Esophagogastric Junction Cancers** a. Authorization may be granted for locoregional disease (Stage I-III) prescribed docetaxel in combination with cisplatin for use as: i. Definitive chemoradiation for 1) Members who are medically unfit		

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				for surgery or who decline surgery for T1b, N+ or T2-4a, N0-N+ disease 2) Members who are medically unfit for surgery with T1b, N0 tumors with poor prognostic features 3) T4b disease ii. Concurrent chemoradiation for locoregional recurrence in patients who have had surgery but no prior chemoradiation b. Authorization may be granted docetaxel for Stage IV disease or for palliative therapy and the following criteria are met: i. Docetaxel will be used a single agent or in combination with cisplatin, with cisplatin and 5FU, or with oxaliplatin and 5FU, and ii. Karnofsky Performance Status (PS) ≥ 60% or Eastern Cooperative Oncology Group (ECOG) PS 0-2, and iii. Member has ANY of the following: 1) T4b squamous cell carcinoma with invasion of the trachea, great vessels, or heart 2) Macroscopic residual disease 3) T1b, N+, T2-T4a, or unresectable T4b disease in members who are unfit for or do not elect surgery 4) Persistent, unresectable locally advanced, locally recurrent or metastatic disease **5. Gastric Cancer (Adenocarcinoma)** a. Authorization may be granted docetaxel for use as chemoradiation for primary treatment of locoregional disease (Stage I-III) and tumor is unresectable or member is unfit for surgery. b. Authorization may be granted docetaxel for Stage IV disease or for palliative therapy and the following criteria are met: i. Docetaxel will be used a single agent or in combination with cisplatin, with cisplatin and 5FU, or with oxaliplatin and 5FU, and ii. Karnofsky PS ≥ 60% or ECOG PS 0-2, and iii. Member has ANY of the following: 1) Locoregional disease and member is medically unfit for surgery 2) Macroscopic residual disease following surgical resection 3) Medically inoperable or unresectable residual disease following primary treatment 4) Unresectable locally advanced, locally recurrent, or metastatic disease		

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				6. Head and Neck Cancer (SCCHN) **6.1 Induction Therapy for Locally Advanced, Non-nasopharyngeal Disease** a. Authorization may be granted docetaxel in combination with cisplatin and 5FU, followed by RT or chemoradiation, and member has Stage III or IVA/B cancer of the glottic larynx, supraglottic larynx, or hypopharynx. **6.2 Primary Chemotherapy for Metastatic, Nasopharyngeal Disease** a. Authorization may be granted for docetaxel in combination with cisplatin or carboplatin for primary therapy for metastatic (Stage IVC) disease. **6.3 Chemotherapy for Very Advanced Local Disease, Unresectable, Recurrent/Persistent, or Metastatic Disease (Palliative)** a. Authorization may granted for members with ECOG PS 0-3 who are prescribed docetaxel as single-agent therapy and ANY of the following criteria are met: i. Newly diagnosed T4b, any N disease ii. Unresectable nodal disease with no metastases iii. Unresectable locoregional recurrence and no prior RT iv. Member is unfit for surgery b. Authorization may be granted docetaxel as 1) a single agent (in members with PS 0-2), 2) in combination with cisplatin (in members with PS 0-1), 3) in combination with carboplatin (in members with PS 0-1), or 4) in combination with cisplatin and cetuximab (non-nasopharyngeal, PS 0-1) and member has ANY of the following: i. Unresectable locoregional recurrence and prior RT ii. Second primary neoplasm and prior RT iii. Distant metastases (Stage IVC) **7. Non-Small Cell Lung Cancer (NSCLC)** **7.1 Neoadjuvant, Adjuvant, or Induction Therapy (Stage I-III Disease)** a. Authorization may be granted for docetaxel in combination with cisplatin for use as: i. Neoadjuvant or induction chemotherapy for Stage I-III disease		

BRAND NAME DRUG(S)	PRE-AUTH GROUP DESCRIPTION	COVERED USES	EXCLUSION CRITERIA	MEDICAL CRITERIA	PRESCRIBER RESTRICTION	COVERAGE DURATION
				ii. Adjuvant chemotherapy for 1) Stage IB disease that is either margin-positive or high-risk and margin-negative 2) Stage II or Stage III disease **7.2 Chemotherapy for Recurrent or Metastatic (Stage IV) Disease or Palliative Therapy** a. Authorization may be granted docetaxel for mediastinal lymph node recurrence or metastatic (Stage IV) disease or for palliative therapy and ANY of the following criteria are met i. First-line treatment as a single agent or in combination with cisplatin, carboplatin or gemcitabine in members with ECOG PS 0-2 ii. First-line treatment in cisplatin- or carboplatin-based regimens in combination with bevacizumab for members with PS 0-1, tumors of nonsquamous cell histology, and no history of recent hemoptysis iii. Second-line treatment as a single agent for progression in patients with a negative or unknown EGFR mutation status if not already given iv. Third-line treatment as a single agent for progressive disease in patients with PS 0-2 if not already given and erlotinib or crizotinib were used as first- or second-line therapy **8. Occult Primary (Cancer of Unknown Primary)** **8.1 Adenocarcinoma or Carcinoma Not Otherwise Specified** a. Authorization may be granted for members with ECOG PS 0-2 who are prescribed docetaxel in combination with carboplatin or gemcitabine for use as either of the following: i. Chemoradiation for localized disease with inguinal nodal involvement, or ii. Chemotherapy for disseminated metastases or for localized disease involving any of the following sites: 1) Lung nodules 2) Breast marker-negative pleural effusion 3) Liver (resectable or unresectable) 4) Peritoneal mass with non-ovarian histology **8.2 Squamous Cell Carcinoma (SCC)** a. Authorization may be granted for members with ECOG PS 0-2 who are prescribed docetaxel in combination with cisplatin, carboplatin, or cisplatin and 5FU for use as either of the following: i. Chemoradiation therapy for localized disease with axillary or inguinal		

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				nodal involvement, or ii. Chemotherapy for disseminated metastases or for SCC involving multiple lung nodules or with pleural effusion **9. Ovarian Cancer** **9.1 Epithelial Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer** a. Authorization may be granted for members who are prescribed docetaxel in combination with carboplatin for: i. Neoadjuvant therapy for bulky Stage III-IV disease in poor surgical candidates ii. Primary treatment for one of the following: 1) Incompletely staged members (Stage IA-IB, grade 2-3 or clear cell and Stage IC) with no suspected residual disease 2) Incompletely staged Stage II-IV members with suspected unresectable residual disease iii. Primary adjuvant treatment for one of the following: 1) Pathologic Stage IA-IB (grades 2-3 or clear cell) and Stage IC (all grades) 2) Pathologic Stage II-IV disease following completion surgery in selected cases a. Authorization may be granted for docetaxel in combination with carboplatin for clinical or biochemical (ie, rising CA-125 levels) relapse/recurrence in members who have not received prior chemotherapy. b. Authorization may be granted for docetaxel as a single agent (if platinum-resistant) or in combination with carboplatin (if platinum-sensitive) for: i. Persistent disease, or ii. Recurrence and docetaxel will not be used for immediate treatment of biochemical relapse **9.2 Malignant Sex-Cord Stromal Tumors** a. Authorization may be granted for members with Stage II-IV disease who are prescribed docetaxel as a single agent for clinical relapse. **10. Penile Cancer** a. Authorization may be granted docetaxel for second-line treatment of metastatic disease as single-agent therapy.		

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				11. Prostate Cancer a. Authorization may be granted for docetaxel for either of the following: i. Castration-recurrent metastatic prostate cancer, or ii. Metastatic small-cell carcinoma of the prostate (metastases with small cell features) **12. Small Cell Lung Cancer (SCLC)**a. Authorization may be granted for members with ECOG PS 0-2 who are prescribed docetaxel for subsequent chemotherapy (ie, second-line) as a single agent for ANY of the following: i. Relapse within 6 months of completing initial therapy ii. Stable disease following initial therapy iii. Primary progressive disease **13. Soft Tissue Sarcoma (STS)** **13.1 Angiosarcoma** a. Authorization may be granted docetaxel as a single agent or in combination with gemcitabine. **13.2 Retroperitoneal or Intra-abdominal STS** a. Authorization may be granted docetaxel in combination with gemcitabine for either of the following: i. Primary therapy for attempted down-staging of unresectable, recurrent or metastatic disease, or ii. Palliative therapy for unresectable or progressive disease **13.3 Rhabdomyosarcoma** a. Authorization may be granted docetaxel in combination with gemcitabine for pleomorphic rhabdomyosarcoma. **13.4 STS of the Extremity or Superficial Trunk** a. Authorization may be granted for docetaxel in combination with gemcitabine for: i. Primary chemotherapy or chemoradiation for Stage II-III disease that is either 1) Unresectable (primary tumor or local recurrence), or 2) Resectable with adverse functional outcomes ii. Primary or palliative chemotherapy for synchronous Stage IV disease iii. Palliative chemotherapy for recurrent disease with disseminated metastases		

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				14. Uterine Neoplasms **14.1 Endometrial Carcinoma With Endometrioid Adenocarcinoma Histology** a. Authorization may be granted for members in whom paclitaxel is contraindicatedand docetaxel is prescribed for ANY of the following: i. Primary treatment in combination with carboplatin and with sequential RT and brachytherapy for extrauterine pelvic disease (ie, vaginal, bladder, bowel/rectum, parametrial) ii. Primary treatment in combination with carboplatin following surgery (eg, hysterectomy + bilateral salpingo-oophorectomy), with or without RT and/or hormonal therapy, for extra-abdominal or liver disease iii. Adjuvant treatment in combination with carboplatin for surgically staged Stage IIIA, IIIB, IIIC and IV members (with or without RT) iv. Chemotherapy in combination with carboplatin for local/regional recurrence (with or without RT) or disseminated metastases **14.2 Endometrial Carcinoma With Serous Adenocarcinoma, Clear Cell Adenocarcinoma, or Carcinosarcoma Histology** a. Authorization may be granted for members in whom paclitaxel is contraindicated and docetaxel is prescribed for adjuvant therapy in combination with carboplatin for Stage I to IV disease (with or without brachytherapy or RT) **14.3 Uterine Sarcoma: Leiomyosarcoma and High-Grade (Undifferentiated) Endometrial Sarcoma** a. Authorization may be granted docetaxel in combination with gemcitabine for ANY of the following: i. Medically inoperable disease limited to the uterus ii. Following surgery (eg, total hysterectomy ± bilateral salpingo-oophorectomy) for Stage II-IV disease iii. Local vaginal recurrence iv. Extrapelvic recurrence in patients with no prior RT v. Isolated or disseminated metastases		
EGRIFTA	GROWTH HORMONE MODIFIER	All FDA-approved indications		Must meet the following criteria: Diagnosis of excessive abdominal fat in HIV-infected patient with lipodystrophy. For reauthorization: 1) Diagnosis of excessive abdominal fat in HIV-infected patient with lipodystrophy and 2) Patient had a reduction in visceral adipose tissue (VAT).		26 Weeks for initial therapy and 26 weeks upon renewal

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ELAPRASE	HUNTER SYNDROME	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Hunter Syndrome		
ELELYSO	GAUCHER DISEASE	All FDA-approved indications		Must meet the following criteria: Diagnosis of Type 1 Gaucher Disease		
ELIGARD	HORMONAL THERAPIES	Prostate Cancer		Meets the following criteria: 1) Locally advanced, recurrent, or metastatic disease (regional lymph nodes or distant metastases) 2) Initial neoadjuvant/concomitant/adjuvant androgen deprivation therapy (ADT) in combination with radiation therapy for clinically localized disease with intermediate or high risk of recurrence		24 Months
ELOCTATE	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		Meets the following criteria: 1) Diagnosis of Hemophilia A		
ELOXATIN, OXALIPLATIN	ONCOLOGY	All FDA-approved indications		Meets the following criteria: 1) Cancer type/location, tumor histology and grade, staging, new cancer/recurrence, metastases, prior treatments, treatment intent (eg, initial chemotherapy, neoadjuvant, adjuvant, or palliative) 2) Treatment plan with treatment regimen including dose, frequency, length of each cycle, number of cycles, and additional therapies (eg, other medications, radiation) 3) Height, weight, and body surface area (BSA)		Up to 12 Months

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ENBREL	ARTHRITIS/ PSORIASIS	All FDA-approved indications		Must meet the following criteria: Rheumatoid Arthritis (RA): 1) Diagnosis of moderately to severe active RA and 2) Trial and failure or inadequate response to at least one or more DMARDs. Juvenile Idiopathic Arthritis (JIA): 1) Diagnosis of moderately to severe active polyarticular course JIA and 2) Trial and failure or inadequate response to at least one or more DMARDs is required. Psoriatic Arthritis (PsA): 1) Diagnosis of active PsA and 2) Trial and failure or inadequate response to at least one or more DMARDs is required. Ankylosing Spondylitis (AS): 1) Diagnosis of AS. Plaque Psoriasis: 1) Diagnosis of chronic moderate to severe plaque psoriasis requiring systemic or phototherapy. For all Diagnosis: If patient is receiving a different TNF blocking agent, therapy must be discontinued prior to initiating new TNF. For all above diagnosis, must be must FDA approved dosage guidelines.	Rheumatologist or dermatologist must recommend/ requested therapy for RA, JRA, PsA, AS. Dermatologist must recommend therapy for Plaque Psoriasis.	12 Months
ENTYVIO	INFLAMMATORY BOWEL DISEASE	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Moderate-to Severely active Crohn's or Ulcerative Colitis 2) Inadequate response, intolerance, or contradiction to at least 1 DMARD, prednisone, or alternative product PLUS at least 1 TNF-alpha inhibitor		Up to 12 Months
EPOPROSTENOL, FLOLAN	PULMONARY HYPERTENSION	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of PAH 2) NYHA functional class symptoms, Pulmonary arterial pressures, PCWP, Pulmonary Vascular Resistance measurements commensurate with the disease		

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ERBITUX	ONCOLOGY	All FDA-approved indications		Must meet the following Criteria: 1) Head and Neck Cancer a) In combination with radiation for squamous cell head and neck cancer b) In combination with platinum-based therapy with 5-fluorouracil for first line treatment with recurrent locoregional disease or metastatic squamous cell carcinoma of the head & neck c) As a single agent for recurrent metastatic squamous cell carcinoma of the head & neck in patients failing platinum-based therap. 2) Colorectal Cancer a) KRAS mutation negative, EGRF expressing, metastatic colorectal cancer: i) In combination with FOLFIRI as first line treatment ii) In combination with irinotecan in patients who are refractory to irinotecan-based chemotherapy iii) As a single agent for those failing oxaliplatin and irinotecan based chemotherapy 3) Non-Small Cell Lung Cancer (NSCLC) a) Stage IV disease or those where Erbitux is used in combination with platinum-based chemotherapy as a first line treatment and Erbitux is being continued with response or stable disease. 4) Squamous Cell Skin Cancer a) Recurrent or metastatic disease.		Up to 24 months
ERIVEDGE	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: Skin Cancer: 1) Diagnosis of metastatic or locally advanced basal cell carcinoma that has recurred after surgery or cannot be treated by surgery or radiation.	Oncologist must recommend Erivedge.	12 Months
ESBRIET	IDIOPATHIC PULMONARY FIBROSIS	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Idiopathic Pulmonary Fibrosis		

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EXJADE	CHRONIC IRON OVERLOAD	All FDA-approved indications	Creatinine Clearance < 40mL/min	Must meet the following criteria: 1) Diagnosis of Iron Overload 2) Must provide lab values a) Serum creatinine b) Pretreatment serum ferritin c) Liver Iron concentration (LIC)		
EYLEA	RETINAL DISORDERS	All FDA-approved indications		Must meet the following criteria: 1) Must have one of the following diagnosis a) Neovascular (wet) age-related macular degeneration b) Macular edema following retinal vein degeneration c) Diabetic macular edema d) Diabetic retinopathy with macular edema	Ophthalmologist	12 Months
FABRAZYME	FABRY DISEASE	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Fabry Disease		
FARYDAK	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Multiple Myeloma 2) History of Myocardial infarction and/or ST-segment or T-wave abnormalities 3) QTC interval 4) Serum electrolytes 5) Prior use of Velcade and a immunomodulating agent		
FEIBA NF, FEIBA VH	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		Must meet the following criteria: Hemophilia A & B		
FERRIPROX	IRON OVERLOAD	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of transfusional iron overload		

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FIRAZYR	HEREDITARY ANGIOEDEMA	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of HAE		
FIRMAGON	ONCOLOGY	PROSTATE CANCER		Must meet the following criteria: 1) Locally advanced, recurrent, or metastatic prostate cancer 2) Neoadjuvant ADT for radical prostatectomy		24 Months
FOLLISTIM AQ	INFERTILITY	All FDA-approved indications		Coverage is based on member's benefit.		
FORTEO	OSTEOPOROSIS	All FDA-approved indications	Paget's disease Unexplained elevations of alkaline phosphatase, Open epiphyses, Prior radiation therapy of the skeleton, Skeletal malignancy, Bone metastases, Pre-existing hypercalcemia	Must meet the following criteria: 1) Indications a) Treatment of postmenopausal woman with osteoporosis at high risk of fracture b) Treatment to increase bone mass in men with primary or hypo-gonadal osteoporosis at high risk of fracture c) Treatment of osteoporosis associated with glucocorticoid therapy at high risk 2) Trial or documented intolerance to bisphosphonates 3) Fracture history and T-Score indicative of osteoporosis		24 Months
FUZEON	HIV TREATMENT	All FDA-approved indications		Must meet the following criteria: 1) Must have the following diagnosis 2) HIV-1 infection 3) Provide baseline CD-4 and HIV Viral Load		
GANIRELIX	INFERTILITY	All FDA-approved indications		Coverage is based on member's benefit.		

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GATTEX	GASTRO-INTESTIONAL DISORDER AGENT	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of short bowel syndrome. 2) Dependent on parenteral nutrition.		
GENOTROPIN, HUMATROPE, NORDITROPIN, NORDITROPIN NORDIFLEX,NUTROPIN AQ, NUTROPIN, OMNITROPE, SAIZEN,TEV-TROPIN	GROWTH HORMONE AGENTS	All FDA-approved indications	Idopathic Short Stature	Must meet the following criteria: ADULT with Diagnosis of: 1) Adult-onset growth hormone deficiency (GHD) due to hypothalamic-pituitary disease or 2) History of cranial irradiation or 3) Documented childhood-onset GHD and for all adult indications have been evaluated for other endocrine disorders and failed stimulation test. A trial and failure of the preferred agent (norditropin) is required unless member has been on a non-preferred agent for greater than 6 months. Renewal (Adult): Monitoring of serum insulin-like growth factor (IGF-1). CHILDREN with Diagnosis of: 1) Isolated GHD/pituitary dwarfism with a) Open bony epiphyses, b) Growth velocity less than the 10th percentile, c) Bone age less than chronological age d) Height less than the 5th percentile for chronological age e) Two documented failed stimulation test f) Bone age less than 16 years for boys or less than 14 years for girls g) Height velocity is 2.5 cm/year over the previous untreated rate h) Child has not reached the 25th percentile of normal adult height for sex. or 2) Panhypopituitarism 3) Iatrogenic Pituitary Disorder 4) Chronic renal insufficiency prior to transplantation 5) Pituitary Tumor 6) Turner syndrome with short stature 7) Prader-Willi syndrome 8) Noonan syndrome in pre-pubertal children with short stature and a) with height at least 2SDs below the mean for chronological age and b) sex and growth velocity measured over 1 year prior to initiation of therapy of 1 or more SDs before the mean for age and sex. 9) Small for gestational age (SGA) defined as weight or length more than 2SDs below the mean for gestational age who have failed to reach catch-up age by age two. For all pediatric indications, a trial and failure of the preferred agent (norditropin) is required unless member has been on a non-preferred agent for greater than 6 months. For all pediatric indications, patient should be evaluated for other causes of growth failure such as thyroid deficiency. Renewal (child): 1) One of above diagnosis 2) For GHD: a) Child's bone age is less than 16 years for boys or less than 14 years for girls, and b) Child's height velocity is 2.5 cm/year over the previous untreated rate and c) Child has not reached the 25th percentile of normal adult height for sex.		12 months

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GILOTRIF	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: Metastatic non-small cell lung cancer (NSCLC) and presence of tumors with epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test.	Oncologist has recommended Gilotrif.	12 Months
GLASSIA	ALPHA-1 ANTITRYPSIN DEFICIENCY	All FDA-approved indications	IgA deficiency with antibodies against IgA due to risk of severe hypersensitivity	Must meet the following criteria: 1) Diagnosis of ATT deficiency 2) Emphysema		
GLEEVEC	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis with one of the following: a) Chronic myeloid leukemia (CML) b) Acute lymphoblastic leukemia (ALL) or lymphoblastic lymphoma c) Myelodysplastic syndromes (MDS)/myeloproliferative diseases (MPD) d) Aggressive systemic mastocytosis (ASM) e) Melanoma f) Gastrointestinal stromal tumor (GIST) g) Hypereosinophilic syndrome (HES)/chronic eosinophilic leukemia (CEL) h) Desmoid tumor i) Dermatofibrosarcoma protuberans (DFSP) j) Pigmented villonodular synovitis (PVNS)/tenosynovial giant cell tumor (TGCT) k) Chordoma 2) Disease state based Cytogenic and/or molecular testing if necessary: a) Ph Chromosome b) BCR-ABL gene c) Platelet-derived growth factor (PDGF) gene rearrangements d) D816V KIT mutation e) C-KIT mutation	Oncologist has recommended Gleevec.	
GONAL F	INFERTILITY	All FDA-approved indications		Coverage is based on member's benefit.		

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HARVONI	HEPATITIS C	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Hepatitis C 2) Hepatitis C Viral Load 3) Hepatitis C genotype 4) METAVIR fibrosis score 5) Co-infection status a) Decompensated liver disease b) Cirrhosis c) Post liver transplant HIV d) Must meet the following criteria: Hemophilia A		Up to 24 Months
HELIXATE FS	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications				
HEMOFIL M	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		Must meet the following criteria: Hemophilia A		
HERCEPTIN	ONCOLOGY	All FDA-approved indications		1) Breast Cancer a) HER2-positive breast cancer in combination: i) with neoadjuvant treatment ii) with or following chemotherapy for adjuvant treatment b) HER2-positive recurrent or metastatic with or without previous exposure 2) Esophageal, Gastric, or Gastroesophageal Junction Cancer a) Use in combination with chemotherapy in Her2-positive tumor types 3) Non-Small Cell Lung Cancer Use for HER2-positive tumor types		Up to 24 Months
HETLIOZ	NON-24 HOUR SLEEP-WAKE DISORDER	All FDA-approved indications		Must meet the following criteria: a) 1) Diagnosis of non-24 hour sleep-wake disorder		
H.P. ACTHAR	SIEZURE DISORDER			Must meet the following criteria: 1) Diagnosis of one of the following: a) Infantile spasm b) Diagnostic testing of adrenalcortical function c) Collagen disease (SLE) d) Dermatologic disorders including Stevens-Johnson syndrome, severe erythema multiforme e) Multiple sclerosis f) Nephrotic syndrome g) Ophthalmic disorders including iritis, keratitis, optic neuritis		

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				h) Rheumatic disease including Rheumatoid arthritis, ankylosing spondylitis i) Serum sickness j) Symptomatic sarcoidosis Trial of parenteral corticosteroids		
HUMATE-P	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		2) Must meet the following criteria: Diagnosis of Hemophilia A, or von Willebrand Syndrome		
HUMIRA	ARTHRITIS/ PSORIASIS/ CHROHN'S/ ULCERATIVE COLITIS	All FDA-approved indications		Must meet the following criteria: Moderate to severe Rheumatoid Arthritis (RA): 1) Diagnosis of moderate-to-severe active rheumatoid arthritis and 2) Trial and failure/inadequate response to at least one or more DMARDs. Juvenile Idiopathic Arthritis (JIA): 1) Diagnosis of moderate-to-severe active polyarticular JIA and 2) Trial and failure or inadequate response to at least one or more DMARDs. Psoriatic arthritis (PsA): 1) Diagnosis of active PsA and 2) Trial and failure/inadequate response to at least one or more DMARDs Ankylosing spondylitis (AS): 1) Diagnosis of active Ankylosing Spondylitis. Plaque Psoriasis: 1) Moderately to severely chronic plaque psoriasis and 2) Failed phototherapy or systemic therapy Crohn's disease: 1) Diagnosis of moderate to severe active Crohn's Disease and 2) Trial and failure of at least one or more conventional therapy such as 5-ASA, systemic corticosteroids or immunosuppressants. For all Diagnosis: If patient is receiving a different TNF blocking agent, therapy must be discontinued prior to initiating new TNF. For all above diagnosis, must be must FDA approved dosage guidelines.	Rheumatologist or Dermatologist must recommend therapy for RA, JIA, AS, PsA. Dermatologist must recommend therapy for Plaque Psoriasis. Gastroenterologist must recommend therapy for Crohn's disease.	12 Months
HYALURONATE & DERIVATIVES, HYALGEN, SUPARTZ, EUFLEXXA, ORTHOVISC, GEL-ONE, MONOVISC	OSTEOARTHRITIS	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Hip, knee, or shoulder OA 2) Trail of non-drug therapy including: weight loss, exercise Trial of NSAID's, acetaminophen, Ultram, intra-articular corticosteroid injection		

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HYCAMTIN	ORAL ONCOLOGY	All FDA-approved indications		3) Must meet the following criteria: Lung Cancer: 1) Diagnosis of small cell lung cancer (SCLC) and 2) Prior responder to first line chemotherapy.	Oncologist has recommended Hycamtin.	12 Months
IBRANCE	BREAST CANCER	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Breast cancer 2) Stage of Breast Cancer 3) Pathology: a) Her-2 status Estrogen receptor status		
ICLUSIG	ORAL ONCOLOGY	All FDA-approved indications		b) Must meet the following criteria: Leukemia: 1) Diagnosis of chronic phase, accelerated phase, or blast phase chronic myeloid leukemia (CML) that is resistant or intolerant to prior tyrosine kinase inhibitor therapy 2) Diagnosis of Philadelphia chromosome-positive acute lymphocytic leukemia (ALL) that is resistant or intolerant to prior tyrosine kinase inhibitor therapy.	Oncologist has recommended Iclusig.	12 Months
ILARIS	CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS)			Must meet the following criteria: 1) Diagnosis of CAPS, including FDAS (Familial cold auto-inflammatory syndrome) and MWS (Muckle-Wells Syndrome).		
IMBRUVICA	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: Lymphoma: 1) Diagnosis of mantle cell lymphoma (MCL) 2) Has received at least one prior therapy towards treatment of mantle cell lymphoma. Leukemia: 1) Diagnosis of chronic lymphocytic leukemia (CLL) 2) Has received at least one prior therapy towards treatment with chronic lymphocytic leukemia.	Oncologist has recommended Ibrutinb.	12 Months

BRAND NAME DRUG(S)	PRE-AUTH GROUP DESCRIPTION	COVERED USES	EXCLUSION CRITERIA	MEDICAL CRITERIA	PRESCRIBER RESTRICTION	COVERAGE DURATION
IMMUNE GLOBULIN, BIVIGAM, CARIMUNE NF, FLEBOGAMMA, GAMASTAN S/D, GAMMAGARD, GAMMAKED, GAMMAPLEX, GAMUNEX, HIZENTRA, HYQVIA, OCTAGAM, PRIVIGEN	IMMUNE THERAPIES	All FDA-approved indications	IgA deficiency with antibodies to IgA AND a history of hypersensitivity	Must meet the criteria for: 1) Diagnosis of an approved disease state including: Primar immunodeficiency, Chronic inflammatory demyelinating polyneuropathy, Multifocal motor neuropathy, Dermatomyositis, Guillain-Barre Syndrome, Myasthenia Gravis, Lambert-eaton myasthenic syndrome, ITP, Parvovirus B19-induced red cell aplasia, Kawasaki syndrome, Fetal/neonatal alloimmune thrombocytopenia, or B-Cell Chronic Lymphocytic Leukemia.		Up to 24 Months
INCIVEK	HEP C AGENTS	All FDA-approved indications		a) Must meet the following criteria: For Initial treatment: In Incivek_Pegasys (preferred agent) or Peg-Intron (non-preferred)_ Ribavirin triple therapy plan requires the following: 1) Diagnosis of Hepatitis C, genotype-1, and 2) Prior treatment and outcome if applicable, and 3) must be naïve to Incivek and Victrelis therapy, and 4) History of compensated liver disease (i.e. cirrhosis), and 5) baseline (pre-treatment) HCV-RNA and 6) Labs and clinical documentation must be included with request and 7) Treatment with preferred agent (Pegasys) is required unless member is already receiving Peg-Intron, Note for initial treatment: In Peg-interferon_Ribavirin_Incivek triple therapy, Pegasys (preferred agent) or Peg-Intron (non-preferred) and Incivek are initially authorized for 8 weeks (Ribavin does not require authorization) **For Continuation Treatment** with Incivek_Peg-interferon_Ribavirin, plan requires the following: 1) result of HCV-RNA levels at TW 4,12 and 24 to evaluate continuation or stopping of therapy per manufacturer guidelines and 2) HCV-RNA less than 1000 IU_ml at TW4 is required to continue therapy and 3) HCV-RNA level less than1000IU_ml at TW12 is required to continue therapy and 4) HCV-RNA level undetectable at TW24 is required to continue therapy. Note for continuation treatment: Incivek may be renewed for additional 4 weeks depending on therapy and clinical response (maximum total length of therapy for Incivek is 12 weeks) and peg-interferon may be renewed for up to an		Initial: 8 weeks of Incivek. Continuation: 4 weeks depending on therapy and clinical response.

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				additional 40 weeks (maximum total length of therapy for peg-interferon is 48 weeks) depending on therapy and clinical response.		
INCRELEX	IGF-1 HORMONES	All FDA-approved indications		Must meet the following criteria: Growth failure due to severe primary IGF-1 deficiency (primary IGFD) 1) Dx of primary IGFD and 2) Other causes of growth failure have been ruled out and 3) Bone epiphyses is open and 4) Height standard deviation score is less than or equal to -3.0 and 5) Basal IGF-1 standard deviation score is less than or equal to -3.0 and 6) Growth hormone level is normal or elevated. Diagnosis of growth hormone gene deletion 1) Dx of growth hormone gene deletion with neutralizing antibodies to growth hormone and 2) Other causes of growth failure have been ruled out.		12 Months
INLYTA	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: Renal (Kidney) Cancer: 1) Diagnosis of advanced renal cell carcinoma and 2) Trial and failure of Nexavar, Sutent or Votrient.	Oncologist has recommended Inlyta.	12 Months
INTRAVENOUS IMMUNE GLOBULIN (IVIG)				Medical Policy		
INTRON-A	HEPATITIS C, AIDS-RELATED KAPOSI SARCOMA, FOLLICULAR LYMPHPOMA, HAIRY CELL LEUKEMIA, MALIGNANT MELANOMA	All FDA-approved indications	Autoimmune hepatitis, decompensated liver disease, uncontrolled major depression, severe mental illness	Must meet the following criteria: 1) Diagnosis of one of the following: a) Hepatitis B virus b) Hepatitis C virus c) Condylomata acuminate d) Chronic myelogenous leukemia (CML) e) Malignant melanoma f) Renal cell carcinoma g) Clinically aggressive follicular non-Hodgkin's lymphoma h) Giant cell tumor of the bone i) Systemic light chain amyloidosis j) Desmoid tumor k) Adult T-cell leukemia/lumphoma l) Hairy cell leukemia m) AIDS-related Kaposi's Sarcoma n) Mycosis fungoides/Sezary syndrome Polycythemia Vera		

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JAKAFI	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Myleofibrosis: o) Diagnosis of intermediate or high-risk myleofibrosis, including primary myelofibrosis, pos-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis.	Hematologist/Oncologist has recommended Jakafi.	12 Months
JUXTAPID	HOMOZYGOUS FAMILIAM HYPERCHOLESTEROLEMIA	All FDA-approved indications	Hepatic impairment (Child-Pugh class B or C)	Must meet the following criteria: 1) Diagnosis of Familial hypercholesterolemia (HoFH) 2) Diagnosis of Coronary Artery Disease (CAD) 3) Serum LDL-C and Triglyceride levels 4) Gene mutation status 5) Trial of previous agents including: a) High-Potency Statin b) Fibric acid/Fenofibric acid c) Niacin/nicotinic acid d) Cholestyramine e) Ezetimibe a) Liver function tests	Lipid specialist or Cardiologist	
KADCYLA	ONCOLOGY	All FDA-approved indications		Must meet the following criteria: 1) Recurrent metastatic breast cancer 2) HER-2 status 6) Previous trial of Herceptin		
KALBITOR	HEREDITARY ANGIOEDEMA	All FDA-approved indications		Must meet the following criteria: 3) 1) Diagnosis of HAE		
KALYDECO	CYSTIC FIBROSIS AGENTS	All FDA-approved indications		Must meet the following criteria: Cystic Fibrosis: 1) Diagnosis of cystic fibrosis and 2) G551D mutation confirmed using a FDA-approved test.		12 Months
KINERET	ARTHRITIS	All FDA-approved indications		Must meet the following criteria: Rheumatoid Arthritis (RA): 1) Diagnosis of moderate to severe active RA and 2) Trial and failure or inadequate response to at least one or more DMARDs and 3) If patient is receiving a different TNF blocking agent, therapy must be discontinued prior to initiating new TNF. Must meet the following criteria: CAPS including Neonatal-onset multisystem inflammatory disease (NOMID): 1) Diagnosis of CAPS including NOMID	Rheumatologist must recommend therapy for RA.	24 Months

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KOATE-DVI	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		Must meet the following criteria: Hemophilia A, von Willebrand disease		
KOGENATE FS	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		Must meet the following criteria: Hemophilia A		
KORLYM	HYPERGLYCEMIA ASSOCIATED WITH CUSHING SYNDROME	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Cushing's syndrome 2) Surgical history 3) History of type 2 diabetes or glucose intolerance	Endocrinologist	
KUVAN	PHENYLKETONURIA	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of one of the following: 2) PHENYLKETONURIA 3) Biopterin metabolic defect a) Autosomal dominant guanine triphosphate deficiency (Segawa disease) b) Autosomal recessive guanine (GTP) cyclohydrolase deficiency c) 6-pyruvoyl-tetrahydropterin synthase (6-PTS) deficiency d) Dihydropteridine reductase (DHPR) deficiency e) Pterin-4a-carbinolamine dehydrase deficiency (primapterinuria) 4) Phenyl-free/phenylalanine-restricted diet Baseline Phenylalanine level		
KYNAMRO	HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA	All FDA-approved indications	Hepatic impairment (Child-Pugh class B or C)	Must meet the following criteria: 1) Diagnosis of Familial hypercholesterolemia (HoFH) 2) Diagnosis of Coronary Artery Disease (CAD) 3) Serum LDL-C and Triglyceride levels 4) Gene mutation status 5) Trial of previous agents including: a) High-Potency Statin b) Fibric acid/Fenofibric acid	Lipid Specialist or Cardiologist	

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				c) Niacin/nicotinic acid d) Cholestyramine e) Ezetimibe 5) Liver function tests		
LEMTRADA	MULTIPLE SCLEROSIS	All FDA-approved indications	HIV infection	Must meet the following criteria: 1) Diagnosis of one of the following forms of multiple sclerosis: a) Progressive-relapsing MS b) Relapsing-remitting MS c) Secondary progressive MS 6) Adequate response to 2 or more drugs indicated for MS		
LENVIMA	THYROID CANCER	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of thyroid carcinoma 2) Tumor histology 3) Stage of tumor 4) Radio-iodine trial 2)		
LETAIRIS	PULMONARY HYPERTENSION	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of PAH 2) NYHA functional class symptoms, Pulmonary arterial pressures, PCWP, Pulmonary Vascular Resistance measurements commensurate with the disease		Up to 24 Months
LEUKINE		All FDA-approved indications		Must meet the following criteria: For new starts: 1) Acute myeloid leukemia and receiving induction or consolidation chemo or 2) Myeloid recovery after autologous or allogenic BMT or 3) Allogenic or autologous BMT failure with engraftment delay or failure or 4) Peripheral blood progenitor cell transplantation. For all of the above listed diagnosis, a CBC and platelet count must be performed before and during therapy. If patient has received Leukine therapy within the past month then must meet following criteria: 1) Diagnosis of neutropenia (ANC less than 500) and 2) Have complete CBC with differential and platelet count during therapy and 3) Have no record of excessive leukocytosis.		4 Months

BRAND NAME DRUG(S)	PRE-AUTH GROUP DESCRIPTION	COVERED USES	EXCLUSION CRITERIA	MEDICAL CRITERIA	PRESCRIBER RESTRICTION	COVERAGE DURATION
LEUPROLIDE ACETATE, LUPRON, LUPRON DEPOT-PED	CENTRAL PRECOCIOUS PUBERTY, ENDOMETROSIS, PROSTRATE CANCER, UTERINE FIBROIDS	All FDA-approved indications		1) Endometriosis a) Lupron Depot and Depot-3Month are indicated for pain relief and reduction of endometroitic lessions. b) Lupron Depot, Depot-3Month, and Lupaneta Pack are indicated for initial management of endometriosis and for the management of recurrent symptoms. 2) Uterine Fibroids a) Lupron Depot and Depot-3Month are approved for use in combination with iron therapy for the preoperative hematologic improvement from Fibroids. b) Preoperatively to facilitate surgery 3) Ovarian Cancer a) Lupron Depot is indicated for relapse in patients with stage II-IV granulosa cell tumors b) Lupron Depot is indicated for epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer for persistent or recurrent disease. 4) Breast Cancer a) Lupron Depot is considered an adjuvant in premenopausal women with hormone receptor positive disease b) Lupron Depot can be used in combination with endocrine therapy for premenopausal women with hormone receptor positive recurrent or metastatic disease 5) Prostate Cancer a) Lupron Depot, Depot 3 Month, Depot 4-Month, Depot-6 Month are indicated for palliative treatment of advanced prostate cancer b) Locally advanced recurrent or metastatic disease Initial neoadjuvant/concomitant/adjuvant androgen deprivation therapy in combination with radiation for disease with intermediate to high risk of recurrence.		Up to 12 Months
LOVAZA, VASCEPA	OMEGA-3 ACID	All FDA-approved indications		c) Must meet the following criteria: 1) Diagnosis of hypertriglyceridemia and 2) TG level greater than 500mg/dL.		12 Months

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LUCENTIS	RETINAL DISORDERS	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of one of the following: a) Neovascular (wet) age-related macular degeneration b) Macular edema following retinal vein occlusion c) Diabetic macular edema Diabetic retinopathy with macular edema	Ophthalmologist	12 Months
LUMIZYME	POMPE DISEASE	All FDA-approved indications		Must meet the following criteria: d) 1) Diagnosis of Pompe Disease		
LYNPARZA	OVARIAN CANCER	All FDA-approved indications		Must meet the following criteria: 1) Advanced Ovarian Cancer 2) BRCA mutation testing Previous Chemotherapy History		
MACUGEN	RETINAL DISORDERS	All FDA-approved indications		Must meet the following criteria: 3) Neovascular (wet) Macular degeneration		
MEKINIST	ORAL ONCOLOGY	All FDA-approved indications		1) Must meet the following criteria: 1) Diagnosis of unresectable or metastatic melanoma. 2) BRAF V600E or V600K mutation confirmed using a FDA-approved test.	Oncologist has recommended Mekinist.	12 Months
MENOPUR, REPRONEX	INFERTILITY	All FDA-approved indications		Coverage is based on member's benefit.		
MIRCERA	ANEMIA	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Anemia in chronic kidney disease 2) Laboratory values: Hemoglobin, Hematocrit		
MONOCLATE-P	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		a) Must meet the following criteria: Hemophilia A		

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MONONINE	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		Must meet the following criteria: Hemophilia B		
MYALEPT	LIPODYSTROPHY	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of congenital or acquired lipodystrophy History of obesity, leptin deficiency, diabetes, hypertriglyceridemia, or HIV		
MYOZYME	POMPE DISEASE	All FDA-approved indications		Must meet the following criteria: 2) 1) Diagnosis of Pompe disease		
NAGLAZYME	MAROTEAUX-LAMY SYNDROME	All FDA-approved indications		Must meet the following criteria: 1) Maroteaux-Lamy Syndrome		
NATPARA	ENDOCRINE	All FDA-approved indications		Must meet the following criteria: 1) Hypocalcemia associated with hypoparathyroidism 2) Past medical and surgical history pertinent to hypoparathyroidism 3) Total serum calcium levels 4) Vitamin D levels 5) Use of calcium and Vitamin D		
NEULASTA	WBC STIMULANTS	All FDA-approved indications		Must meet the following criteria: New Start: 1) Diagnosis of Non-myeloid cancer receiving myelosuppressive chemotherapy and 2) CBC and platelet count must be performed before and during therapy. If patient has received Neulasta Therapy within the past month then meet the following criteria: 1) Diagnosis of neutropenia with Absolute Neutrophil Count (ANC less than 500/mm^3) or 2) Have moderate to high risk for developing neutropenia based on chemotherapy regimen and patient characteristics and 3) Have complete CBC with differential and platelet count during therapy and 4) No record of excessive leukocytosis.		4 Months

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NEUMEGA	PLATELET PROLIFERATION STIMULANTS	All FDA-approved indications	Patients receiving myeloblative chemotherapy.	Must meet the following criteria: 1) Patient has a diagnosis of non-myeloid cancer and 2) Patient is receiving myelosuppressive chemo and 3) Patient is at risk for severe thrombocytopenia.		4 Months
NEUPOGEN GRANIX	WBC STIMULANTS	All FDA-approved indications		Must meet the following criteria: New starts: 1) Non-myeloid cancer receiving myelosuppressive chemotherapy or 2) Acute myeloid leukemia (AML) receiving induction or consolidation chemo or 3) Severe chronic neutropenia or 4) Non-myeloid cancer receiving myeloablative chemotherapy followed by a BMT or 5) Peripheral blood progenitor cell transplantation. For all of the above listed diagnosis, a CBC and platelet count must be performed before and during therapy. If patient has received Neupogen Therapy within the past month then meet the following criteria: 1) Diagnosis of neutropenia with Absolute Neutrophil Count (ANC less than 500/mm^3) or 2) Have moderate to high risk for developing neutropenia based on chemotherapy regimen and patient characteristics and 3) Have complete CBC with differential and platelet count during therapy and 4) No record of excessive leukocytosis.		4 Months
NEXAVAR	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: Renal Cell Carcinoma: Diagnosis of advanced renal cell carcinoma or Hepatocellular Carcinoma: Diagnosis of unresectable hepatocellular carcinoma (HCC).	Oncologist has recommended Nexavar.	12 Months
NORTHERA	NEUROGENIC ORTHOSTATIC HYPOTENSION	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Neurogenic orthostatic hypotension 2) History of autonomic dysfunction from Parkinson's disease 3) History of non-diabetes related autonomic dysfunction History of Dopamine beta hydroxylase deficiency		
NOVOSEVEN	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		4) Must meet the following criteria: Hemophilia A & B and Congenital Factor VII deficiency		

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NPLATE	IDIOPATHIC THROMBOCYTOPENIA (ITP)	All FDA-approved indications		Must meet the following criteria: 1) Chronic ITP with an insufficient response to corticosteroids, immunoglobulins, or splenectomy. Cyclic thrombocytopenia.		Up to 12 Months
NUVIGIL	SLEEP DISORDER AGENTS	All FDA-approved indications		2) Must meet the following criteria: Narcolepsy: Diagnosis of narcolepsy documented by sleep study. Fatigue associated Mutiple Sclerosis: Symptoms of fatigue associated with MS. Shift Work Sleep Disorder (SWSD): Symptoms of excessive sleepiness associated with SWSD. Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS): Symptom of excessive sleepiness associated with OSAHS treated with continuous positive airway pressure (CPAP).		12 Months
OCTREOTIDE ACETATE, SANDOSTATIN, SANDOSTATIN LAR	ACROMEGALY	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of one of the following: a) Acromegaly b) Thymic carcinoma c) Unresectable, recurrent meningioma d) Lung neuroendocrine tumor e) Congenital hyperinsulinism f) Poorly differentiated)high-grade) neuroendocrine tumor/large or small cell tumors g) Carcinoid tumors h) Pancreatic endocrine tumors/islet cell tumors 2) Physical signs and symptoms consistent with the disease state identified above including: a) Frontal bossing b) Course facial features c) Thick lips d) Protruding jaw e) Widely spaced teeth Large hands & feet		
OFEV	IDIOPATHIC PULMONARY FIBROSIS	All FDA-approved indications		Must meet the following criteria: 1) Idiopathic pulmonary fibrosis a) High-resolution CT b) Lung biopsy 2) Past medical history indicative with IPF f) Liver function tests	Pulmonologist	

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OLYSIO	HEP C AGENTS	All FDA-approved indications		3) Must meet the following criteria: 1) Age 18 years or older 2) Diagnosis of chronic Hepatitis C Virus (HCV) Genotype 1, with a baseline positive HCV RNA 3) Used in combination with peginterferon alfa and ribavirin 4) If screened, negative for NS3 Q89K polymorphism 5) Has not failed therapy with a regimen containing Olysion, Victrelis, or Incivek		VARIES
OPSUMIT	PULMONARY HYPERTENSION	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of PAH 2) NYHA functional class symptoms, Pulmonary arterial pressures, PCWP, Pulmonary Vascular Resistance measurements commensurate with the disease		Up to 24 Months
OVIDREL	INFERTILITY	All FDA-approved indications		Coverage is based on member's benefit.		
ORENCIA SQ	ARTHRITIS	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of moderate to severe active Rheumatoid Arthritis (RA) 2) Trial and failure or inadequate response to at least one or more DMARDs such as Methotrexate, Imuran, Ridaura, Plaquenil, Cuprimine, Azulfidine or Arava. 3) Use of FDA approved dosing 4) If patient is receiving a different TNF blocking agent, therapy must be discontinued prior to initiating new TNF agent Orencia SQ. 5) Trial and failure or inadequate response to one preferred agent, Humira or Enbrel along with Cimzia.	Rheumatologist has recommended Orencia SQ.	12 Months
ORFADIN	HEREDITARY TYROSINEMIA TYPE 1	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Hereditary tryosinemia Type 1 Diagnosis confirmed by biochemical testing		
OTEZLA	PSORIATIC ARTHRITIS	All FDA-approved indications		2) Must meet the following: Psoriatic Arthritis (PsA): 1) Diagnosis of active PsA and 2) Trial and failure or inadequate response to at least one or more DMARDs is required. 3) If patient is receiving a different TNF blocking agent, therapy must be discontinued prior to initiating new TNF. 4) Must meet FDA approved dosage guidelines.	Rheumatologist or dermatologist must recommend/ requested therapy for PsA.	12 Months

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OTREXUP, RASUVO	RHEUMATOID ARTHRITIS	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Rheumatoid arthritis or Psoriasis 2) Trial of phytotherapy, cyclosporine, or acitretin (Psoriasis)		Up to 24 Months
PEGASYS, PEGINTRON, PEGINTRON REDIPEN	HEP C AGENTS	All FDA-approved indications		Must meet the following criteria: For Chronic Hepatitis C initial authorization: Pegasys (preferred agent) or Peg-Intron (non-preferred), plan requires the following: 1) Diagnosis of Hepatitis C and 2) Genotype test result and 3) Prior treatment and outcome if applicable and 4) History of compensated liver disease (i.e. cirrhosis) and 5) baseline (pre-treatment) HCV-RNA and 6) Labs and clinical documentation must be included with request and 7) Treatment with preferred agent (Pegasys) is required unless member is already receiving Peg-Intron. For all genotypes, initial authorization (if approved) is granted for 16 weeks only. HCV-RNA level should be evaluated at 12 weeks and results submitted with continuing authorization request. For Continuing authorization, plan requires the following: 1) result of HCV-RNA levels at week 12 to evaluate continuation or stopping of therapy per manufacturer guidelines (2 log drop in HCV-RNA at treatment week 12 is required to continue therapy, 2) Continuing authorization (if approved) is granted for a maximum of 32 additional weeks for genotype 1, 4, and 8 additional weeks for genotypes 2, 3, 5, 6 based on lab evaluation. For treatment of Hepatitis B with Pegasys only, length of authorization is 48 weeks.		Hep C: 48 weeks for Genotype 1, 4 and 24 weeks for Genotype 2,3,5, 6, Hep B: 48 weeks
PERJETA	ONCOLOGY	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of breast cancer 2) Pathology including Her-2 Previous chemotherapy regimens		
PLEGRIDY	MULTIPLE SCLEROSIS	All FDA-approved indications		Must meet the following criteria: 1) Patient must have one of the following diagnoses: a) Relapsing-remitting multiple sclerosis (RRMS) b) Progressive-relapsing multiple sclerosis (PRMS) c) Secondary progressive multiple sclerosis (SPMS) d) Primary progressive multiple sclerosis (PPMS)		

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				e) First clinical episode of multiple sclerosis f) Crohn's disease 3) Trial of other multiple sclerosis agents		
POMALYST	ORAL ONCOLOGY	All FDA-approved indications		2) Must meet the following criteria: Multiple Myeloma: Diagnosis of multiple myeloma and trial and failure of both Revlimid and Velcade.		12 Months
PROFILNINE SD	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		Must meet the following criteria: Hemophilia B		
PROGESTERONE IN OIL	INFERTILITY AGENTS	All FDA-approved indications		Coverage is based on member's benefit.		
PROLASTIN-C	ALPHA-1 ANTITRYPSIN DEFICIENCY	All FDA-approved indications	IgA deficiency with antibodies against IgA due to risk of severe hypersensitivity	Must meet the following criteria: 1) Diagnosis of ATT deficiency 2) Emphysema		
PROMACTA	IDIOPATHIC THROMBOCYTOPENIA	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis with one of the following: a) Chronic or persistent primary immune thrombocytopenia (ITP) b) Thrombocytopenia associated with chronic hepatitis C c) MYH9-related disease with thrombocytopenia d) Refractory severe aplastic anemia e) Cyclic thrombocytopenia 2) Trial of corticosteroids or immunoglobulin 3) Splenectomy (if pertinent) 4) Select laboratory values: a) Liver function tests Platelet count		
PROVENGE	ONCOLOGY	All FDA-approved indications		b)		

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PROVIGIL	SLEEP DISORDER AGENTS	All FDA-approved indications		Must meet the following criteria: Narcolepsy: A diagnosis of narcolepsy as documented by a sleep study, Fatigue associated with multiple sclerosis: Symptom of fatigue associated with MS, Shift Work Sleep Disorder (SWSD): Symptom of excessive sleepiness associated with SWSD, Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS): Symptom of excessive sleepiness associated with OSAHS treated with continuous positive airway pressure (CPAP) treatment.		12 Months
PULMOZYME	CYSTIC FIBROSIS	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Cystic Fibrosis Confirmation of diagnosis with genetic testing		
RAVICTI	UREA CYCLE DISORDER	All FDA-approved indications		Must met the following criteria: 1) Diagnosed with Urea cycle disorder a) Diagnosis confirmed with enzymatic, biochemical, or genetic testing 2) Patient related variables a) Height, weight, age 2) Trial of Buphenyl		
REVLIMID	ORAL ONCOLOGY	All FDA-approved indications		3) Must meet the following criteria: Multiple Myeloma: Diagnosis of multiple myeloma. Melodysplastic Syndrome (MDS): 1) Transfusion-dependent anemia due to myelodysplastic syndrome (MDS) associated with deletion 5q cytogenetic abnormalities 2) Low risk MDS without deletion 5q cytogenic abnormalities.	Hematologist/ Oncologist has recommended Revlimid.	12 Months
REBETROL, REBETROL SOLUTION, COPEGUS, RIBAVIRIN CAPS, RIBAVIRIN TABS, RIBATAB, RIBAPAK, RIBASPHERE	HEPATITIS C	All FDA-approved indications	Pregnancy	Must meet the following criteria: 1) Diagnosis with one of the following diseases a) Hepatitis C b) Hepatitis B 2) Laboratory Values/Analysis a) Baseline viral load b) Genotype (Hepatitis C) c) METAVIR (Hepatitis C) 3) Additional Conditions a) Cirrhosis b) Decompensated liver disease c) HIV co-infection Post liver transplant		

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RECOMBINATE	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		d) Must meet the following criteria: Hemophilia A		
REMICADE	INFLAMMATORY BOWEL DISEASE	All FDA-approved indications	Untreated latent TB or Active Tuberculosis infection	Must meet the following criteria: 1) Diagnosis of one of the following diseases: a) Moderate to severe Crohn's disease b) Moderate to severe Ulcerative colitis c) Moderate to severe Rheumatoid Arthritis in combination with methotrexate d) Active ankylosing spondylitis e) Active psoriatic arthritis f) Chronic severe plaque psoriasis g) Axial spondyloarthritis h) Behcet's syndrome i) Wegner's granulomatosis j) Hidradenitis suppurativa k) Juvenile idiopathic arthritis l) Pyoderma gangrenosum m) Sarcoidosis n) Takayasu's arteritis o) Uveitis 2) List of current and previous therapies 3) Pretreatment Tuberculosis testing status 4) Disease activity measure (RA only)		Up to 24 Months
REVATIO, SILDENAFIL	PULMONARY HYPERTENSION	All FDA-approved indications	Patients taking nitrates	Must meet the following criteria: 1) Diagnosis of Pulmonary Hypertension.		Up to 24 Months
RIASTAP	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		Must meet the following criteria: 1) Treatment of acute bleeding episodes in patients with congenital fibrinogen deficiency including afibrinogemenemia and hypofibrinogenemia		3 Months
RITUXAN	ONCOLOGY	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of an Approved Condition: a) Non-Hodgkin's Lymphoma (NHL): i) Relapse or refractory low-grade follicular, CD-20 positive, B-cell NHL as a single agent ii) Previously untreated follicular, CD-20		Up to 12 Months

BRAND NAME DRUG(S)	PRE-AUTH GROUP DESCRIPTION	COVERED USES	EXCLUSION CRITERIA	MEDICAL CRITERIA	PRESCRIBER RESTRICTION	COVERAGE DURATION
				positive, B-cell NHL in combination with first line chemotherapy and in patients with a complete or partial response to Rituxan in combination with chemotherapy as a single-agent maintenance therapy iii) Previously untreated diffuse large B-cell CD-20 positive NHL in combination with cyclophosphamide, doxorubicin, vincristine, and prednisone (CHOP) or other anthracycline-based chemotherapy regimens. iv) Marginal zone lymphomas (splenic, MALT) v) Diffuse large B-cell lymphoma in combination with chemotherapy in non-transplant candidates vi) Mantle cell lymphoma vii) Burkitt lymphoma in combination with chemotherapy viii) AIDS-related B-cell lymphoma ix) Hairy cell leukemia, relapse or refractory x) Small lymphocytic lymphoma (SLL) xi) Post-transplant lymphoproliferative disorder (PTLD) xii) Primary cutaneous B-cell lymphoma b) Chronic Lymphocytic Leukemia (CLL) c) Wegner's granulomatosis and Microscopic Polyangitis d) Rheumatoid Arthritis e) Sjogren's syndrome f) Acute Lymphoblastic Leukemia (ALL) in combination with chemotherapy g) Hodgkins lymphoma, lymphocyte-predominant h) Multicentric Castleman's disease with HIV i) Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma (LPL) j) Acquired blood factor VIII deficiency k) Autoimmune hemolytic anemia l) Chronic graft-versus-host disease (GVHD) m) Relapse/refractory ITP n) TTP o) Prevention of Epstein-Barr virus-related PTLD in high risk patients 2) Testing or analysis conforming CD-20 protein on the surface of the B-cello (if applicable) Hepatitis B screening		

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RIXUBIS	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		3) Must meet the following criteria: Hemophilia B		
RUCONEST	HEREDITARY ANGIOEDEMA	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of HAE		
SABRIL	REFRACTORY COMPLEX PARTIAL SEIZURES	All FDA-approved indications		Must meet the following criteria: 1) Diagnosed with the following conditions: a) Infantile spasms b) Complex partial seizures 2) Patient characteristics a) Height, weight, age Previous use of Sabril, Tegretol, Dilantin		
SAMSCA	HYPONATREMIA	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis with the following condition a) Hypervolemic hyponatremia b) Euvolemic hyponatremia 3) Liver function tests/history of liver disease		
SENSIPAR	HYPOPARATHYROIDISM	All FDA-approved indications	Hypocalcemia	Must meet the following criteria: 1) Diagnosis of one of the following diseases: a) Secondary hyperparathyroidism b) Parathyroid carcinoma c) Primary hyperparathyroidism 2) Laboratory values: a) Serum calcium levels b) Intact parathyroid hormone (iPTH) level 2) History of kidney transplant or parathyroidectomy		
SEROSTIM		All FDA-approved indications		3) Must meet the following criteria: Initial therapy for AIDS associated cachexia or wasting: 1) Diagnosis of AIDS wasting and/or cachexia and 2) Continuing prescribed anti-viral therapy and 3) Evaluated for inadequate nutritional intake, malabsorption and/or hypogonadism. Renewal: 1) Continuing prescribed anti-viral therapy and 2) Positive response to initial therapy/not continuing to lose weight.		12 Weeks initial treatment, renew for 12 weeks, Maximum length of therapy is 24 weeks.
SIGNIFOR		All FDA-approved indications		Must meet the following criteria: Cushing's Disease: 1) Diagnosis of Cushing's disease 2) Not a candidate for pituitary surgery or pituitary surgery has not been curative.		12 Months

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SIMPONI	ARTHRITIS	All FDA-approved indications		Must meet the following criteria: Rheumatoid Arthritis (RA): 1) Diagnosis of moderately to severely active rheumatoid arthritis and 2) Must be used in combination with Methotrexate (MTX) and 3) A trial and failure or inadequate response to at least one or more DMARDs. Ankylosing Spondylitis (AS): 1) Diagnosis of active ankylosing spondylitis. Psoriatic Arthritis (PsA): 1) Diagnosis of active Psoriatic arthritis and 2) A trial and failure or inadequate response to at least one or more DMARDs. For all diagnosis: 1) Must use FDA approved dosage per indication. 2) For RA, PSA, and AS: Trial and failure or inadequate response to one preferred agent, Humira or Enbrel. 3) If patient is already receiving a different TNF blocking agent, therapy must be discontinued prior to treatment with Golimumab (Simponi). 4) For all above diagnosis, must be must FDA approved dosage guidelines.	Rheumatologist or dermatologist must recommend/ requested therapy for RA, AS, PsA.	12 Months
SOLIRIS	PAROXYSMAL NOCTURNAL HEMOGLOBINURIA	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Paroxysmal Nocturnal Hemoglobinuria or Atypical Hemolytic Uremic Syndrome		
SOLODYN	MINOCYCLINE HCL	All FDA-approved indications		Meets the following criteria : 1) Diagnosis of inflammatory non-nodular moderate to severe acne vulgaris 2) Patient has tried and failed generic doxycycline, generic minocycline or generic tetracycline.		12 Months
SOMAVERT	ACROMEGALY	All FDA-approved indications		Meets the following criteria: 1) Diagnosis of Acromegaly 2) Physical signs and symptoms consistent with the disease state identified above including: a) Frontal bossing b) Course facial features c) Thick lips d) Protruding jaw e) Widely spaced teeth f) Large hands & feet 3) Pretreatment IGF-1 value 4) History of surgery or radiotherapy Trial of octreotide		

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SOVALDI	HEP C AGENTS (SOFOSBUVIR)	All FDA-approved indications		5) Must meet the following criteria: 1) Age 18 years or older 2) Diagnosis of Chronic Hepatitis C Virus Genotype 1, 2, 3, or 4, with a baseline positive HCV RNA 3) Used in combination with peginterferon alfa and ribavirin for Genotype 1 or 4. 4) Used in combination with ribavirin for Genotype 2 or 3 and Genotype 1 (with contraindication to interferon) 5) Genotype 1, 2, 3 or 4 and hepatocellular carcinoma, awaiting liver transplant.		VARIES
SPRYCEL	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: Chronic Myeloid Leukemia (CML): 1) Diagnosis of chronic, accelerated or myeloid or lymphoid blast phase Philadelphia chromosome-positive (Ph+) CML that is resistant or intolerant to Gleevec. Newly diagnosed CML: 1) Newly diagnosed Philadelphia chromosome-positive chronic myeloid leukemia in chronic phase. Acute Lymphoblastic Leukemia (ALL): 1) Diagnosis of Philadelphia Chromosome-positive acute lymphoblastic leukemia (Ph+ALL) that is resistant or intolerant to prior therapy.	Hematologist/ Oncologist has recommended Sprycel.	12 Months
STIMATE NASAL SPRAY	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		Must meet the following criteria: 1) One of the following diagnoses: a) Hemophilia A with factor VIII level >5% and mild to moderate type 1 VWD b) Type 2A, 2M, 2N VWD, and acquired von Willebrand syndrome c) Qualitative platelet disorders Menorrhagia associated with bleeding disorder		
STIVARGA	ORAL ONCOLOGY	All FDA-approved indications		d) Must meet the following criteria: Metastatic colorectal cancer (CRC): 1) Diagnosis of metastatic colorectal cancer that has been previously treated with fluorpyrimidine, oxaliplatin, irinotecan-based chemotherapy, plus an anti-VEGF therapy, plus if KRAS wild type, an anti-EGFR therapy.		12 Months

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STELARA	PSORIATIC ARTHRITIS/ PSORIASIS	All FDA-approved indications		Must meet the following criteria: Psoriatic Arthritis (PsA): 1) Diagnosis of active PsA and 2) Trial and failure or inadequate response to at least one or more DMARDs is required. Plaque Psoriasis: 1) Diagnosis of chronic moderate to severe plaque psoriasis requiring systemic or phototherapy. For all Diagnosis: If patient is receiving a different TNF blocking agent, therapy must be discontinued prior to initiating new TNF. For all above diagnosis, must be must FDA approved dosage guidelines.	Rheumatologist or dermatologist must recommend/ requested therapy for PsA. Dermatologist must recommend therapy for Plaque Psoriasis.	12 Months
SUTENT	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: Gastrointestinal Stromal Tumor (GIST): 1) Diagnosis of progressive GIST and 2) Has failed or is intolerant to Gleevec. Renal Cell Carcinoma: Diagnosis of advanced renal cell carcinoma. Progressive Neuroendocrine Tumor: Diagnosis of PNET of pancreatic origin that is unresectable, locally advanced or metastatic.	Oncologist has recommended Sutent.	12 Months
SYLATRON	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: Diagnosis of surgically resected melanoma with microscopic or gross nodal involvement.	Oncologist must recommend Sylatron.	12 months
SYNAGIS	RESPIRATORY SYNCYTIAL VIRUS	All FDA-approved indications		Must meet the following criteria: 1) Chronic Lung Disease of Prematurity a) First RSV season during the first year of life in preterm infants developing CLD defined as: i) Gestational age ≤ 31 weeks, 6 days AND ii) Requirement for > 21% oxygen for at least the first 28 days after birth b) Second RSV season during the second year of life in preterm infants who: i) Satisfy the definition of CLD of prematurity AND ii) Continue to require medical support for CLD during the 6-month period prior to the start of the second RSV season 2) Congenital Heart Disease a) Infants and children < 12 months with hemodynamically significant CHD b) Infants and children < 24 months undergoing cardiac transplant during RSV season 3) Congenital Abnormality of the Airway/Neuromuscular Condition Prematurity, born at 28 weeks, 6 days of gestation or earlier for the first RSV season that occurs during the first 12 months of life		

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TAFINLAR	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of unresectable or metastatic melanoma. 2) BRAF V600E or V600K mutation confirmed using a FDA-approved test.	Oncologist has recommended Tafinlar.	12 months
TARCEVA	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: Non-Small Cell Lung Cancer (NSCLC): Diagnosis of locally advanced or metastatic NSCLC after trial and failure of at least one chemotherapy regimen Pancreatic Cancer: 1) Diagnosis of locally advanced, unresectable or metastatic pancreatic cancer and 2) Will be used in combination with Gemcitabine (Gemzar).	Oncologist has recommended Tarceva.	12 Months
TARGRETIN	ORAL CHEMOTHERAPY	All FDA-approved indications	Pregnancy	Must meet the following criteria: 1) Diagnosis of one of the following: 2) Cutaneous T-cell lymphoma (Mycosis fungoides/Sezary syndrome) 3) Adult T-cell leukemia/lymphoma (ATLL) Primary cutaneous B-cell lymphoma		
TASIGNA	ORAL ONCOLOGY	All FDA-approved indications		4) Must meet the following criteria: Chronic Myeloid Leukemia (CML): 1) Diagnosis of accelerated phase or chronic phase Philadelphia chromosome positive CML that has been resistant or intolerant to a prior therapy with Imatinib (Gleevec) or 2) Newly diagnosed Ph+ CML in chronic phase.	Oncologist has recommended Tasigna.	12 Months
TEMODAR, TEMOZOLOMIDE	ORAL ONCOLOGY	All FDA-approved indications	Pregnancy	Must meet the following criteria: 1) Diagnosis of one of the following: a) Soft tissue sarcoma i) Rhabdomyosarcoma ii) Hemangiopericytoma iii) Angiosarcoma iv) Solitary fibrous tumor v) Sarcoma of the extremity/trunk vi) Sarcoma of the retroperitoneal/intra-abdominal area b) Ewing's sarcoma c) CNS cancer i) CNS lymphoma ii) Supratentorial astrocytoma/oligodendroglioma iii) Adult medulloblastoma iv) Anaplastic glioma	Oncologist has recommended Temodar.	

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				v) Supratentorial primitive neuroectodermal tumor (PNET) vi) Brain metastases vii) Glioblastoma d) Uterine sarcoma e) Melanoma f) Islet cell tumors g) Lung neuroendocrine tumors h) Cutaneous T-cell lymphoma (Mycosis fungoides/Sezary syndrome) i) Small cell lung cancer List other drugs used in combination		
THALOMID	THALIDOMIDE	All FDA-approved indications		Must meet the following criteria: Multiple Myeloma: Newly diagnosed with multiple myeloma. Erthema Nodosum Leprosum (ENL): 1) Moderate to severe erythema nodosum leprosum (ENL) and 2) Patient is not using as monotherapy.		12 Months
TIKOSYN	CLASS III ANTIARRHYTHMIC	All FDA-approved indications	Congenital or acquired long-QT syndrome	Must meet the following criteria: 1) Diagnosis of one of the following: a) Atrial fibrillation b) Paroxysmal supraventricular tachycardia (PSVT) c) Ventricular tachycardia 2) Patient's serum creatinine 3) Patient's height, weight, age 2) History of using drugs with severe drug interactions with Tikosyn		

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TOBI, TOBI PODHALER, TOBRAMYCIN INHALED SOLUTION, BETHKIS, KITABIS PAK	CYSTIC FIBROSIS	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Cystic Fibrosis or Bronchiectasis Pseudomonas aeruginosa cultures present in airways		
TREANDA	ONCOLOGY	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of one of the following: 2) Chronic lymphocytic leukemia (CLL) 3) Indolent B-cell non-Hodgkin's Lymphoma that has progressed during or within 6 months of treatment with Rituxan 4) B-cell non-Hodgkins's lymphoma 5) Waldenstrom's macroglobunemia/lymphoplasmacytic lymphoma 6) Hodgkin lymphoma 4) Multiple myeloma salvage therapy for relapse, progressive, or refractory disease		
TRELSTAR	HORMONAL THERAPIES	All FDA-approved indications		Must meet the following criteria: 1) Prostate cancer: a) Locally advanced, recurrent, or metastatic disease (regional lymph nodes or distant metastases) b) Initial neoadjuvant/concomitant/adjuvant androgen deprivation therapy (ADT) in combination with radiation therapy for clinically localized disease with intermediate or high risk of recurrence		24 Months
TRETTEN	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Congenital Factor XIII A-subunit deficiency 2) Factor XIII assay 7) Genotyping		

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TYKERB	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: Breast Cancer: 1) Diagnosis of HER2 receptor positive advanced or metastatic breast cancer and has tried and failed at least one chemotherapy regimen including an anthracycline, a taxane or trastuzumab (Herceptin) and will use Tykerb in combination with Capecitabine (Xeloda) or 2) Diagnosis of Postmenopausal with HER2 receptor positive metastatic breast cancer and will use Tykerb in combination with Letrozole (Femara).	Oncologist has recommended Tykerb.	12 Months
TYSABRI	MULTIPLE SCLEROSIS & INFLAMMATORY BOWEL DISORDER	All FDA-approved indications		Must meet the following criteria: 1) Moderately to severely active Crohn's disease a) Inadequate response, intolerance, or contraindication to conventional therapy AND TNF-alpha inhibitor 3) Relapsing forms of Multiple Sclerosis		24 Months
TYVASO, REMODULIN, ORENITRAM	PULMONARY HYPERTENSION	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Pulmonary arterial hypertension		
VALCHLOR	ORAL CHEMOTHERAPY	All FDA-approved indications		Must meet the following criteria: Diagnosis of Mycosis fungoides-type cutaneous T-cell lymphoma (CTCL) 2)		
VANTAS	HORMONAL THERAPIES	All FDA-approved indications		Must meet the following criteria: 1) Prostate cancer: a) Palliative treatment for advanced prostate cancer b) Locally advanced, recurrent, or metastatic disease (regional lymph nodes or distant metastases) Initial long-term (two to three years) neoadjuvant/concomitant/adjuvant ADT in combination with radiation therapy for clinically localized disease with high risk of recurrence.		24 Months

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VELCADE	ONCOLOGY	All FDA-approved indications		1) Multiple Myeloma a) Multiple myeloma or progressive solitary plasmacytoma (PSP): b) Primary therapy in combination with dexamethasone (with or without cyclophosphamide, doxorubicin, lenalidomide, or thalidomide) for transplant patients c) Primary therapy in combination with dexamethasone or with melphalan and prednisone (MPB regimen) for nontransplant patients d) Maintenance therapy as a single agent e) Salvage therapy for relapsed, refractory or progressive disease as a single agent or in combination with dexamethasone (with or without cyclophosphamide, doxorubicin, lenalidomide, or thalidomide), melphalan and prednisone, liposomal doxorubicin, chemotherapy (eg, VTD-PACE regimen), or vorinostat 2) Mantle Cell Lymphoma a) Indicated for the treatment of patients with mantle cell lymphoma who have received at least 1 prior therapy. 3) Systemic light chain amyloidosis, primary treatment as a single agent or in combination with dexamethasone (with or without melphalan or cyclophosphamide) 4) Non-Hodgkin's lymphoma (NHL) subtypes: a) Adult T-cell leukemia/lymphoma b) Mantle cell lymphoma, second-line therapy with or without rituximab for relapsed, refractory or progressive disease c) Mycosis fungoides/Sézary syndrome d) Peripheral T-cell lymphoma, as second-line therapy for relapsed or refractory disease e) Primary cutaneous B-cell lymphoma, second-line therapy in combination with bendamustine and rituximab (BVR regimen) Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma, as a single agent or in combination with dexamethasone or rituximab		12 to 24 Months

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VELETRI	PULMONARY HYPERTENSION	All FDA-approved indications		Must meet the following criteria: c) 1) Diagnosis of Pulmonary arterial hypertension		
VENTAVIS	PULMONARY HYPERTENSION	All FDA-approved indications		Must meet the following criteria: 5) 1) Diagnosis of Pulmonary arterial hypertension		
VICTRELIS	HEP C AGENTS	All FDA-approved indications		Must meet the following criteria: For Initial treatment: In Victrelis_Pegasys (preferred agent) or Peg-Intron (non-preferred) Ribavirin triple therapy plan requires the following: 1) Diagnosis of Hepatitis C, genotype-1 and 2) Prior treatment and outcome if applicable, and 3) Must be naïve to Incivek and Victrelis therapy, and 4) History of compensated liver disease (i.e. cirrhosis), and 5) Baseline (pre-treatment) HCV-RNA, and 6) Labs and clinical documentation must be included with request and 7) Treatment with preferred agent (Pegasys) is required unless member is already receiving Peg-Intron. Notes: Duration of initial therapy: In Peg-interferon_Ribavirin_Victrelis triple therapy, Pegasys (preferred agent) and Peg-Intron (non-preferred) is initially authorized for 12 weeks (Ribavin does not require authorization). Authorization for Victelis starts at week 5 of triple therapy. **For Continuation Treatment** with Victrelis_Peg-interferon_Ribavirin, plan requires the following: 1) Result of HCV-RNA levels at TW 4, 8, 12 and 24 to evaluate continuation or stopping of therapy per manufacturer guidelines, and 2) HCV-RNA less than 100 IU per ml at TW12 is required to continue therapy, and 3) Confirmed undetectable HCV-RNA at TW24 is required to continue therapy. Notes: Continuation Treatment: Maximum total length of therapy for Victrelis is 32 weeks. Peg-interferon may be renewed for additional 36 weeks, maximum total length of therapy for Peg-Interferon is 48 weeks, depending on therapy and clinical response. Initial: 8 weeks Victrelis. Continuation: 24 weeks depending on therapy and clinical response.		

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VIEKIRA PAK	HEPATITIS C	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Hepatitis C 2) Hepatitis C Viral Load 3) Hepatitis C genotype 4) METAVIR fibrosis score 5) Co-infection status a) Decompensated liver disease b) Cirrhosis c) Post liver transplant HIV		Up to 24 Months
VIMIZIM	MORQUIO A SYNDROME	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Morquio A Syndrome		
VISUDYNE	RETINAL DIORDERS	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of one of the following: a) Classic choroidal neovascularization (CNV) due to AMD b) Occult CNV due to AMD c) CNV due to pathologic myopia d) Juxta foveal retinal telangiectasia e) Choroidal hemangioma f) Central serous retinopathy 1) Polypoidal choroidal vasculopathy		
VOTRIENT	ORAL ONCOLOGY	All FDA-approved indications		d) Must meet the following criteria: Renal Cell Carcinoma: Diagnosis of advanced renal cell carcinoma. Soft Tissue Sarcoma: Diagnosis of advanced soft tissue sarcoma with prior chemotherapy including anthracycline.	Oncologist must recommend Votrient.	12 Months
VPRIV	GAUCHER DISEASE	All FDA-approved indications		Must meet the following criteria: 1) Gaucher DIsease		
WILATE	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		g) Must meet the following criteria: Hemophilia A & von Willebrand Syndrome		

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XALKORI	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: Non-Small Cell Lung Cancer (NSCLC): Diagnosis of locally advanced or metastatic NSCLC. Anaplastic lymphoma: Diagnosis of anaplastic lymphoma kinase (ALK) positive confirmed using a FDA-approved test.	Oncologist must recommend Xalkori.	12 Months
XELJANZ	ARTHRITIS	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of moderate to severe active Rheumatoid Arthritis (RA) 2) Trial and failure or inadequate response to at least one or more DMARDs such as Methotrexate, Imuran, Ridaura, Plaquenil, Cuprimine, Azulfidine or Arava. 3) Use of FDA approved dosing 4) If patient is receiving a different TNF blocking agent, therapy must be discontinued prior to initiating new TNF agent Xeljanz 5) Trial and failure or inadequate response to one preferred agent, Humira or Enbrel along with Cimzia.	Rheumatologist must recommend Xeljanz.	12 Months
XELODA, CAPECITABINE	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of Dukes' C colon cancer and has undergone complete resection of the primary tumor or 2) Diagnosis of metastatic colorectal cancer or 3) In combination with Taxotere, Tykerb, or Ixempra for advanced or metastatic breast cancer in patients non-respondent to prior therapy or 4) As monotherapy for advanced metastatic breast cancer in patients non-respondant to prior therapy.	Oncologist must recommend Xeloda.	12 Months
XENAZINE	HUNTINGTON'S DISEASE	All FDA-approved indications	Patients who are suicidal or with untreated/inadequately treated major depression, hepatic impairment, use of MAO inhibitors within the last 14 days	Must meet the following criteria: 1) Diagnosis of one of the following: a) Chorea b) Hemiballismus c) Chronic tics associated with Tourette's syndrome d) Tardive dyskinesia 2) Depression screening		

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XGEVA	ONCOLOGY	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of one of the following: diseases: a) Prevention of skeletal-related events in patients with bone metastes from solid tumors b) Treatment of giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity Treatment with calcium & Vitamin D		24 months
XOLAIR	ALLERGIC ASTHMA	All FDA-approved indications		Must meet the following criteria: 1) Allergic asthma a) Moderate to severe persistent asthma who have a positive skin test to perennial aeroallergen(s) and who's symptoms are inadequately controlled with inhaled corticosteroids Chronic Idiopathic Urticaria persisting despite H1 antihistamine.		24 Months
XTANDI	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: Metastatic castration-resistant prostate cancer: 1) Diagnosis of metastatic castration-resistant prostate cancer and 2) Has received prior chemotherapy containing docetaxel.	Oncologist must recommend Xtandi.	12 Months
XYNTHA	HEMOPHILIA AND RELATED BLEEDING DISORDERS	All FDA-approved indications		2) Must meet the following criteria: Hemophilia A		
XYPREM		All FDA-approved indications		2) Must meet the following criteria: Narcolepsy: 1) Diagnosis of narcolepsy with excessive daytime sleepiness and trial and failure of a CNS stimulant or 2) Diagnosis of narcolepsy with cataplexy and trial and failure of a CNS stimulant		12 Months
YERVOY	ONCOLOGY	All FDA-approved indications		Must meet the following criteria: 1) Unresectable metastatic melanoma 2) Recurrent melanoma Reinduction in select patients experiencing no significant systemic toxicity during prior Yervoy therapy and who relapse after initial clinical response or progress after stable disease greater than 3 months		16 Weeks

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ZAVESCA	GAUCHER DISEASE	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of mild-to-moderate type 1 Gaucher disease		24 Months
ZELBORAF	ORAL ONCOLOGY	All FDA-approved indications		Must meet their following criteria: Melanoma: 1) Diagnosis of unresectable or metastatic melanoma and 2) BRAF V60E mutation has been confirmed by a FDA-approved test.	Oncologist must recommend Zelboraf.	12 Months
ZOLADEX	HORMONAL THERAPIES	All FDA-approved indications		Must meet the following criteria: 1) Prostate Cancer a) Indicated for use in combination with flutamide for the management of locally confined Stage T2b-T4 (Stage B2-C) carcinoma of the prostate. b) Palliative treatment of advanced carcinoma of the prostate. c) Locally advanced, recurrent, or metastatic disease (regional lymph nodes or distant metastases) d) Initial neoadjuvant/concomitant/adjuvant androgen deprivation therapy (ADT) in combination with radiation therapy for clinically localized disease with intermediate or high risk of recurrence 2) Endometriosis a) Including pain relief and reduction of endometriotic lesions for the duration of therapy. (Zoladex 3.6 mg dose only) b) Zoladex is indicated for use as an endometrial-thinning agent prior to endometrial ablation for dysfunctional uterine bleeding. (Zoladex 3.6 mg dose only) 3) Breast Cancer a) Palliative treatment of advanced breast cancer in pre- and perimenopausal women. (Zoladex 3.6 mg dose only) b) Treatment of premenopausal women with hormone receptor-positive disease i) with adjuvant endocrine therapy 3) for recurrent or metastatic disease		Up to 24 Months

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ZOLEDRONIC ACID, ZOMETA, RECLAST	ONCOLOGY	All FDA-approved indications		Must meet the following Criteria: 1) Hypercalcemia of Malignancy a) Zometa is indicated for the treatment of hypercalcemia of malignancy defined as an albumin-corrected calcium of ≥12 mg/dL [3.0 mmol/L] using the formula: corrected Ca = serum Ca (mg/dL) + 0.8 ([4 g/dL] – [measured albumin g/dL]). 2) Multiple Myeloma and Bone Metastases of Solid Tumors a) Zometa is indicated for the treatment of patients with multiple myeloma and patients with documented bone metastases from solid tumors, in conjunction with standard antineoplastic therapy. 3) Prostate Cancer a) Prostate cancer should have progressed after treatment with at least one hormonal therapy. Treatment or prevention of osteoporosis secondary to androgen-deprivation therapy (ADT) in prostate cancer patients at high risk for fracture.		24 Months
ZOLINZA	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: Cutaneous T-cell Lymphoma (CTCL): 1) Diagnosis of progressive, persistent or recurrent cutaneous T-cell lymphoma (CTCL) and 2) Has tried and failed two other systemic therapies for CTCL.	Oncologist has recommended Zolinza.	12 Months
ZORBTIVE	SOMATROPIN (ZORBTIVE)	All FDA-approved indications		Meets the following criteria: 1) Diagnosis of short bowel syndrome and 2) Patient receiving specialized nutritional support.		12 Months
ZYDELIG	ORAL CHEMOTHERAPY	All FDA-approved indications		Must meet the following criteria: 1) Diagnosis of one of the following: 2) Relapsed Chronic Lymphocytic Lymphoma 3) Relapsed Follicular B-cell non-Hodgkin's Lymphoma 4) Relapsed Small Lymphocytic Lymphoma ii)		24 Months

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ZYKADIA	ORAL CHEMOTHERAPY	All FDA-approved indications		Must meet the following criteria: 1) Non-small cell lung cancer (NSCLC) a) Metastatic disease b) Anaplastic lymphoma kinase (ALK) mutation status		
ZYTIGA	ORAL ONCOLOGY	All FDA-approved indications		Must meet the following criteria: Prostate Cancer: 1) Diagnosis of metastatic castration-resistant prostate cancer and 2) Patient has received prior chemotherapy containing docetaxel.	Oncologist has recommended Zytiga.	12 Months

Reviewing all pertinent medical information including the diagnosis, reason why this medication is medically necessary, and treatment modalities tried thus far.