



Prior Authorization Criteria

**for Select Drugs on the
Peoples Health 2012 Formulary**

The following are prior authorization group names that appear for select drugs on the 2012 Peoples Health formulary. Descriptions for each of these group names are found on the corresponding pages of this document.

ACETYLCYSTEINE.....	1
ALOSETRON	2
ANABOLIC STEROIDS	3
AZATHIOPRINE	4
BANZEL	5
BOCEPREVIR	6
BOTULINUM	7
COLESEVELAM.....	8
ENDOTHELIN RECEPTOR ANTAGONISTS	9
ENTACAPONE.....	10
EPLERENONE	11
ES AGENTS	12
GUANIDINE.....	13
ITRACONAZOLE.....	14
IV AND IM DRUGS.....	15
LINEZOLID	16
LMWH	17
MOTOFEN.....	18
MYCOPHENOLATE	19
NAFARELIN ACETATE.....	20
PART B DRUGS.....	21
PHOSPHODIESTERASE INHIBITORS	22
PROMACTA	23
RESTASIS.....	24
RILUZOLE	25
SODIUM OXYBATE	26
SPECIALTY.....	27
SPECIALTY-CC	28
TELAPREVIR	29
VIMPAT	30
VORICONAZOLE	31
XOLAIR	32

To determine if your drug has a prior authorization requirement, use the Peoples Health online Prescription Drug Search at <http://www.peopleshealth.com/formulary>.



Prior Authorization Criteria for:

MUCOMYST (acetylcysteine)

To request prior authorization for MUCOMYST (acetylcysteine), a [Pharmacy Request Form](#) documenting diagnosis, drug, dosage and duration of therapy is required, as well as documentation of any prior drugs used for treatment of diagnosis.

Criteria for Approval

If the drug is given by nebulization in the patient's home, coverage is under Medicare Part B. If the drug is administered by nebulization to a patient in a long-term care facility, coverage is under Medicare Part D. The drug should be used:

- For adjunctive treatment of chronic bronchopulmonary disorders, including chronic bronchitis or chronic obstructive pulmonary disease (COPD); OR
- For adjunctive treatment of acute bronchopulmonary disorders, such as atelectasis caused by mucus obstruction, pulmonary complications of cystic fibrosis, thoracic and cardiovascular surgery complications and post-traumatic chest conditions; OR
- **For coverage under Medicare Part D only:** In conjunction with hydration for nephrotoxicity prophylaxis against radiographic-contrast-induced reductions in renal function in those patients with pre-existing renal insufficiency (SCr > 1.2mg/dL OR CrCl < 60ml/min), or who are otherwise at risk for contrast-agent-induced renal damage (diabetes, peripheral vascular disease, congestive heart failure)

Coverage Duration

For the adjunctive treatment of chronic or acute bronchopulmonary disorders, coverage for the drug is limited to 12 months.

For use in conjunction with hydration for nephrotoxicity prophylaxis, the duration of approval is two days.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.

Updated 09/2011

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Prior Authorization Criteria for:

LOTRONEX (alosetron)

To receive prior authorization for LOTRONEX (alosetron), complete a [Pharmacy Request Form](#).

Criteria for Approval

- Patient receiving the drug must be female, 18 years of age or older and has been diagnosed with severe, chronic, diarrhea-predominant irritable bowel syndrome (IBS) that has lasted six months or longer with at least one of the following symptoms:
 - Frequent and severe abdominal pain/discomfort,
 - Frequent bowel urgency or fecal incontinence, OR
 - Disability or restriction of daily activities
- Prescribing physician must be a gastroenterologist enrolled in the GlaxoSmithKline prescribing program for LOTRONEX (alosetron).

Coverage Duration

The drug will be covered for up to 60 tablets per month for one month, initially. If the patient tolerates the drug and responds to treatment after one month, subsequent requests may be approved for up to 12 months.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.



Prior Authorization Criteria for:

Anabolic Steroids

To receive prior authorization for anabolic steroids, complete a [Pharmacy Request Form](#).

Coverage Duration

The duration of coverage for the drug is 12 months.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D. Total testosterone level must be below 300 ng/mL for initial approval or less than 827 ng/dL for continued therapy.

Exclusions

The drug will not be covered by Medicare Part D if the drug is used for athletic performance enhancement.

Updated 09/2011

This page was printed from the Peoples Health 2012 online formulary at
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Prior Authorization Criteria for:

IMURAN or AZASAN (azathioprine)

To receive prior authorization for IMURAN or AZASAN (azathioprine), complete a [Pharmacy Request Form](#).

Criteria for Approval

For *Medicare Part B* coverage:

- The drug must be an adjunct for the prevention of rejection in renal homotransplantations.

For *Medicare Part D* coverage, the drug must be:

- Indicated for the management of severe, active rheumatoid arthritis not responsive to conventional management, including rest, aspirin or other non-steroidal drugs, or to agents in the class of which gold is an example, OR
- Used to suppress the symptoms and reduce inflammation caused by refractory Crohn's disease, OR
- Used to control inflammation or reduce symptoms caused by steroid-resistant or steroid-dependent ulcerative colitis, OR
- Used for the treatment of systemic lupus erythematosus (SLE), OR
- Used for the treatment of myasthenia gravis in patients who are poorly controlled with cholinesterase inhibitor therapy
- Used for the treatment of autoimmune hepatitis

Coverage Duration

The duration of coverage for the drug is 12 months.

Covered Uses

Applies only to patients being initiated on treatment. This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.



Prior Authorization Criteria for:

BANZEL (rufinamide)

To receive prior authorization for BANZEL (rufinamide), complete a [Pharmacy Request Form](#).

Coverage Duration

The duration of coverage for the drug is 12 months.

Covered Uses

Applies to patients being initiated on treatment. This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.



Prior Authorization Criteria for:

VICTRELIS (boceprevir)

To request prior authorization for VICTRELIS (boceprevir), a [Pharmacy Request Form](#) documenting diagnosis, drug, dosage and duration of therapy is required, as well as documentation of any prior drugs used for treatment of diagnosis.

Covered Uses

This drug is covered for the treatment of genotype 1 only chronic hepatitis C infection in combination with peginterferon and ribavirin

Contraindications

1. Decompensated liver disease
2. Co-infection with human immunodeficiency virus (HIV) or hepatitis B
3. Organ transplant recipient
4. Members not receiving concomitant therapy with peginterferon or ribavirin
5. Prior treatment course (other than currently requested) that included boceprevir or telaprevir for any period of time
6. Current treatment with the following:
 - a. Alfuzosin
 - b. Carbamazepine, phenobarbital, phenytoin
 - c. Cisapride
 - d. Dihydroergotamine, ergonovine, ergotamine, methylergonovine
 - e. Drospirenone-containing oral contraceptives
 - f. Lovastatin, simvastatin, atorvastatin doses exceeding 20mg/day
 - g. Midazolam (oral) or triazolam
 - h. Pimozide
 - i. Rifampin
 - j. Sildenafil (REVATIO) and tadalafil (ADCIRCA) for pulmonary hypertension

Coverage Duration

- Initial approval for eight weeks.
- Continuation of therapy beyond eight weeks requires documentation of HCV-RNA levels less than or equal to 100 IU/mL at treatment course week 12 (considering four week lead-in). An additional duration of up to 36 weeks may then be granted (maximum total of 44 weeks boceprevir).

Definitions

- *Lead-in*: initial four weeks of peginterferon and ribavirin without boceprevir
- *Treatment course week*: point in therapy, which considers total treatment course including 4-week lead-in and combination therapy with boceprevir

Updated 09/2011

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Prior Authorization Criteria for:

BOTOX (onabotulinumtoxin)

To receive prior authorization for BOTOX (onabotulinumtoxin), complete a [Pharmacy Request Form](#).

Coverage Duration

The duration of coverage for the drug is one month.

Covered Uses

- All FDA-approved indications not otherwise excluded from Medicare Part D.
- To treat blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorders.
- To treat cervical dystonia in adults to decrease the severity of abnormal head position and neck pain associated with cervical dystonia.
- To treat strabismus.
- To treat severe primary axillary hyperhidrosis (excessive sweating) not managed by available topical treatments.
- To treat hemifacial spasm.
- To treat spasmodic dystonia.
- To treat chronic anal fissure refractory to conservative treatment.
- To treat esophageal achalasia in patients for whom surgical treatment is not indicated.
- To treat spasticity or tremor refractory to other treatments.
- To treat sialorrhea (excessive drooling) associated with neurological disorders (i.e., Parkinson's disease, amyotrophic lateral sclerosis, cerebral palsy).
- For prophylaxis of headache in adults with chronic migraine headache.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for cosmetic purposes.
- The drug is used for the treatment of headache types other than chronic migraine as described.
- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.

Updated 11/2011

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Prior Authorization Criteria for:

WELCHOL (colesevelam HCl)

To receive prior authorization for WELCHOL (colesevelam HCl), a [Pharmacy Request Form](#) documenting diagnosis, drug, dosage and duration of therapy is required, as well as documentation of any prior drugs used for treatment of diagnosis.

Criteria for Approval

- For use in patients with a serum triglyceride level obtained within eight weeks of the request for coverage not exceeding 500 mg/dL; AND
- For use in reducing elevated low-density lipoprotein cholesterol (LDL-C). Must have attempted cholestyramine; have intolerance or a contraindication for use of cholestyramine; and have attempted at least one of the following cholesterol-lowering agents covered by the Peoples Health formulary, but did not reach goal, did not tolerate treatment or have a contraindication for use of the drug:
 - fenofibrate
 - lovastatin
 - pravastatin
 - simvastatin
 - crestor
 - lipitor
- When prescribed by a gastroenterologist for the treatment of bile acid malabsorption-related diarrhea caused by terminal ileal disease or resection or post-cholecystectomy with a previous trial or intolerance of cholestyramine

Coverage Duration

The duration of coverage for the drug is 12 months.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.

Updated 09/2011

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Prior Authorization Criteria for:

Endothelin Receptor Antagonists

To request prior authorization for endothelin receptor antagonists, a [Pharmacy Request Form](#) documenting diagnosis, drug, dosage and duration of therapy is required, as well as documentation of any prior drugs used for treatment of diagnosis.

Criteria for Approval

The drug must be prescribed by a cardiologist or pulmonologist, AND:

- For patients being initiated on therapy, a normal liver function test (LFT) (below three times the upper limit or normal) must be provided.
- For any chronic treatment, normal LFTs must be provided every six months for continued approval.

Covered Duration

This drug is covered for six months at a time.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- Patient has pulmonary venous hypertension
- Patient has pulmonary hypertension associated with disorders of the respiratory system or hypoxemia
- Patient is pregnant or lactating.
- Patient is currently on cyclosporine-A or glyburide.
- Patient has pulmonary hypertension caused by thrombotic or embolic diseases
- Patient has pulmonary hypertension caused by diseases affecting the pulmonary vasculature
- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.

No changes made since 11/2010

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Prior Authorization Criteria for:

COMTAN (entacapone)

To request prior authorization for COMTAN (entacapone), a [Pharmacy Request Form](#) documenting diagnosis, drug, dosage and duration of therapy is required, as well as documentation of any prior drugs used for treatment of diagnosis.

Coverage Duration

Coverage for the drug is limited to 12 months.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is not prescribed as an adjunct to levodopa/carbidopa therapy in patients with idiopathic Parkinson's Disease.
- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.



Prior Authorization Criteria for:

INSPRA (eplerenone)

To request prior authorization for INSPRA (eplerenone), a [Pharmacy Request Form](#) documenting diagnosis, drug, dosage and duration of therapy is required, as well as documentation of any prior drugs used for treatment of diagnosis.

Coverage Duration

Coverage for the drug is limited to 12 months.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for diagnoses other than treatment of congestive heart failure or high blood pressure.
- The member has not failed spironolactone due to gynecomastia or breast pain.
- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.

Updated 09/2011

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Prior Authorization Criteria for:

PROCRIT or EPOGEN (epoetin alfa/erythropoiesis-stimulating agents)

To receive prior authorization for PROCRIT or EPOGEN (epoetin alfa), complete a [Pharmacy Request Form](#).

Criteria for Approval

Patient's hemoglobin must be equal to or less than 13 mg/dL. Hematocrit (HCT) must be equal to or less than 39 percent. If HCT increases by more than four points in any two-week period, the dose must be reduced by 25 percent.

- For *preoperative purposes*: Coverage is through Medicare Part B.
- For *chronic renal failure*: Coverage is through Medicare Part D for self-administration for non-dialysis patients, and is through Medicare Part B in the office setting and for administration to dialysis patients.
- For *anemia associated with AZT therapy*: Coverage is through Medicare Part D for self-administration, and through Medicare Part B when administered in the office setting.
- For *secondary anemia, including cancer*: Coverage is through Medicare Part D for self-administration, and through Medicare Part B when administered in the office setting.
- If an ESA is being used for cancer patients, the prescription must be written by a hematologist/oncologist.

Coverage Duration

The drug will be covered for three months, with re-evaluation.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for the treatment of anemia in cancer patients due to other factors, such as iron or folate deficiencies, hemolysis or gastrointestinal bleeding.
- The drug is used to improve symptoms of anemia, quality of life, fatigue or patient well-being.
- The drug is used in patients receiving hormonal agents, therapeutic biologic products or radiotherapy, unless receiving concomitant myelosuppressive chemotherapy.
- The drug is used for anemic patients who are willing to donate autologous blood.
- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.

Updated 09/2011

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Prior Authorization Criteria for:

Guanidine

To request prior authorization for guanidine, a [Pharmacy Request Form](#) documenting diagnosis, drug, dosage and duration of therapy is required, as well as documentation of any prior drugs used for treatment of diagnosis.

Coverage Duration

Coverage for the drug is limited to 12 months.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.



Prior Authorization Criteria for:

SPORANOX (itraconazole)

To receive prior authorization for SPORANOX (itraconazole), complete a [Pharmacy Request Form](#).

Coverage Duration

The drug will be covered for 90 days for treatment of toenails and 35 days for treatment of fingernails. All other FDA-approved indications will be covered for 12 months.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for cosmetic purposes.
- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.

Updated 09/2011

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Prior Authorization Criteria for:

Intravenous and Intramuscular Drugs

To receive prior authorization for intravenous (IV) and intramuscular (IM) drugs, complete a [Pharmacy Request Form](#).

Coverage Duration

The duration of coverage for the drug is 12 months.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is dosed for a quantity outside of FDA-approved



Prior Authorization Criteria for:

ZYVOX (linezolid)

To request prior authorization for ZYVOX (linezolid), a [Pharmacy Request Form](#) documenting diagnosis, drug, dosage and duration of therapy is required, as well as documentation of any prior drugs used for treatment of diagnosis.

Criteria for Approval

- The prescribing physician must be an infectious disease specialist, or the agent must be prescribed on behalf of an infectious disease specialist.
- Confirmation of corresponding positive culture(s) required.

Coverage Duration

The drug will be covered for up to 28 days of total therapy, including inpatient therapy.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.



Prior Authorization Criteria for:

LOVENOX (enoxaprin)

To receive prior authorization for LOVENOX (enoxaprin), complete a [Pharmacy Request Form](#).

Coverage Duration

The drug will be covered for 21 days for a hip-knee replacement, 12 days for abdominal surgery, 17 days for deep vein thrombosis/pulmonary embolism (DVT/PE) and 10 days for bridge therapy.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D and for bridge therapy.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.



Prior Authorization Criteria for:

MOTOFEN (difenoXin/atropine)

To request prior authorization for MOTOFEN (difenoXin/atropine), a [Pharmacy Request Form](#) documenting diagnosis, drug, dosage and duration of therapy is required, as well as documentation of any prior drugs used for treatment of diagnosis.

Coverage Duration

This drug is covered for up to eight tablets per day for no more than 48 hours.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is not prescribed for acute nonspecific diarrhea or acute exacerbations of chronic functional diarrhea where atropine/diphenoxylate (LOMOTIL) has failed.
- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.

Age Restrictions

The patient must be at least 12 years of age.



Prior Authorization Criteria for:

**CELLCEPT or MYFORTIC (mycophenolate mofetil,
mycophenolate sodium)**

To receive prior authorization for CELLCEPT or MYFORTIC (mycophenolate mofetil, mycophenolate sodium), complete a [Pharmacy Request Form](#).

Criteria for Approval

For *Medicare Part B* coverage, the drug must be used:

- For the prophylaxis of organ rejection in patients receiving allogeneic renal, cardiac or hepatic transplants.
- Concomitantly with cyclosporine and corticosteroids.

For *Medicare Part D* coverage, the drug must be used for:

- The treatment of refractory acute kidney transplant rejection, OR
- The treatment of diffuse proliferative lupus nephritis, OR
- The adjuvant treatment of pemphigus vulgaris and pemphigus foliaceus, OR
- The treatment of myasthenia gravis

Coverage Duration

The duration of coverage for the drug is 12 months.

Covered Uses

Applies only to patients being initiated on treatment. This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.



Prior Authorization Criteria for:

SYNAREL (nafarelin)

To receive prior authorization for SYNAREL (nafarelin), complete a [Pharmacy Request Form](#).

Covered Duration

This drug is covered for endometriosis and is limited to no more than 180 days. For other FDA-approved indications, the duration of coverage is limited to the lesser of the duration requested or 12 months.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.



Prior Authorization Criteria for:

Medications Eligible for Medicare Part B and Medicare Part D

This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

To receive coverage for one of these drugs under Medicare Part D, the drug must receive prior authorization. To receive prior authorization, a [Pharmacy Request Form](#) documenting diagnosis, drug, dosage and duration of therapy is required, as well as documentation of any prior drugs used for treatment of diagnosis.

Coverage Duration

Coverage for the drug is limited to the least of the following:

- The duration of coverage requested.
- The duration of coverage approved.
- The duration of coverage permitted by law.
- 12 months.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.



Prior Authorization Criteria for:

Phosphodiesterase Inhibitors

To request prior authorization for endothelin receptor antagonists, complete a [Pharmacy Request Form](#).

Criteria for Approval

The drug must be prescribed by a cardiologist or pulmonologist.

Covered Duration

This drug is covered for 12 months.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- Patient has pulmonary venous hypertension
- Patient has pulmonary hypertension associated with disorders of the respiratory system or hypoxemia
- Patient is currently on nitrates
- Patient has pulmonary hypertension caused by thrombotic or embolic diseases
- Patient has pulmonary hypertension caused by diseases affecting the pulmonary vasculature
- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations
- The drug is already covered under Medicare Part B



Prior Authorization Criteria for:

PROMACTA (eltrombopag)

To receive prior authorization for PROMACTA (eltrombopag), complete a [Pharmacy Request Form](#).

Coverage Duration

The duration of coverage for the drug is 12 months.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.



Prior Authorization Criteria for:

RESTASIS (cyclosporine ophthalmic emulsion)

To request prior authorization for RESTASIS (cyclosporine ophthalmic emulsion), a [Pharmacy Request Form](#) documenting diagnosis, drug, dosage and duration of therapy is required, as well as documentation of any prior drugs used for treatment of diagnosis.

Criteria for Approval

The drug must:

- Be prescribed by an ophthalmologist, optometrist or rheumatologist;
- Be used to increase tear production in patients whose tear production is presumed to be suppressed due to ocular inflammation associated with keratoconjunctivitis sicca, i.e., for dry eyes; AND meet one of the following:
 - Have a positive (less than or equal to 10mm of moisture) Schirmer tear production test
 - Have a test involving fluorescein eye drops, which contain a dye that is placed in the eye
 - Have a test measuring for the molecule lactoferrin

Coverage Duration

Coverage for the drug is limited to 12 months.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.

Updated 09/2011

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Prior Authorization Criteria for:

RILUTEK (riluzole)

To request prior authorization for RILUTEK (riluzole), a [Pharmacy Request Form](#) documenting diagnosis, drug, dosage and duration of therapy is required, as well as documentation of any prior drugs used for treatment of diagnosis.

Coverage Duration

Coverage for the drug is limited to 12 months.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.



Prior Authorization Criteria for:

XYREM (sodium oxybate)

To receive prior authorization for XYREM (sodium oxybate), complete a [Pharmacy Request Form](#).

Coverage Duration

The duration of coverage for the drug is 12 months.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.



Prior Authorization Criteria for:

Specialty Pharmaceuticals

To receive prior authorization for specialty pharmaceuticals, complete a [Pharmacy Request Form](#).

Coverage Duration

The duration of coverage for the drug is 12 months.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.



Prior Authorization Criteria for:

Specialty Pharmaceuticals – CC

To receive prior authorization for specialty pharmaceuticals, complete a [Pharmacy Request Form](#).

Coverage Duration

The duration of coverage for the drug is 12 months.

Covered Uses

Applies only to patients being initiated on a specialty pharmaceutical. Covered specialty pharmaceuticals are approved for FDA-approved indications and dosing that are not otherwise excluded from Medicare Part D or are covered under Medicare Part B.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.



Prior Authorization Criteria for:

INCIVEK (telaprevir)

To receive prior authorization for INCIVEK (telaprevir), a [Pharmacy Request Form](#) documenting diagnosis, drug, dosage and duration of therapy is required, as well as documentation of any prior drugs used for treatment of diagnosis.

Coverage Duration

The duration of coverage for the drug is four weeks initially, followed by up to eight additional weeks with documentation of HCV-RNA less than or equal to 1,000 IU/mL at therapy week four.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.



Prior Authorization Criteria for:

VIMPAT (lacosamide)

To receive prior authorization for VIMPAT (lacosamide), complete a [Pharmacy Request Form](#).

Criteria for Approval

The drug must be indicated as adjunctive therapy for the treatment of partial onset seizures in patients 17 years of age and older or used for the management of diabetic neuropathic pain.

Coverage Duration

The duration of coverage for the drug is 12 months.

For treatment initiation for diabetic neuropathic pain, coverage for the drug will last for six months to assess for efficacy. After this trial, documentation of efficacy will need to be provided to receive continued approval to receive coverage of the drug until the end of the contract year.

Covered Uses

Applies to patients being initiated on treatment. This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.



Prior Authorization Criteria for:

VFEND (voriconazole)

To request prior authorization for VFEND (voriconazole), a [Pharmacy Request Form](#) documenting diagnosis, drug, dosage and duration of therapy is required, as well as documentation of any prior drugs used for treatment of diagnosis.

Criteria for Approval

Drug must be used for the:

- Treatment of invasive aspergillosis, OR
- Treatment of candidemia and disseminated *Candida* infections involving skin, abdomen, kidney or bladder wall in non-neutropenic patients **AND** failure, contraindication or intolerance to fluconazole, OR
- Empiric therapy of fungal infections in febrile neutropenic, high-risk patients (e.g., recipients of bone marrow transplants and individuals with relapsed leukemia), OR
- Treatment for fungal infection caused by *Scedosporium apiospermum* and *Fusarium* spp. in patients intolerant of, or refractory to, other therapy, OR
- Treatment of esophageal candidiasis **AND** failure, contraindication or intolerance to fluconazole, OR
- Prophylaxis of invasive aspergillosis in transplant patients.

Coverage Duration

The drug will be covered for up to 30 days of total therapy, including inpatient therapy. If the requested duration of therapy is longer than 30 days, the patient must be re-evaluated after the initial treatment period.

Covered Uses

- This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.



Prior Authorization Criteria for:

XOLAIR (omalizumab)

To receive prior authorization for XOLAIR (omalizumab), a [Pharmacy Request Form](#) documenting diagnosis, drug, dosage and duration of therapy is required, as well as documentation of any prior drugs used for treatment of diagnosis.

Criteria for Approval

- All requests for the drug require documentation of the dose requested, the patient's body weight and serum total IgE level.
- The drug must be indicated to decrease the incidence of asthma exacerbations in patients who have moderate to severe persistent asthma as prescribed by a pulmonologist.
- There must be a documented positive skin test reactivity to perennial aeroallergens.
- There must be inadequate symptom control with inhaled corticosteroids.
- The patient must be greater than 12 years of age.

Coverage Duration

The duration of coverage for the drug is 12 months.

Covered Uses

This drug is covered for all FDA-approved indications not otherwise excluded from Medicare Part D.

Contraindications

Patients with a prior history of severe hypersensitivity reaction to XOLAIR administration.

Exclusions

If any of the following apply, the drug will not be covered by Medicare Part D:

- The drug is used for indications or dosed for a quantity outside of FDA-approved recommendations.
- The drug is already covered under Medicare Part B.