

## **BCN Advantage HMO-POS<sup>SM</sup>**



Medicare and more

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

## **BCN Advantage HMO-POS<sup>SM</sup> 2012 Step Therapy and Prior Authorization requirements outlined for Providers**

The goal of the BCN Pharmacy department is to ensure that all members receive high-quality, cost-effective pharmaceutical care. To meet this objective, BCN Advantage requires prior authorization for certain medications, and clinical criteria must be met before coverage is approved. Clinical criteria are based on current medical information and recommendations of BCBSM/BCN's Pharmacy and Therapeutics Committee. In addition, as required by the Centers for Medicare & Medicaid Services, drugs that can be processed under either Part B or Part D may require prior authorization in order to determine how to process the claim. Drugs that are covered under Part B, based on the member's circumstance, cannot be processed as a Part D claim.

To request an override of one of BCN's drug utilization management tools, health care providers should contact the Clinical Pharmacy Help Desk at 800-437-3803, Monday-Friday, 24 hours a day, 7 days a week. Responses to requests for coverage determinations are made within 72 hours. The provider should alert the Pharmacy Help Desk if the request is urgent. Urgent requests include requests for drugs without which the BCN Advantage member's life, health or ability to regain maximum function would be jeopardized or that, in the opinion of the prescriber with knowledge of the member's condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment requested. The provider should consider these criteria when providing documentation if the request is urgent. A response to these requests will be provided within 24 hours.

**ST** = STEP THERAPY if prior authorization criteria are met in member's medication pharmacy claims history, the medication will process at the pharmacy without need for further authorization.

**PA** = Prior Authorization. Medications must be prior authorized using the procedure described above before the medication will process at the pharmacy.

Medication / Drug Class	Criteria
<b>Administrative PA (Part D vs Part B processing)</b>	
<p><b>PART B VERSUS PART D COVERAGE DETERMINATION</b></p> <p><b>REQUIRED FOR MEMBERS WITH END STAGE RENAL DISEASE (ESRD) WITH RENAL DIALYSIS AND PRESCRIPTIONS FOR:</b></p> <p>BONIVA<sup>®</sup>            CALCITRIOL            CUBICIN<sup>®</sup>            HECTOROL<sup>®</sup>            LEVOCARNITINE            MICALCIN<sup>®</sup>            PAMINDRONATE            VANCOMYCIN IV            ZEMPLAR            PROCRT<sup>®</sup>            EPOGEN<sup>®</sup>            ARANESP<sup>®</sup></p>	<p>REQUIRES DOCUMENTATION OF DIAGNOSIS.</p> <p>THE MEDICATIONS LISTED ARE NOT PAYABLE UNDER THE PART D BENEFIT IF THEY ARE BEING USED FOR MEMBERS WITH ESRD WITH RENAL DIALYSIS.</p> <p>OTHER DIAGNOSES MAY BE COVERED UNDER PART D</p>
<p><b>REQUIRES DOCUMENTATION THAT THE DRUG IS NOT COVERED UNDER PART B</b></p> <p><b>REQUIRED FOR ALL MEMBERS WITH PRESCRIPTIONS FOR:</b></p> <p>AMIFOSTINE            ARZERRA<sup>®</sup>            AZASAN<sup>®</sup>            AZATHIOPRINE            CELLCEPT<sup>®</sup>            CYCLOPHOSPHAMIDE            CYCLOSPORINE            GENGRAF<sup>®</sup>            METHOTREXATE TABS            MYCOPHENOLATE            MYFORTIC<sup>®</sup>            ORTHOCLONE<sup>®</sup> OKT3            PROGRAF<sup>®</sup>            RAPAMUNE<sup>®</sup>            RHEUMATREX            SANDIMMUNE<sup>®</sup>            TACROLIMUS            TREANDA            TRELSTAR MIXJECT            TREXALL<sup>™</sup>            ZORTRESS<sup>®</sup></p>	<p>REQUIRES DOCUMENTATION THAT THE DRUG IS NOT COVERED UNDER PART B BEFORE IT CAN PROCESS UNDER PART D.</p> <p>REQUIRES DIAGNOSIS.</p> <p>INFORMATION ON LOCATION OF MEDICATION ADMINISTRATION,</p> <p>TRANSPLANT PAYOR INFORMATION (WHERE APPROPRIATE), AND OTHER INFORMATION TO DETERMINE PART B OR PART D COVERAGE.</p>

Medication / Drug Class	Criteria
ANZEMET EMEND® GRANISETRON ONDANSETRON NEUMEGA® CARIMUNE ENGERIX-B® GAMASTAN® S/D GAMMAGARD LIQUID GAMUNEX® IMOVAX RABIES VIVAGLOBIN® ALLOPURINOL IV	
<b>Anti-emetic (PA)</b>	
<b>SANCUSO®</b> (Granisetron transdermal)	COVERED FOR THE PREVENTION AND OR TREATMENT OF NAUSEA AND OR VOMITING ASSOCIATED WITH CHEMOTHERAPY AND OR RADIATION. SANCUSO® IS REQUIRES DOCUMENTATION OF TREATMENT FAILURE/INTOLERANCE WITH ZOFTRAN® (g), AND ORAL KYTRIL® (g). <b>NOT COVERED FOR</b> HYPEREMESIS GRAVIDARUM, NAUSEA AND VOMITING OF PREGNANCY, AND POST-OPERATIVE NAUSEA AND VOMITING. LENGTH OF APPROVAL: 1 YEAR
<b>Antidepressants (ST)</b>	
For members in the <b>Individual BCN Advantage benefit</b> , the following Antidepressants require authorization:  PEXEVA® (Paroxetine mesylate) SARAFEM® (Fluoxetine hcl) LUVOX CR (fluvoxamine hcl) PRISTIQ™ (Desvenlafaxine succinate) VIIBRYD™ (vilazodone hcl)  <b>LEXAPRO IS A NONFORMULARY DRUG (NOT COVERED)</b>	<b>PEXEVA, SARAFEM®, LUVOX CR, AND VIIBRYD</b> REQUIRE THAT MEMBER HAS EXPERIENCED FAILURE OF OR INTOLERANCE TO AT LEAST ONE GENERIC ANTIDEPRESSANT, SUCH AS CELEXA® (g), PAXIL® (g), PROZAC® (g), OR WELLBUTRIN/SR™ (g) OR ZOLOFT® (g). <b>PRISTIQ™</b> REQUIRES DOCUMENTATION OF FAILURE OF AT LEAST 30 DAYS OF AT LEAST ONE GENERIC ANTIDEPRESSANT AND 30 DAYS TRIAL OF VENLAFAXINE EXTENDED RELEASE.  LENGTH OF APPROVAL: 1 YEAR
Patients who are enrolled in a BCN ADVANTAGE <b>GROUP PLAN</b> may have LEXAPRO in their drug benefit. <b>They still require authorization.</b> LEXAPRO® (Escitalopram oxalate)	APPROVAL FOR LEXAPRO REQUIRES THAT MEMBER HAS EXPERIENCED FAILURE OF OR INTOLERANCE TO AT LEAST ONE GENERIC ANTIDEPRESSANT, SUCH AS CELEXA® (g), PAXIL® (g), PROZAC® (g), OR WELLBUTRIN/SR™ (g) OR ZOLOFT® (g).  LENGTH OF APPROVAL: 1 YEAR
<b>Antineoplastics (PA)</b>	

Medication / Drug Class	Criteria
AFINITOR <sup>®</sup> (Everolimus)	<p>AFINITOR<sup>®</sup> MUST BE PRESCRIBED BY AN ONCOLOGIST</p> <p>AFINITOR<sup>®</sup> IS COVERED FOR:</p> <p>1) DOCUMENTED ADVANCED RENAL CELL CARCINOMA AND FAILURE OF TREATMENT OR DISEASE PROGRESSION WITH NEXAVAR<sup>®</sup> OR SUTENT<sup>®</sup>.</p> <p>2) TREATMENT OF PROGRESSIVE NEUROENDOCRINE TUMORS (PNET) OF PANCREATIC ORIGIN THAT IS UNRESECTABLE, LOCALLY ADVANCED OR METASTATIC.</p> <p>3) PATIENTS WITH SUBEPENDYMAL GIANT CELL ASTROCYTOMA (SEGA) ASSOCIATED WITH TUBEROUS SCLEROSIS (TS) WHO REQUIRE THERAPEUTIC INTERVENTION BUT ARE NOT CANDIDATES FOR CURATIVE SURGICAL RESECTION.</p> <p>COVERAGE IS NOT PROVIDED IN COMBINATION WITH NEXAVAR<sup>®</sup> OR SUTENT<sup>®</sup>.</p> <p>LENGTH OF APPROVAL : 1 year</p>
VOTRIENT <sup>®</sup> (Pazopanib hcl)	<p>COVERED FOR THE TREATMENT OF PATIENTS WITH ADVANCED RENAL CELL CARCINOMA.</p> <p>MUST BE PRESCRIBED BY AN ONCOLOGIST</p> <p>LENGTH OF APPROVAL: 1 YEAR</p>
<b>Arthritis/Psoriasis/Crohn's (PA)</b>	
<p><b>TNF-alpha agents (self-injectables)</b></p> <p>CIMZIA<sup>®</sup> (Crtolizumab pegol)</p> <p>ENBREL<sup>®</sup> (Etanercept)</p> <p>HUMIRA<sup>®</sup> (Adalimumab)</p> <p>KINERET<sup>®</sup> (Anakinra)</p> <p>SIMPONI<sup>™</sup> (Golimumab)</p> <p>STELARA<sup>™</sup> (Ustekinumab)</p>	<p><b>LENGTH OF APPROVALS FOR ALL TNF AGENTS: 1 YEAR</b></p> <p><b><u>ENBREL:</u></b></p> <p><b>FOR RHEUMATOID ARTHRITIS, JUVENILE RA OR PSORIATIC ARTHRITIS:</b></p> <p>THREE MONTH TRIAL ON TWO CONCURRENT NONBIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS), ONE OF WHICH MUST BE METHOTREXATE UNLESS CONTRAINDICATED.</p> <p><b>FOR MODERATE TO SEVERE PSORIASIS:</b></p> <p>A TRIAL WITH A TOPICAL STEROID AND PUVA (UNLESS PUVA CONTRAINDICATED).</p> <p>IN ADDITION TO ABOVE, THERAPY MUST BE SUPERVISED BY A DERMATOLOGIST</p> <p><b>FOR ALKYLISING SPONDYLITIS, REQUIRES THERAPY IS BEING SUPERVISED BY A RHEUMATOLOGIST</b></p> <p><b><u>HUMIRA:</u></b></p>

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	<p><b>FOR RHEUMATOID ARTHRITIS, JUVENILE RA OR PSORIATIC ARTHRITIS:</b>  HUMIRA REQUIRES A TRIAL ON TWO CONCURRENT NONBIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS), ONE OF WHICH MUST BE METHOTREXATE UNLESS CONTRAINDICATED.</p> <p><b>MODERATE TO SEVERE PSORIASIS:</b>  IN ADDITION TO ABOVE, THERAPY MUST ALSO BE SUPERVISED BY A DERMATOLOGIST</p> <p><b>MODERATELY TO SEVERELY ACTIVE CROHN'S DISEASE:</b>  COVERED FOR MEMBERS 18 YEARS OF AGE AND OLDER  WITH A HISTORY OF INADEQUATE RESPONSE TO CONVENTIONAL THERAPY, [DEFINED BY ANY ONE OF THE FOLLOWING (a-c) AND (d)]:  (a) INEFFECTIVE TREATMENT WITH DAILY SYSTEMIC CORTICOSTEROIDS (e.g., 40 mg to 60 mg PREDNSIONE PER DAY FOR 7 TO 14 DAYS)  <b>OR</b>  (b) SYSTEMIC CORTICOSTEROIDS ARE CONTRAINDICATED <b>OR</b>  (c) THE PATIENT HAS BEEN UNABLE TO TAPER OFF SYSTEMIC CORTICOSTEROIDS WITHOUT EXPERIENCING WORSENING OF DISEASE  <b>AND</b> (d) THE PATIENT IS EXPERIENCING BREAKTHROUGH DISEASE (e.g., ACTIVE DISEASE FLARES) WHILE STABLIZED ON AN IMMUNOMODULATORY MEDICATION (such as azathioprine, mercaptopurine, cyclosporine, or methotrexate) UNLESS TREATMENT WITH THESE AGENTS IS CONTRAINDICATED</p> <p><b>FOR ALKYLOSING SPONDYLITIS:</b>  APPROVAL FOR HUMIRA REQUIRES DOCUMENTATION OF PREVIOUS TREATMENT WITH A TOPICAL STEROID AND TREATMENT WITH PUVA (UNLESS PUVA CONTRAINDICATED)  REQUIRES THERAPY SUPERVISED BY A RHEUMATOLOGIST</p> <p><b><u>KINERET:</u></b>  <b>RHEUMATOID ARTHRITIS:</b>  REQUIRES A TREATMENT FAILURE OR CONTRAINDICATION TO ENBREL AND HUMIRA.</p> <p><b><u>SIMPONI™ :</u></b>  <b>FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS AND ALKYLOSING SPONDYLITIS:</b>  REQUIRES THE MEMBER HAS TRIED AND FAILED <b>BOTH</b> HUMIRA® AND ENBREL®, EXCEPT IF NOT</p>

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	<p>TOLERATED DUE TO DOCUMENTED CLINICAL SIDE EFFECTS.</p> <p><b><u>CIMZIA:</u></b>  <b>RHEUMATOID ARTHRITIS:</b>  REQUIRES THE MEMBER HAS TRIED AND FAILED BOTH HUMIRA® AND ENBREL®, EXCEPT IF NOT TOLERATED DUE TO DOCUMENTED CLINICAL SIDE EFFECTS..</p> <p><b>CROHN's DISEASE:</b>  REQUIRES  1) AT LEAST 2 MONTHS ON AN IMMUNOMODULATOR MEDICATION (such as azathioprine, mercaptopurine, cyclosporine, or methotrexate).  AND  2) AT LEAST AN INITIAL 3-DOSE INDUCTION PERIOD OF Adalimumab (Humira®), EXCEPT IF NOT TOLERATED DUE TO DOCUMENTED CLINICAL SIDE EFFECTS.</p> <p><b><u>STELARA™</u></b>  <b>CHRONIC PLAQUE PSORIASIS</b>  REQUIRES  1) TREATMENT WITH ONE ORAL SYSTEMIC AGENT FOR PSORIASIS THAT IS INEFFECTIVE OR NOT TOLERATED, UNLESS ALL ARE CONTRAINDICATED. (E.,G CYCLOSPORINE, METHOTREXATE, ACITRETIN). <b>AND</b>  2) TRIAL AND FAILURE <b>ANY ONE</b> OF THE FOLLOWING:  <b>a)</b> INFLIXIMAB (REMICAIDE) AFTER AT LEAST AN INITIAL INDUCTION PERIOD (5 MG/KG ON WEEKS 0,2, 6), EXCEPT IF NOT TOLERATED DUE TO DOCUMENTED CLINICAL SIDE EFFECTS <b>-OR-</b>  <b>b)</b> ADALIMUMAB (HUMIRA) <b>-or-</b> (ENBREL) AFTER AT LEAST A 12 WEEK TREATMENT COURSE, EXCEPT IF NOT TOLERATED DUE TO DOCUMENTED CLINICAL SIDE EFFECTS</p> <p>MUST BE PRESCRIBED BY A DERMATOLOGIST</p>
<b>Cardiovascular</b>	
<b>Beta-Blockers (ST)</b>	

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<p>For members enrolled in a <b>BCN Advantage INDIVIDUAL</b> benefit.</p> <p>COREG CR<sup>®</sup> (Carvedilol CR)</p> <p><b>BYSTOLIC IS NON FORMULARY (NO COVERAGE)</b></p>	<p>COVERAGE FOR COREG CR<sup>®</sup> REQUIRES DOCUMENTATION THAT THE MEMBER HAS HAD A 30 DAY TRIAL OF TOPROL XL<sup>®</sup>(g) OR COREG<sup>®</sup> (g).</p> <p>LENGTH OF APPROVAL: LIFETIME</p>
<p>Members enrolled in a <b>BCN Advantage GROUP</b> benefit may have both Beta Blockers in their drug benefit. <b>They still require authorization.</b></p> <p>BYSTOLIC<sup>™</sup> (Nebivolol)</p>	<p><b>BYSTOLIC<sup>™</sup></b> THERAPY REQUIRES DOCUMENTATION THAT THE MEMBER HAS EXPERIENCED FAILURE OF OR INTOLERANCE TO AT LEAST TWO GENERIC CARDIOSELECTIVE BETA-BLOCKERS, SUCH AS SECTRAL<sup>®</sup> (g), TENORMIN<sup>®</sup> (g), KERLONE<sup>®</sup> (g), ZEBETA<sup>®</sup> (g), LOPRESSOR<sup>®</sup> (g), OR TOPROL XL<sup>®</sup> (g).</p>
Hyperlipidemia (ST)	
<p>For members enrolled in a <b>BCN Advantage INDIVIDUAL</b> benefit</p> <p>ADVICOR<sup>®</sup> (Niacin/lovastatin)  ALTOPREV<sup>®</sup> (Lovastatin)  CRESTOR<sup>®</sup> (Rosuvastatin calcium)  SIMCOR<sup>®</sup> (Simvastatin/niacin)  TRILIPIX<sup>®</sup> (Fenofibric acid)  VYTORIN<sup>®</sup> (Ezetimibe/simvastatin)  ZETIA<sup>®</sup> (Ezetimibe)</p> <p><b>ATORVASTATIN IS AVAILABLE WITHOUT authorization</b>  <b>BRAND LIPITOR<sup>®</sup> is NON FORMULARY (not covered)</b>  <b>CADUET IS NON FORMULARY</b></p>	<p>ALTOPREV<sup>®</sup>, CRESTOR<sup>®</sup> REQUIRE DOCUMENTATION OF FAILURE WITH OR INTOLERANCE TO GENERIC LOVASTATIN, SIMVASTATIN, PRAVASTATIN OR ATORVASTATIN</p> <p>COVERAGE OF ADVICOR<sup>®</sup> REQUIRES DOCUMENTATION OF STABLE THERAPY OF LOVASTATIN AND EXTENDED RELEASE NIACIN, AS DEMONSTRATED BY TRIALS OF AT LEAST 30 DAYS OF THE INDIVIDUAL AGENTS.</p> <p>COVERAGE OF SIMCOR<sup>®</sup> REQUIRES DOCUMENTATION OF STABLE THERAPY OF SIMVASTATIN AND EXTENDED RELEASE NIACIN, AS DEMONSTRATED BY TRIALS OF AT LEAST 30 DAYS OF THE INDIVIDUAL AGENTS.</p> <p>COVERAGE OF TRILIPIX<sup>®</sup> REQUIRES DOCUMENTATION OF STABLE THERAPY OF FENOFIBRATE AND GEMFIBROZIL, AS DEMONSTRATED BY TRIALS OF AT LEAST 30 DAYS OF THE INDIVIDUAL AGENTS.</p> <p>COVERAGE OF VYTORIN<sup>®</sup> REQUIRES DOCUMENTATION OF STABLE THERAPY OF SIMVASTATIN AND ZETIA<sup>®</sup>, AS DEMONSTRATED BY TRIALS OF AT LEAST 30 DAYS OF THE INDIVIDUAL AGENTS.</p> <p>LENGTH OF APPROVAL: LIFETIME</p>
<p>Members enrolled in a <b>BCN ADVANTAGE EMPLOYER GROUP</b> benefit have brand name Lipitor and Caduet in their drug benefit. <b>They still require authorization for the Brand Product.</b></p> <p><b>GENERIC ATORVASTATIN IS AVAILABLE WITHOUT</b></p>	<p>LIPITOR<sup>®</sup> REQUIRES DOCUMENTATION OF FAILURE WITH OR INTOLERANCE TO A GENERIC STATIN (E.G., LOVASTATIN, PRAVASTATIN, SIMVISTATIN, ATORVASTATIN).</p> <p>LENGTH OF APPROVAL: LIFETIME</p>

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<p><b>AUTHORIZATION</b></p> <p>LIPITOR® BRAND</p> <p>CADUET® (Amlodipine/atorvast cal)</p>	<p>COVERAGE OF CADUET® REQUIRES DOCUMENTATION OF STABLE THERAPY OF LIPITOR® AND AMLODIPINE, AS DEMONSTRATED BY TRIALS OF AT LEAST 30 DAYS OF THE INDIVIDUAL AGENTS</p>
<b>Misc Cardiovascular Agents (ST)</b>	
<p>AZOR® (Amlodipine bes /olmesartan med)</p> <p>EXFORGE® (Amlodipine/valsartan)</p> <p>EXFORGE HCT® (Amlodipine/valsartan/hctz)</p>	<p>COVERAGE OF EXFORGE® OR AZOR® REQUIRES DOCUMENTATION THAT THE MEMBER HAS BEEN ON STABLE DOSES OF NORVASC® (g) AND AN ANGIOTENSIN RECEPTOR BLOCKER (ARB) FOR AT LEAST 30 DAYS.</p> <p>COVERAGE FOR EXFORGE HCT® REQUIRES DOCUMENTATION THAT THE MEMBER HAS HAD AT LEAST A 30 DAY TRIAL OF EXFORGE®.</p> <p>LENGTH OF APPROVAL: LIFETIME</p>
<b>Diabetic Agents (Oral) (ST)</b>	
<p>ACTOS® (Pioglitazone hcl)</p> <p>AVANDIA® (Rosiglitazone maleate)</p> <p>AVANDAMET® (Rosiglitazone/metformin hcl)</p> <p>ACTOPLUS MET® (Pioglitazone hcl/metformin hcl)</p> <p>AVANDARYL® (Rosiglitazone/glimepiride)</p> <p>DUETACT® (Pioglitazone/glimepiride)</p> <p>JANUVIA® (Sitagliptin phosphate)</p> <p>JANUMET® (Sitagliptin phos/ metformin hcl)</p> <p>PRANDIMET® (Repaglinide/metformin hcl)</p>	<p>COVERAGE FOR AVANDIA®, ACTOS® OR JANUVIA® REQUIRES DOCUMENTATION THAT THE MEMBER HAS EXPERIENCED FAILURE WITH GLUCOPHAGE® (g), A SULFONYLUREA DRUG, OR A COMBINATION PRODUCT CONTAINING GLUCOPHAGE®(g) OR SULFONYLUREA.</p> <p>COVERAGE FOR AVANDAMET® REQUIRES DOCUMENTATION THAT THE MEMBER HAS HAD A 30 DAY TRIAL OF AVANDIA® AND METFORMIN.</p> <p>COVERAGE FOR ACTOPLUS® MET REQUIRES DOCUMENTATION THAT THE MEMBER HAS HAD A 30 DAY TRIAL OF ACTOS® AND METFORMIN.</p> <p>COVERAGE FOR AVANDARYL® REQUIRES DOCUMENTATION THAT THE MEMBER HAS HAD A 30 DAY TRIAL OF AVANDARYL® AND GLIMEPIRIDE.</p> <p>COVERAGE OF DUETACT® REQUIRES DOCUMENTATION THAT THE MEMBER HAS HAD A 30 DAY TRIAL OF ACTOS® AND GLIMEPIRIDE</p> <p>COVERAGE FOR JANUMET® REQUIRES DOCUMENTATION THAT THE MEMBER HAS HAD A 30 DAY TRIAL OF JANUVIA® AND METFORMIN.</p> <p>COVERAGE FOR PRANDIMET® REQUIRES DOCUMENTATION THAT THE MEMBER HAS HAD A 30 DAY TRIAL OF PRANDIN® AND METFORMIN.</p> <p>LENGTH OF APPROVAL: LIFETIME</p>
<b>Endocrine Agents (PA)</b>	
<p>SYMLIN® (Pramlintide)</p>	<p><b>BYETTA</b> IS COVERED FOR PATIENTS WHO HAVE TYPE 2 DIABETES WHO ARE CURRENTLY TAKING, OR HAVE TRIED, (OR HAVE CONTRAINDICATIONS</p>

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<p>BYETTA® (Exenatide)</p> <p><b>VICTOSA IS NONFORMULARY (NOT COVERED)</b></p>	<p>TO):</p> <ul style="list-style-type: none"> <li>○ METFORMIN, A SULFONYLUREA, A THIAZOLIDINEDIONE, A COMBINATION OF METFORMIN AND A SULFONYLUREA OR A COMBINATION OF METFORMIN AND A THIAZOLIDINEDIONE (A TRIAL OF AT LEAST TWO OF THESE THREE AGENTS IS REQUIRED) AND</li> <li>○ HAVE DEMONSTRATED A LACK OF EFFICACY OF INSULIN .</li> </ul> <p>IN ADDITION TO THE ABOVE CRITERIA THE PATIENT MUST HAVE A HEMOGLOBIN A1C OF GREATER THAN 7 PER CENT.</p> <p>BYETTA WILL NOT BE COVERED FOR WEIGHT LOSS IN PATIENTS WITH OR WITHOUT DIABETES.</p> <p><b>SYMLIN</b> IS COVERED FOR PATIENTS THAT HAVE FAILED INTENSIVE TREATMENT WITH INSULIN MONOTHERAPY.</p> <p>SYMLIN IS COVERED FOR CONCURRENT USE WITH AN INSULIN PRODUCT</p> <p>LENGTH OF APPROVAL; LIFETIME</p>
<b>Hematopoietic Agents (PA)</b>	
<p><b>Erythropoiesis stimulating agents (ESAs)</b></p> <p>ARANESP® (Darbepoetin alfa)</p> <p>EPOGEN® (Epoetin alfa)</p> <p>PROCRIT® (Epoetin alfa)</p>	<p>COVERED FOR THE TREATMENT OF ANEMIA ASSOCIATED WITH CHRONIC RENAL FAILURE, INCLUDING PATIENTS ON DIALYSIS (END-STAGE RENAL DISEASE) AND PATIENTS NOT ON DIALYSIS, TO ELEVATE OR MAINTAIN THE RBC LEVEL (AS MANIFESTED BY HEMATOCRIT OR HEMOGLOBIN DETERMINATIONS) AND TO DECREASE THE NEED FOR TRANSFUSIONS IN THESE PATIENTS. ALSO</p> <p>COVERED FOR ANEMIA SECONDARY TO ACTIVE CHEMOTHERAPY OF SOLID TUMORS, ANEMIA SECONDARY TO ACTIVE ZIDOVUDINE (AZT) THERAPY,</p> <p>ANEMIA IN MYELODYSPLASTIC DISORDERS, AND PROPHYLACTIC USE DURING MAJOR SURGERIES.</p> <p>ARANESP AND EPOGEN USE REQUIRES TRIAL AND FAILURE OF PROCRT.</p> <p>COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE EXCLUDED BY PART D.</p> <p><b>EXCLUSIONS:</b></p> <p>ANEMIA DUE TO FOLATE, VITAMIN B12, IRON DEFICIENCIES,</p> <p>HEMOLYSIS, BLEEDING, OR BONE MARROW FIBROSIS.</p> <p>ANEMIA ASSOCIATED WITH TREATMENT OF</p>

Medication / Drug Class	Criteria
	<p>ACUTE AND CHRONIC MYELOGENOUS LEUKEMIAS OR ERYTHROID CANCERS.</p> <p>ANEMIA DUE TO CANCER TREATMENT IN PATIENTS WITH UNCONTROLLED HYPERTENSION.</p> <p>ANEMIA NOT ASSOCIATED WITH CANCER TREATMENT OR RENAL DISEASE UNDER INCLUSIONS.</p> <p>ANEMIA ASSOCIATED ONLY WITH RADIOTHERAPY.</p> <p>PROPHYLACTIC USE TO PREVENT CHEMOTHERAPY INDUCED ANEMIA.</p> <p>PROPHYLACTIC USE TO REDUCE TUMOR HYPOXIA.</p> <p>ERYTHROPOIETIN-TYPE RESISTANCE DURE TO NEUTRALIZING ANTIBODIES.</p> <p>DOCUMENTATION OF HEMOGLOBIN MAY BE REQUIRED:</p> <p>HEMOGLOBIN LESS THAN 13 FOR PROPHYLACTIC USE DURING SOME MAJOR SURGERIES FOR EPOGEN. HEMOGLOBIN LESS THAN 12MG/DL FOR REMAINING COVERED USES</p> <p>LENGTH OF APPROVAL: THREE MONTHS</p>
MOBOZIL <sup>®</sup> (Plerixafor)	<p>COVERED FOR PATIENTS WITH NON-HODGKINS LYMPHOMA AND MULTIPLE MYELOMA REQUIRING AUTOLOGOUS TRANSPLANTATION, WHEN POOR RESPONSE IS DOCUMENTED TO APHERESIS WITH GRANULOCYTE COLONY STIMULATING FACTOR ALONE.</p> <p>REQUIRES:</p> <p>DOCUMENTATION OF DIAGNOSIS AND THAT GRANULOCYTE COLONY STIMULATING FACTOR IS ADMINISTERED CONCOMITANTLY</p> <p>DOCUMENTATION OF POOR RESPONSE TO APHERESIS WITH GRANULOCYTE COLONY STIMULATING FACTOR</p> <p>.</p> <p>LENGTH OF APPROVAL: 1 MONTH</p>
PROMACTA <sup>®</sup> (Eltrombopag)	<p>INITIAL COVERAGE IS PROVIDED FOR PROMACTA IN PATIENTS WHO MEET THE FOLLOWING CRITERIA:</p> <p>AGE 18 YEARS OR GREATER</p> <p>HEMATOLOGIST CONSULTATION REQUIRED.</p> <p>DIAGNOSIS OF CHRONIC IMMUNE THROMBOCYTOPENIA PURPURA, PERSISTENT THROMBOCYTOPENIA DEFINED BY PLATELET COUNT LESS THAN 150,000 MCL FOR MINIMUM 2 MONTHS, AND</p> <p>INADEQUATE RESPONSE OR DOCUMENTED</p>

Medication / Drug Class	Criteria
	<p>INTOLERANCE FOR THERAPY WITH CORTICOSTEROIDS, IMMUNOGLOBULINS, OR SPLENECTOMY AND</p> <p>CURRENT PLATELET COUNT OF LESS THAN OR EQUAL TO 50,000 MCL AND A PRESCRIBED DAILY DOSE OF 75MG OR LESS.</p> <p>RENEWAL OF THERAPY IS COVERED FOR PATIENTS WHO MEET THE FOLLOWING CRITERIA: RECENT PLATELET COUNT OF 30,000 TO 150,000 MCL, AND A DAILY DOSE OF 75MG OR LESS.</p> <p>LENGTH OF APPROVAL: INITIATION OF THERAPY - 12 WEEKS, CONTINUATION THERAPY - 12 MONTHS</p>
<b>Gastrointestinal agents</b>	
<b>Misc GI Agents (PA)</b>	
<p>RELISTOR™ (Methylnaltrexone bromide)</p>	<p>FOR THE TREATMENT OF OPIOID-INDUCED CONSTIPATION IN PATIENTS WITH ADVANCED ILLNESS WHO ARE RECEIVING PALLIATIVE CARE, WHEN RESPONSE TO LAXATIVE THERAPY HAS NOT BEEN SUFFICIENT.</p> <p>REQUIRES ADEQUATE TREATMENT CONSISTING OF 5 DAYS DURATION OF TREATMENT OF AGENTS FOR CONSTIPATION, INCLUDING AT LEAST ANY TWO OF THE FOLLOWING: BULK LAXATIVES, SALINE LAXATIVES OR OSMOTIC LAXATIVES. COVERAGE MAY NOT BE PROVIDED IF THERE ARE CONTRAINDICATIONS TO METHYLNALTREXONE THERAPY.</p> <p>LENGTH OF APPROVAL: 3 MONTHS</p>
<p>AMITZA® (Lubiprostone)</p>	<p>COVERED FOR WOMEN 18 YEARS OR OLDER AND DIAGNOSED WITH IBS WITH CONSTIPATION.</p> <p>COVERED FOR ADULTS WITH FOR THE TREATMENT OF CHRONIC IDIOPATHIC CONSTIPATION.</p> <p>DOCUMENTATION OF FAILURE WITHIN THE LAST 12 MONTHS OF USE OF A FIBER LAXATIVE AND ONE OF THE FOLLOWING: A STIMULANT LAXATIVE OR AN OSMOTIC LAXATIVE.</p> <p>DRUG INDUCED CONSTIPATION MUST BE RULED OUT.</p> <p>LENGTH OF APPROVAL: 1 YEAR</p>
<b>Proton Pump Inhibitors</b>	

Medication / Drug Class	Criteria
<p>For members enrolled in a <b>BCN Advantage INDIVIDUAL</b> benefit  <b>All PPIs are NONFORMULARY (not covered) EXCEPT Omeprazole and Pantoprazole.</b></p> <p>OMEPRAZOLE 40mg (PA)</p> <p><b>ACIPEX, NEXIUM, LANSOPRAZOLE, DEXILANT AND ZEGERID ARE NON-FORMULARY (NOT COVERED)</b></p>	<p><b>OMEPRAZOLE 40MG</b>  REQUIRES:  DOCUMENTATION OF INTOLERANCE TO 2 DOSES OF 20MG OMEPRAZOLE.  LENGTH OF APPROVAL: 1 YEAR</p>
<p>Members enrolled in a <b>BCN ADVANTAGE GROUP</b> benefit have these PPIs in their drug benefit. <b>They still require authorization.</b></p> <p>ACIPHEX® (Rabeprazole sodium)  NEXIUM® (Esomeprazole)  DEXILANT™ (Dexlansoprazole)  ZEGERID® (Omeprazole/bicarbonate) (generic only)</p>	<p><b>ACIPHEX® AND ZEGERID® (g)</b> REQUIRE DOCUMENTATION OF FAILURE WITH OR INTOLERANCE TO OMEPRAZOLE (g).</p> <p><b>NEXIUM®</b> IS COVERED AFTER A 30 DAY TRIAL OF TWO PREFERRED FORMULARY PRODUCTS OF PANTOPRAZOLE OR OMEPRAZOLE. HIGH DOSE THERAPY IS REQUIRED OF ONE DRUG TRIAL, FOR EXAMPLE, 40MG OR GREATER PER DAY OF OMEPRAZOLE OR 80MG OR GREATER PER DAY OF PANTOPRAZOLE.</p> <p><b>DEXILANT™</b> REQUIRES DOCUMENTATION OF FAILURE WITH OR INTOLERANCE TO AT LEAST TWO FORMULARY PREFERRED PPI AGENTS (OMEPRAZOLE AND PANTOPRAZOLE). AT LEAST ONE OF THESE THERAPIES MUST BE TRIED TWICE DAILY.</p>
<b>Gout Therapy (ST)</b>	
<p>ULORIC® (Febuxostat)</p>	<p>CLAIMS FOR ULORIC WILL APPROVE IF PREVIOUS CLAIMS HAVE BEEN FILLED FOR AT LEAST 30 DAYS OF ALLOPURINOL 300 MG PER DAY IN PREVIOUS 120 DAYS, OTHERWISE PRIOR AUTH WILL BE REQUIRED.</p> <p>IF PA REQUIRED: LENGTH OF APPROVAL: 1 YEAR</p>
<b>Growth Hormone (PA)</b>	
<p>NUTROPIN® (Somatropin)  SAIZEN® (Somatropin)  GENOTROPIN® (Somatropin)  HUMATROPE® (Somatropin)  NORDITROPIN® (Somatropin)  OMNITROPE® (Somatropin)  SEROSTIM® (Somatropin)  TEV-TROPIN® (Somatropin)  ZORBTIVE® (Somatropin)  INCRELEX® (Somatropin)  iPLEX® (Mecasermin rinfabate/PF)  SOMAVERT® (Pegvisomant)</p>	<p>COVERED FOR THE REPLACEMENT OF ENDOGENOUS GROWTH HORMONE IN ADULTS WITH GROWTH HORMONE DEFICIENCY OF CHILDHOOD ONSET OR ADULT ONSET,</p> <p>COVERED IF INITIAL DIAGNOSIS BASED ON TWO GROWTH HORMONE STIMULATION TESTS AND THAT THE PATIENT DOES NOT HAVE EDEMA, ARTHRALGIAS, OR CARPAL TUNNEL SYNDROME.</p> <p>GROWTH HORMONE IS COVERED FOR ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.</p> <p><b>SEROSTIM</b> IS COVERED FOR AIDS WASTING CACHEXIA. <b>NORDITROPIN</b> IS COVERED FOR NOONAN SYNDROME, TURNER SYNDROME, AND</p>

Medication / Drug Class	Criteria
	<p>ADULT GROWTH HORMONE DEFICIENCY.</p> <p><b>NUTROPIN</b> IS COVERED FOR TURNER SYNDROME, AND ADULT GROWTH HORMONE DEFICIENCY.</p> <p><b>OMNITROPE AND SAIZEN</b> ARE COVERED FOR ADULT GROWTH HORMONE DEFICIENCY.</p> <p><b>ZORBTIVE</b> IS COVERED FOR THE TREATMENT OF SHORT-BOWEL SYNDROME IN PATIENTS RECEIVING SPECIALIZED NUTRITIONAL SUPPORT.</p> <p><b>SOMAVERT</b> IS COVERED FOR ACROMEGALY. INITIAL APPROVAL FOR 1 YEAR AND RENEWAL CAN BE OBTAINED IF CLINICAL RESPONSE WITH THERAPY.</p> <p>LENGTH OF APPROVAL: 1 YEAR</p>
<b>Hepatitis (PA)</b>	
<p>INTRON<sup>®</sup> A (Interferon alfa-2B, recomb)  PEGASYS<sup>®</sup> (Peginterferon alfa-2A)  PEG-INTRON<sup>®</sup> REDIPEN (Peginterferon alfa-2B)</p> <p>INCIVEK<sup>™</sup>  VICTRELIS<sup>™</sup></p>	<p>COVERED FOR HEPATITIS C VIRUS INFECTION.</p> <p>COVERED WHEN APPROPRIATE DOSES OF CONCOMITANT RIBAVARIN ARE UTILIZED FOR THE APPROPRIATE VIRAL GENOTYPE.</p> <p>DOCUMENTATION OF CONCOMITANT RIBAVARIN USE (OR CONTRAINDICATIONS) IS REQUIRED WHEN REQUESTING INITIAL USE FOR HEPATITIS C.</p> <p>DOCUMENTATION OF VIRAL GENOTYPE IS REQUIRED FOR HEPATITIS C.</p> <p>DOCUMENTATION OF RESPONSE TO THERAPY IS REQUIRED FOR REQUESTS FOR CONTINUATION OF THERAPY FOR HEPATITIS C.</p> <p>LENGTH OF APPROVAL: INITIATION OF THERAPY - 12 WEEKS, CONTINUATION THERAPY - 24 TO 48 WEEKS</p> <p><b>INCIVEK AND VICTRELIS:</b></p> <p>COVERED FOR PATIENTS 18 YEARS OF AGE OR OLDER</p> <p>COVERED FOR CHRONIC HEPATITIS C, GENOTYPE 1 WITH COMPENSATED LIVER DISEASE (INCLUDING CIRRHOSIS) AND RECENT HCV-RNA LEVEL</p> <p>COVERAGE IS PROVIDED IN SITUATIONS WHERE PATIENTS ARE RECEIVING COMBINATION THERAPY WITH EITHER BOCEPREVIR OR TELAPREVIR AND A PEGINTERFERON ALFA PRODUCT WITH RIBAVIRIN.</p>

Medication / Drug Class	Criteria
	<p>COVERAGE IS NOT PROVIDED FOR MONOTHERAPY</p> <p>COVERAGE IS NOT PROVIDED IN SITUATIONS WHERE PATIENTS HAVE PREVIOUSLY NOT RESPONDED TO THERAPY THAT INCLUDED EITHER BOCEPREVIR OR TELAPREVIR</p> <p><b>INCIVEK:</b> NOT COVERED IN PATIENTS WHO HAVE BEEN TREATED FOR 3 MONTHS OR MORE.</p> <p><b>VICTRELIS:</b> INCIVEK MUST BE CONTRAINDICATED OR NOT RECOMMENDED DO THE PATIENTS' CLINICAL HISTORY (HISTORY OF SEVERE SKIN REACTIONS OR DERMATOLOGIC CONDITIONS, MODERATE TO SEVERE HEPATIC IMPAIRMENT, DRUG-DRUG INTERACTIONS NOT ASSOCIATED WITH BOCEPREVIR)</p> <p><b>FOR AUTHORIZATION. RENEWAL OF VICTRELIS:</b></p> <p>RENEWAL REQUIRES DOCUMENTATION OF HCV RNA LEVEL/VIRAL LOAD LESS THAN OR EQUAL TO 100 IU/ML AFTER TOTAL TREATMENT WEEK 12 AND 24</p> <p>LENGTH OF APPROVAL - INCIVEK: 12 WEEKS. LENGTH OF INITIAL APPROVAL- VICTRELIS: 12 WEEKS. LENGTH OF RENEWAL- VICTRELIS: FIRST RENEWAL: 12 WEEKS. SECOND RENEWAL: 20 WEEKS.</p>
<b>High Risk Drugs in the Elderly (PA)</b>	
<p>Diphenhydramine Thioridizine Nitrofurantoin &amp; Nitrofurantoin Macrocrystals</p>	<p>FOR PATIENTS 65 YEARS OR OLDER:</p> <p><b>DIPHENHYDRAMINE</b> IS APPROVED IF PATIENT HAS FAILED OR IS INTOLERANT TO OTHER SAFER ALTERNATIVE SEDATIVE OR ANXIOLYTIC AGENTS SUCH AS ZOLPIDEM OR IF PATIENT HAS FAILED OR IS INTOLERANT TO OTHER SAFER ALTERNATIVE ANTIHISTAMINES SUCH AS FEXOFENADINE.</p> <p><b>THIORIDIZINE</b> IS COVERED FOR PATIENTS WHO HAVE A HISTORY OF USE. FOR THOSE PATIENTS INITITATING THERAPY, THIORIDIZINE IS COVERED IF PATIENT HAS A FAILURE OF OR INTOLERANCE TO SAFER ALTERNATIVE ANTIPSYCHOTICS SUCH AS ABILIFY OR SEROQUEL.</p> <p>NITROFURANTOIN MONOHYDRATE or MACROCRYSTALS ARE COVERED IF</p>

Medication / Drug Class	Criteria
	<p>1. DOCUMENTATION IS PROVIDED THAT RENAL FUNCTION IS GREATER THAN OR EQUAL TO 60ML/MIN. <b>AND</b></p> <p>2. PATIENT HAS AN ALLERGY TO SAFER ALTERNATIVES <b>OR</b> HAS TRIED AND FAILED SAFER ALTERNATIVES SUCH AS CEPHALOSPORINS, BACTRIM, QUINOLONES, ETC.</p> <p>LENGTH OF APPROVAL: 1 year</p>
<b>Miscellaneous CNS (ST)</b>	
<p>INTUNIV™ (Guanfacine)</p>	<p>REQUIRES DOCUMENTATION OF TREATMENT FAILURE, INTOLERANCE TO, OR CONTRAINDICATION TO A METHYLPHENIDATE CONTAINING PRODUCT AND AN AMPHETAMINE CONTAINING PRODUCT</p> <p>CLAIMS FOR INTUNIV WILL PROCESS IF CLAIMS FOR 30 DAY OF A METHYLPHENIDATE CONTAINING PRODUCT <b>AND</b> AN AMPHETAMINE CONTAINING PRODUCT ARE PROCESSED IN THE PAST 180 DAYS. LENGTH OF APPROVAL, OTHERWISE PA IS REQUIRED.</p> <p>LENGTH OF APPROVAL: LIFETIME</p>
<b>Migraine Therapy (ST)</b>	
<p>AXERT® (Aalmotriptan)  MAXALT® (Rizatriptan benzoate)  FROVA® (Frovatriptan succinate)  Naratriptan hcl (Amerge Brand is non formulary)  RELPAX® (Eletriptan HBr)  ZOMIG® (Zolmitriptan)</p> <p><b>NOTE: SUMAVEL DOSEPRO IS NOT A PART D MEDICATION AND IS NOT A COVERED BENEFIT</b></p>	<p>CLAIMS FOR BRANDED MIGRAINE THERAPY OF NARATRIPTAN, AXERT, MAXALT, FROVA, RELPAX, and ZOMIG WILL PROCESS IF PREVIOUS CLAIMS HAVE BEEN FILLED FOR AT LEAST 6 DAYS OF THERAPY WITH SUMATRIPTAN IN THE PAST 120 DAYS, OTHERWISE, PRIOR AUTHORIZATION WILL BE REQUIRED.</p> <p>LENGTH OF APPROVAL IF AUTHORIZATION IS NEEDED:  1 YEAR</p>
<b>Multiple Sclerosis (ST)</b>	
<p>BETASERON® (Interferon beta-1b)</p>	<p>REQUIRES A LEAST A 30 DAY TRIAL OF EXTAVIA PRIOR TO APPROVAL.</p> <p>CLAIMS WILL PROCESS AUTOMATICALLY AT PHARMACY IF THE MEMBER HAS A MEDICATION HISTORY WITH A 30 DAY SUPPLY OF EXTAVIA WITHIN THE PAST 120 DAYS. OTHERWISE, PRIOR AUTH IS REQUIRED.</p> <p>LENGTH OF APPROVAL: 1 YEAR</p>

Medication / Drug Class	Criteria
<p>GILENYA<sup>®</sup> (Fingolimod), (Prior Authorization required)</p> <p><b>AMPYRA is NON FORMULARY (NOT COVERED)</b></p>	<p>GILENYNA REQUIRES THE TRIAL AND FAILURE OF EITHER GLATIRAMER <b>OR</b> AN INTERFERON BETA PRODUCT.</p> <p>MUST BE PRESCRIBED BY A NEUROLOGIST</p> <p>LENGTH OF APPROVAL: 1 YEAR</p>
<b>Narcotic Analgesics (PA)</b>	
<p>ACTIQ<sup>®</sup> (Fentanyl transmucosal) (geq)</p> <p>FENTORA<sup>®</sup> (Fentanyl buccal)</p> <p>ONSOLIS<sup>™</sup> (Fentanyl Citrate)</p> <p><b>OXYCONTIN<sup>®</sup> is NON FORMULARY (NOT COVERED)</b></p>	<p><b>ACTIQ<sup>®</sup> (GEQ) FENTORA<sup>®</sup> AND ONSOLIS<sup>™</sup> ARE COVERED FOR CANCER OR CANCER RELATED DIAGNOSIS IN PATIENTS ALREADY RECEIVING LONG ACTING OPIOIDS</b></p> <p>REQUIRE:</p> <p>DOCUMENTATION OF DIAGNOSIS AND MEDICATION HISTORY.</p> <p>LENGTH OF APPROVAL: 1 YEAR</p>
<b>Nasal Steroids (ST)</b>	
<p>ALVESCO<sup>®</sup> (Ciclesonide)</p> <p>BECONASE AQ<sup>®</sup> (Beclomethasone dipropionate)</p> <p>NASACORT AQ<sup>®</sup> (Triamcinolone acetonide)</p> <p>NASONEX<sup>®</sup> (Mometasone furoate)</p> <p>OMNARIS<sup>™</sup> (Ciclesonide)</p> <p>RHINOCORT AQUA<sup>®</sup> (Budesonide)</p> <p>VERAMYST<sup>®</sup> (Fluticasone furoate)</p>	<p>REQUIRES A MINIMUM 30 DAY TRIAL WITH FLUNISOLIDE OR FLUTICASONE PRIOR TO APPROVAL.</p> <p>CLAIMS FOR ALVESCO, BECONASE AQ, VERAMYST, NASACORT, NASACORT AQ, NASONEX, OMNARIS AND RHINOCORT AQUA WILL PROCESS IF A CLAIM FOR AT LEAST 30 DAYS OF <b>FLUNISOLIDE OR FLUTICASONE</b> NASAL SPRAY HAS PROCESSED IN THE PAST 120 DAYS</p> <p>LENGTH OF APPROVAL: 1 YEAR</p>
<b>Non-Sedating Antihistamines</b>	
<p><b><i>Non-Sedating Antihistamines are not covered for BCNA members, with the exception of fexofenadine. No authorization is required for this product.</i></b></p>	
<b>Pulmonary Hypertension (PA)</b>	
<p>ADCIRCA<sup>™</sup> (Tadalafil)</p> <p>LETAIRIS<sup>™</sup> (Ambrisentan)</p> <p>REVATIO<sup>®</sup> (Sildenafil citrate)</p> <p>TRACLEER<sup>™</sup> (Bosentan)</p> <p>VENTAVIS<sup>®</sup> (Iloprost)</p>	<p>LETAIRIS, REVATIO, ADCIRCA, TRACLEER AND VENTAVIS ARE COVERED FOR ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.</p> <p>COVERAGE FOR REVATIO AND ADCIRCA IS NOT PROVIDED IN SITUATIONS WHERE PATIENTS ARE RECEIVING NITRATE THERAPY.</p> <p>LENGTH OF APPROVAL: 1 YEAR</p>
<b>Sedative/Hypnotic Agents (ST)</b>	



Medication / Drug Class	Criteria
<p><b>XENAZINE<sup>®</sup></b> (Tetrabenazine)</p>	<p>LENGTH OF APPROVAL: 1 YEAR</p> <p>XENAZINE IS COVERED FOR THE TREATMENT OF <b>CHOREA ASSOCIATED WITH HUNTINGTONS DISEASE</b></p> <p><b>FOR DOSES ABOVE 50MG PER DAY:</b></p> <p>REQUIRE:</p> <p>DOCUMENTATION OF PATIENT CYP2D6 GENOTYPE</p> <p>COVERAGE FOR XENAZINE WILL <b>NOT</b> BE PROVIDED FOR:</p> <p>PATIENTS WHO HAVE HEPATIC FUNCTION IMPAIRMENT, PATIENTS WHO ARE ACTIVELY SUICIDAL OR WHO HAVE UNTREATED OR INADEQUATELY TREATED DEPRESSION, OR PATIENTS TAKING MONAMINE OXIDASE INHIBITORS OR RESERPINE.</p> <p>LENGTH OF APPROVAL: LIFETIME</p>
<p><b>KUVAN<sup>®</sup></b> (Sapropterin)</p>	<p>COVERED FOR PATIENTS WITH <b>HYPERPHENYLALANINEMIA (HPA)</b> DUE TO TETRAHYDROBIOPTERIN (BH4) RESPONSIVE PHENYLKETONURIA (PKU).</p> <p>REQUIRE:</p> <p>DOCUMENTATION OF DIETARY RESTRICTIONS AND DIAGNOSIS FOR INITIAL APPROVAL.</p> <p><b>FOR RENEWAL:</b></p> <p>REQUIRES DOCUMENTATION IN REDUCTION OF PHENYLALANINE FROM BASELINE.</p> <p>LENGTH OF APPROVAL:</p> <p>INITIAL - 2 MONTHS AUTH WILL BE EXTENDED FOR 1 YEAR IF DOCUMENTED 30% OR MORE RESPONSE AFTER INITIAL THERAPY.</p>