Prior Authorization Requirements

Effective: 09/01/2014
PRIOR AUTHORIZATION GROUP DESCRIPTION
ABILIFY MAINTENA

DRUG NAME
ABILIFY MAINTENA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF SCHIZOPHRENIA

AGE RESTRICTIONS
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTED HISTORY OF POOR ADHERENCE TO ORAL MEDICATIONS AND DOCUMENTATION THAT PATIENT EDUCATION TO IMPROVE ADHERENCE HAS BEEN ATTEMPTED. FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ALTERNATIVES (RISPERDAL CONSTA, ZYPREXA RELPREVV, INVEGA SUSTENNA), ONE OF WHICH MUST BE RISPERDAL CONSTA.
PRIOR AUTHORIZATION GROUP DESCRIPTION

ABRAXANE

DRUG NAME
ABRAXANE

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF BREAST CANCER OR DIAGNOSIS OF LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC).

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR BREAST CANCER - DOCUMENTATION OF FAILURE OF COMBINATION CHEMOTHERAPY FOR METASTATIC DISEASE OR RELAPSE WITHIN 6 MONTHS OF ADJUVANT CHEMOTHERAPY AND DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ANTHRACYCLINE AND DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO STANDARD PACLITAXEL THERAPY. FOR NSCLC - DOCUMENTATION OF ABRAXANE USED AS FIRST-LINE TREATMENT IN COMBINATION WITH CARBOPLATIN WHO ARE NOT CANDIDATES FOR CURATIVE SURGERY OR RADIATION THERAPY.
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
ACTEMRA

DRUG NAME
ACTEMRA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF RHEUMATOID ARTHRITIS MADE IN ACCORDANCE WITH THE AMERICAN COLLEGE OF RHEUMATOLOGY CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF RHEUMATOID ARTHRITIS AND DOCUMENTATION OF THE NUMBER OF SWOLLEN OR TENDER JOINTS PRIOR TO INITIATING THERAPY WITH A MINIMUM DOCUMENTED JOINT COUNT OF GREATER THAN FOUR SWOLLEN OR TENDER JOINTS BASED ON A 28 JOINT COUNT OR GREATER THAN SIX SWOLLEN OR TENDER JOINTS BASED ON A 68-70 JOINT COUNT. DX OF JUVENILE IDIOPATHIC ARTHRITIS.

AGE RESTRICTIONS
FOR JIA - MUST BE 2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS
RHEUMATOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
FOR RA: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO HUMIRA AND ENBREL OR REMICADE. FOR JIA: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO HUMIRA AND ENBREL.
PRIOR AUTHORIZATION GROUP DESCRIPTION
ACTEMRA SUBQ

DRUG NAME
ACTEMRA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF RHEUMATOID ARTHRITIS MADE IN ACCORDANCE WITH THE AMERICAN COLLEGE OF RHEUMATOLOGY CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF RHEUMATOID ARTHRITIS AND DOCUMENTATION OF THE NUMBER OF SWOLLEN OR TENDER JOINTS PRIOR TO INITIATING THERAPY WITH A MINIMUM DOCUMENTED JOINT COUNT OF GREATER THAN FOUR SWOLLEN OR TENDER JOINTS BASED ON A 28 JOINT COUNT OR GREATER THAN SIX SWOLLEN OR TENDER JOINTS BASED ON A 68-70 JOINT COUNT.

AGE RESTRICTIONS
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS
RHEUMATOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINICATION TO A MINIMUM 3 MONTH TRIAL OF HUMIRA AND ENBREL.
PRIOR AUTHORIZATION GROUP DESCRIPTION
ACTIQ

DRUG NAME
FENTANYL CITRATE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF USE TO MANAGE BREAKTHROUGH CANCER PAIN IN PATIENTS WITH CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
CONCOMITANT MORPHINE 60 MG/DAY OR MORE, TRANSDERMAL FENTANYL 25 MCG/H, OXYCODONE 30 MG/DAY, ORAL HYDROMORPHONE 8 MG/DAY, OR AN EQUIANALGESIC DOSE OF ANOTHER OPIOID FOR 1 WEEK OR LONGER.
PRIOR AUTHORIZATION GROUP DESCRIPTION

ADEMPAS

DRUG NAME
ADEMPAS

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
WHO FUNCTIONAL CLASS II, III, OR IV SYMPTOMS AND EITHER DOCUMENTATION OF WHO GROUP 1 PULMONARY ARTERIAL HYPERTENSION OR CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH) (WHO GROUP 4) WHICH IS INOPERABLE OR PREVIOUSLY TREATED SURGICALLY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
CARDIOLOGIST OR PULMONOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION OF A BASELINE 6-MINUTE WALKING DISTANCE. FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO SILDENAFIL AND TRACLEER. 6 MONTH REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF AN IMPROVEMENT IN 6-MINUTE WALKING DISTANCE FROM BASELINE OR IMPROVED OR STABLE DIAGNOSIS OF WHO FUNCTIONAL CLASS.
Prior Authorization Requirements

Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
AFINITOR

DRUG NAME
AFINITOR | AFINITOR DISPERZ

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM
PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF RENAL CELL CARCINOMA. DX OF HORMONE-RECEPTOR POSITIVE, HER-2
NEGATIVE ADVANCED BREAST CANCER. DX OF PROGRESSIVE NEUROENDOCRINE
TUMORS OF PANCREATIC ORIGIN (PNET) THAT IS URESECTABLE, LOCALLY
ADVANCED OR METASTATIC. DX OF SUBEPENDYMAN GIANT CELL ASTROCYTOMA
(SEGA) ASSOCIATED WITH TUBEROUS SCLEROSIS (TS) WHO REQUIRE
THERAPEUTIC INTERVENTION BUT ARE NOT CANDIDATES FOR CURATIVE
SURGICAL RESECTION. DX OF RENAL ANGIOMYOLIPOMA AND TUBEROUS
SCLEROSIS COMPLEX/SPORADIC LYMPHANGIOLEIOMYMATOSIS NOT REQUIRING
IMMEDIATE SURGERY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ONCOLOGIST OR NEPHROLOGIST OR UROLOGIST

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
FOR RENAL CELL CARCINOMA: THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR
CONTRAINDICATION TO SUITEN OR NEXAVAR. FOR BREAST CANCER: FAILURE
ON, INTOLERANCE TO, OR CONTRAINDICATION TO PREVIOUS ENDOCRINE
THERAPY TREATMENT AND AFINITOR MUST BE USED IN COMBINATION WITH AN
AROMATASE INHIBITOR. FOR RENAL ANGIOMYOLIPOMA AND TUBEROUS
SCLEROSIS COMPLEX/SPORADIC LYMPHANGIOLEIOMYMATOSIS: AT LEAST ONE
Geisinger Health Plan - 14325
Prior Authorization Requirements

ANGIOMYOLIPOMA OF GREATER THAN OR EQUAL TO 3CM IN LONGEST DIAMETER ON CT/MRI BASED ON LOCAL RADIOLOGY ASSESSMENT.
PRIOR AUTHORIZATION GROUP DESCRIPTION
ALDURAZYME

DRUG NAME
ALDURAZYME

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF HURLER FORM OF MPS I OR HURLER-SCHEIE FORM OF MPS I OR SCHEIE FORM OF MPS WITH MODERATE TO SEvere SYMPTOMS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
METABOLIC SPECIALIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION

ALINIA

DRUG NAME
ALINIA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
AMPYRA

DRUG NAME
AMPYRA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF REMITTING-REPLASING MS WITH DIFFICULTY AMBULATING WITH 25 FT TIMED GAIT TEST

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
NEUROLOGIST

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
CONCOMITANT THERAPY ON BETASERON, COPAXONE, OR AVONEX WITH DEMONSTRATED IMPROVEMENT IN TIMED 25 FT GAIT TEST
DRUG NAME
BENZTROPINE MESYLATE | TRIHEXYPHENIDYL HCL

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF EXTRAPYRAMIDAL SIDE EFFECTS (EPS) OR PARKINSON'S DISEASE

AGE RESTRICTIONS
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION. DIAGNOSIS OF EPS WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AMANTADINE. DIAGNOSIS OF PARKINSON'S WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: CARBIDOPA/LEVODOPA, PRAMIPEXOLE, ROPINIROLE.
PRIOR AUTHORIZATION GROUP DESCRIPTION
APTIOM

DRUG NAME
APTIOM

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PARTIAL ONSET SEIZURES

AGE RESTRICTIONS
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS
NEUROLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOXERENCE TO, OR CONTRAINDICATION TO TWO FORMULARY
ALTERNATIVES ONE OF WHICH MUST BE OXCARBAZEPINE AND DOCUMENTATION
THAT APTIOM IS BEING USED CONCOMITANTLY WITH AT LEAST ONE OTHER
FORMULARY ANTIEPILEPTIC AGENT (INCLUDING BUT NOT LIMITED TO
CARBAMAZEPINE, CARBAMAZEPINE XR, DIVALPROEX SODIUM, DIVALPROEX
SODIUM ER, ETHOSUXIMIDE, POTIGA, FELBAMATE, GABAPENTIN, VIMPAT, LAMOTRIGINE, LAM
OTRIGINE ER, LEVETIRACETAM, LEVETIRACETAM ER, OXCARBAZEPINE, FYCOMPA, PHENOBARBITAL, PHENYTOIN, PHENYTOIN SODIUM
EXTENDED, LYRICA, PRIMIDONE, BANZEL, GABITRIL, TIAGABINE
HCL, TOPIRAMATE, VALPROIC ACID, ZONISAMIDE)
PRIOR AUTHORIZATION GROUP DESCRIPTION
ARALAST

DRUG NAME
ARALAST NP | PROLASTIN C

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF PANACINAR EMPHYSEMA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF A DECLINE IN FORCED EXPIRATORY VOLUME IN 1 SECOND (FEV1) DESPITE OPTIMAL MEDICAL THERAPY (BRONCHODILATORS, CORTICOSTEROIDS, OXYGEN IF INDICATED) AND DOCUMENTATION OF PHENOTYPE ASSOCIATED WITH CAUSING SERUM ALPHA 1-ANTITRYPsin OF LESS THAN 80 MG/DL AND DOCUMENTATION OF AN ALPHA 1-ANTITRYPSIN SERUM LEVEL BELOW THE VALUE OF 35% OF NORMAL (LESS THAN 80 MG/DL).
PRIOR AUTHORIZATION GROUP DESCRIPTION
ARANESP

DRUG NAME
ARANESP

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
FOR NON-SURGICAL INDICATIONS: HEMOGLOBIN MUST BE LESS THAN 11GM/DL FOR NEW STARTS OR LESS THAN 12GM/DL FOR CONTINUATION OF THERAPY. DOCUMENTATION OF ADEQUATE IRON STORES W/ SERUM FERRITIN GREATER THAN 100 NG/ML OR TRANSFERRIN LEVEL SATURATION GREATER THAN 20%. TX OF SYMPTOMATIC ANEMIA OF CHRONIC RENAL INSUFFICIENCY, CHRONIC RENAL FAILURE, INCLUDING ESRD. TX OF SYMPTOMATIC ANEMIA IN AZT TREATED HIV INFECTED INDIVIDUALS - MUST HAVE ENDOGENOUS ERYTHROPOIETIN LEVELS OF 500MU/ML OR LESS AND AZT DOSES OF 4200MG/WEEK OR LESS. TX OF SYMPTOMATIC ANEMIA ASSOCIATE WITH HEP C - MUST BE ON INTERFERON OR PEGYLATED INTERFERON AND RIBIVRIN. TX OF ANEMIA IN NON-HEMATOLOGIC MALIGNANCY - MUST BE ON ANEMIA CAUSING CHEMO OR RECEIVED ANEMIA INDUCING CHEMO IN LAST 3 MONTHS. TX OF SYMPTOMATIC ANEMIA SECONDARY TO MDS - BASELINE ENDOGENOUS ERYTHROPOIETIN LEVEL OF 500MU/ML OR LESS. TX OF SYMPTOMATIC ANEMIA OF CHRONIC DISEASE - SEVERE COMORBIDITY AND IMPAIRMENTS TO ADL, EXERCISE INTOLERANCE, TACHYCARDIA AND SOB WITH MINIMAL ACTIVITY. TX OF ANEMIA IN MULTIPLE MYELOMA - DOCUMENTATION OF CHEMO OR TRANSFUSION DEPENDENCE OR RENAL INSUFFICIENCY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
3 MONTHS
OTHER CRITERIA

FOR SURGICAL INDICATIONS: HEMOGLOBIN MUST BE GREATER THAN 10GM/DL BUT LESS THAN 13GM/DL. FOR ALLOGENEIC BLOOD TRANSFUSION IN ANEMIC INDIVIDUALS UNDERGOING SURGERY IN ELECTIVE NON CARDIAC, NON-VASCULAR SURGERY WHERE ANTICIPATED BLOOD LOSS IS GREATER THAN 2 UNITS AND NEED FOR TRANSFUSION IS ANTICIPATED. TREATMENT OF ANEMIC PATIENTS WHO ARE AT HIGH RISK FOR PERI-OPERATIVE BLOOD LOSS FROM ELECTIVE, NON-CARDIAC, OR NON-VASCULAR SURGERY TO REDUCE THE NEED FOR ALLOGENIC BLOOD TRANSFUSIONS. THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.
PRIOR AUTHORIZATION GROUP DESCRIPTION
ARRANON

DRUG NAME
ARRANON

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF T-CELL ACUTE LYMPHOBLASTIC LEUKEMIA (T-ALL) OR T-CELL LYMPHOBLASTIC LYMPHOMA (T-LBL) OR RELAPSED OR REFRACTORY ACUTE LYMPHOBLASTIC LEUKEMIA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR RELAPSED OR REFRACTORY LYMPHOBLASTIC LEUKEMIA - DOCUMENTATION OF FAILURE TO RESPOND TO OR RELAPSE FOLLOWING TREATMENT WITH A MINIMUM OF 2 CHEMOTHERAPY REGIMENS
PRIOR AUTHORIZATION GROUP DESCRIPTION
ARZERRA

DRUG NAME
ARZERRA

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF CHRONIC LYMPHOCYTIC LEUKEMIA (CLL)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLEANCE TO, OR CONTRAINDICATION TO CAMPATH AND FLUDARABINE OR RITUXAN
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
ASPARAGINASE

DRUG NAME
ERWINAZE

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF TREATMENT OF PATIENT WITH ACUTE LYMPHOBLASTIC LEUKEMIA (ALL) WHO HAS DEVELOPED A HYPERSENSITIVITY TO E.COLI DERIVED ASPARAGINASE (ASPARAGINASE AND PEGASPARGASE)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
AUBAGIO

DRUG NAME
AUBAGIO

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF RELAPSING FORM OF MULTIPLE SCLEROSIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
NEUROLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOxicANCE TO, OR CONTRAINDiCATION TO BETASERON AND COPAXONE
PRIOR AUTHORIZATION GROUP DESCRIPTION

AVASTIN

DRUG NAME
AVASTIN

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF METASTATIC RENAL CELL CARCINOMA WHEN USED IN COMBINATION WITH INTERFERON ALFA. DX OF GLIOBLASTOMA AS A SINGLE AGENT WHERE CANCER HAS PROGRESSED AFTER PRIOR TREATMENT. DX OF METASTATIC COLORECTAL CANCER WHEN GIVEN WITH 5-FU BASED CHEMOTHERAPY FOR FIRST OR SECOND LINE TREATMENT. DX OF METASTATIC COLORECTAL CANCER WITH FLUOROPYRIMIDINE-IRINOTECAN OR FLUOROPYRIMIDINE-OXALIPLATIN BASED CHEMOTHERAPY FOR SECOND LINE TREATMENT IN PATIENTS WHO HAVE PROGRESSED ON A FIRST LINE AVASTIN CONTAINING REGIMEN. DX OF ADVANCED NON-SQUAMOUS NON-SMALL CELL LUNG CANCER WHEN GIVEN IN COMBINATION WITH CARBOPLATIN OR PACLITAXEL AS FIRST LINE THERAPY IN UNRESECTABLE, LOCALLY ADVANCED, RECURRENT OR METASTATIC DISEASE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
BONIVA IV

DRUG NAME
BONIVA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF OSTEOPOROSIS IN POSTMENOPAUSAL WOMEN

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
INTOLERANCE TO ORAL BIPHOSPHONATES OR INABILITY TO REMAIN IN AN UPRIGHT POSITION FOR A MINIMUM OF 30-60 MINUTES AFTER INGESTION OR DISRUPTION OF THE ALIMENTARY TRACT DUE TO ANY OF THE FOLLOWING REASONS WHICH PRECLUDES THE USE OF ORAL BISPHOSPHONATES: OBSTRUCTING STRicture OR NEOPLASM OF THE ESOPHAGUS, STOMACH OR INTESTINE OR SHORT BOWEL SYNDROME SECONDARY TO EXTENSIVE SMALL BOWEL RESECTION OR MOTILITY DISORDER OR MALABSORPTION SECONDARY TO ENTEROVESICAL, ENTEROCUTANEOUS OR ENTEROCOLIC FISTULAS OR PROLONGED PARALYTIC ILEUS FOLLOWING SURGERY OR INJURY AND FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO RECLAST
PRIOR AUTHORIZATION GROUP DESCRIPTION
BOSULIF

DRUG NAME
BOSULIF

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF CHRONIC, ACCELERATED, OR BLAST PHASE PH POSITIVE CHRONIC MYELOGENOUS LEUKEMIA (CML)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OF THE FOLLOWING PRIOR THERAPIES GLEEVEC, SPRYCEL, OR TASIGNA
Prior Authorization Requirements

Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

BRINTELLIX

DRUG NAME

BRINTELLIX

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER

AGE RESTRICTIONS

MUST BE AT LEAST 18 YEARS OF AGE

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST TWO ANTIDEPRESSANT CLASSES.
PRIOR AUTHORIZATION GROUP DESCRIPTION
BUPROPION 24 HR

DRUG NAME
APLENZIN

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER OR SEASONAL AFFECTIVE DISORDER.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLEANCE TO, OR CONTRAINDICATION TO BUPROPION XL.
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
BUTRANS

DRUG NAME
BUTRANS

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF MODERATE TO SEVERE CHRONIC PAIN REQUIRING A CONTINUOUS, AROUND-THE-CLOCK OPIOID ANALGESIC FOR AN EXTENDED PERIOD OF TIME.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY OPIOIDS, ONE OF WHICH MUST BE MORPHINE SULFATE ER.
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

BVD ONLY

DRUG NAME

ABELCET | ACYCLOVIR SODIUM | ALBUTEROL SULFATE | AMBISOME | AMINOSYN II
| AMINOSYN M | AMINOSYN-HBC | AMINOSYN-PF | AMPHOTERICIN B | ANZEMET |
| ASTAGRAF XL | AZASAN | AZATHIOPRINE | BCG VACCINE (TICE STRAIN) | BETHKIS |
| BLEOMYCIN SULFATE | CELLCEPT | CLADRIBINE | CLINISOL | CROMOLYN SODIUM |
| CYCLOSPORINE | CYCLOSPORINE MODIFIED | CYTARABINE | DEXTROSE IN WATER |
| DOXIL | ENGERIX-B ADULT | ENGERIX-B PEDIATRIC-ADOLESCENT | FLUOROURACIL |
| FOSCARNET SODIUM | GANCICLOVIR SODIUM | GENGRAF | GRANISETRON HCL |
| GRANISOL | HAVRIX | HERCEPTIN | IFOSFAMIDE | IMOVAX RABIES VACCINE |
| INTRALIPID | IPRATROPIUM-ALBUTEROL | KEPIVANCE | LIPOSYN III |
| METHOTREXATE | MITOMYCIN | MYCOPHENOLATE MOFETIL | MYFORTIC |
| NEBUPENT | ONDANSETRON HCL | ONDANSETRON ODT | PREMASOL | PROGRAF |
| PROSOC | PULMOZYME | RABAVER | RAMAPUR | RECOMBIVAX HB | SIMULECT |
| SIROLIMUS | TACROLIMUS | TETANUS TOXOID ADSORBED | TOBI | TRAVASOL |
| TROPHAMINE | VAQTA | VINBLASTINE SULFATE | VINCRISSERT SULFATE

COVERED USES

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.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
CEREZYME

DRUG NAME
CEREZYME

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF TYPE 1 GAUCHER DISEASE ALONG WITH AT LEAST ONE OF THE FOLLOWING CONDITIONS: ANEMIA, THROMBOCYTOPENIA, BONE DISEASE, HEPATOMEGALY OR SPLENOMEGALY

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
METABOLIC SPECIALIST WITH EXPERIENCE TREATING GAUCHER DISEASE

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ELELYSO
PRIOR AUTHORIZATION GROUP DESCRIPTION
CIMZIA

DRUG NAME
CIMZIA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF CHROHN'S DISEASE OR RHEUMATOID ARTHRITIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ENBREL AND HUMIRA FOR RA OR HUMIRA FOR CROHN'S DISEASE. FOR CONTINUED THERAPY, MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.
Prior Authorization Requirements

Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
CINRYZE

DRUG NAME
CINRYZE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF HEREDITARY ANGIOEDEMA WITH DOCUMENTATION OF RECURRENT, SELF-LIMITING NON-INFLAMMATORY SUBCUTANEOUS ANGIOEDEMA WITHOUT URTICARIA LASTING MORE THAN 12 HOURS OR LARNGEAL EDEMA OR RECURRENT SELF-REMITTING ABDOMINAL PAIN LASTING MORE THAN 6 HOURS WITHOUT CLEAR ORGANIC ETIOLOGY AND THE PRESENCE OF SPECIFIC ABNORMALITIES IN COMPLEMENT PROTEINS IN THE SETTING OF A SUGGESTIVE CLINICAL HISTORY OF EPISODIC ANGIOEDEMA WITHOUT URTICARIA.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ALLERGIST, IMMUNOLOGIST, HEMATOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

MEDICATION IS USED AS PROPHYLACTIC THERAPY AND FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO DANAZOL AND HISTORY OF MORE THAN ONE SEVERE EVENT PER MONTH
PRIOR AUTHORIZATION GROUP DESCRIPTION
CLOLAR

DRUG NAME
CLOLAR

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF RELAPSED OR REFRACTORY ACUTE LYMPHOBLASTIC LEUKEMIA

AGE RESTRICTIONS
1 TO 21 YEARS OF AGE

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOXERANCE TO, OR CONTRAINICATION TO TWO PRIOR TREATMENT REGIMENS
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
CLOMIPRAMINE HRM

DRUG NAME
CLOMIPRAMINE HCL

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION AND WILL FAILURE ON, INTOXERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: FLUOXETINE, FLUVOXAMINE, SERTRALINE, PAROXETINE
PRIOR AUTHORIZATION GROUP DESCRIPTION
COMETRIQ

DRUG NAME
COMETRIQ

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PROGRESSIVE METASTATIC MEDULLARY THYROID CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ONCOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
CORTICOSTEROID B VERSUS D DETERMINATION

DRUG NAME
A-HYDROCORT | CORTISONE ACETATE | DEXAMETHASONE | DEXAMETHASONE SODIUM PHOSPHATE | HYDROCORTISONE | KENALOG-10 | KENALOG-40 | METHYLPR EDNISOLONE | METHYLPR EDNISOLONE ACETATE | METHYLPR EDNISOLONE SOD SUCC | PREDNISOLONE SODIUM PHOSPHATE | PREDNISONE | SOLU-MEDROL | TRIAMCINOLONE ACETONIDE | VERIPRED 20

COVERED USES
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.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
CRIZOTINIB

DRUG NAME
XALKORI

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) THAT IS ANAPLASTIC LYMPHOMA KINASE (ALK) POSITIVE AS DETECTED BY AN FDA APPROVED TEST

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
THE FDA APPROVED TEST TO MAKE ALK POSITIVE DETERMINATION IS THE VYSIS ALK BREAK-APART FISH PROBE KIT
Prior Authorization Requirements
Effective Date: 09/01/2014

Prior Authorization Group Description
Cycloset

Drug Name
Cycloset

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Required Medical Information
Diagnosis of Type 2 Diabetes Mellitus.

Age Restrictions

Prescriber Restrictions

Coverage Duration
Remainder of contract year

Other Criteria
Documentation of failure on, intolerance to, or contraindication to two oral formulary alternatives.
PRIOR AUTHORIZATION GROUP DESCRIPTION
CYPROHEPTADINE HRM

DRUG NAME
CYPROHEPTADINE HCL

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION. DIAGNOSIS OF ALLERGIC CONDITIONS (PRURITUS, URTICARIA, SEASONAL OR PERENNIAL ALLERGIES) WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO DESLORATADINE AND LEVOCETIRIZINE. USE FOR PROPHYLACTIC THERAPY FOR MIGRAINES WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OTHER FORMULARY MIGRAINE PROPHYLACTIC AGENTS (FORMULARY BETA BLOCKER, TOPIRAMATE, DIVALPROEX, SODIUM VALPROATE, VENLAFAXINE, OR NORTRIPTYLINE).
PRIOR AUTHORIZATION GROUP DESCRIPTION
DACOGEN

DRUG NAME
DACOGEN

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF MYELODYSPLASTIC SYNDROME (MDS) INCLUDING PREVIOUSLY TREATED AND UNTREATED, DE NOVO AND SECONDARY MDS OF ALL FRENCH-AMERICAN-BRITISH SUBTYPES (REFRACTORY ANEMIA, REFRACTORY ANEMIA WITH RINGED SIDEROBLASTS, REFRACTORY ANEMIA WITH EXCESS BLASTS, REFRACTORY ANEMIA WITH EXCESS BLASTS IN TRANSFORMATION, AND CHRONIC MYELOMONOCYTIC LEUKEMIA) AND INTERMEDIATE-1, INTERMEDIATE-2, AND HIGH RISK INTERNATIONAL PROGNOSTIC SCORING SYSTEM GROUPS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO VIDAZA
PRIOR AUTHORIZATION GROUP DESCRIPTION
DALIRESP

DRUG NAME
DALIRESP

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF COPD ASSOCIATED WITH CHRONIC BRONCHITIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
CONCOMITANT USE OF, FAILURE ON, INTOXERANCE TO, OR CONTRAINDICATION TO SPIRIVA AND ONE LONG ACTING BETA AGONISTS.
PRIOR AUTHORIZATION GROUP DESCRIPTION
DUAVEE

DRUG NAME
DUAVEE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF AN INTACT UTERUS. DOCUMENTATION OF USE FOR ABNORMAL VASOMOTOR FUNCTION OR PREVENTION OF POSTMENOPAUSAL OSTEOPOROSIS

AGE RESTRICTIONS
AGE LESS THAN 75 YEARS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR ABNORMAL VASOMOTOR FUNCTION: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO FEMRING. FOR PREVENTION OF POSTMENOPAUSAL OSTEOPOROSIS: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: ALENDRONATE, IBANDRONATE, RALOXIFENE, RISEDRONATE.
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
ELAPRASE

DRUG NAME
ELAPRASE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF HUNTER'S SYNDROME (MPS II)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
METABOLIC SPECIALIST WITH EXPERIENCE TREATING MPS II

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION

ELELYSO

DRUG NAME
ELELYSO

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF TYPE 1 GAUCHER DISEASE WITH AT LEAST ONE OF THE FOLLOWING - ANEMIA, THROMBOCYTOPENIA, BONE DISEASE, HEPATOMEGALY OR SPLENOMEGALY

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
METABOLIC SPECIALIST WITH EXPERIENCE TREATING GAUCHER DISEASE

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
ELIDEL

DRUG NAME
ELIDEL

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF ATOPIC DERMATITIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
DERMATOLOGIST OR ALLERGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO AT LEAST 2 FORMULARY TOPICAL CORTICOSTEROIDS UNLESS INADVISABLE DUE TO RISKS (SUCH AS USE ON SENSITIVE SKIN AREAS (FACE, AXILLAE, GROIN))
PRIOR AUTHORIZATION GROUP DESCRIPTION
ELITEK

DRUG NAME
ELITEK

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF HYPERURICEMIA IN PATIENTS WITH LEUKEMIA, LYMPHOMA, AND SOLID TUMOR MALIGNANCIES

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
1 COURSE OF THERAPY (5 DAYS)

OTHER CRITERIA
DOCUMENTATION OF A HIGH RISK OF TUMOR LYISIS SYNDROME CHARACTERIZED BY ELEVATED SERUM CREATININE OR LEUKEMIAS WITH VERY HIGH WHITE BLOOD CELL COUNTS OF GREATER THAN OR EQUAL TO 25,000 / MM(3) OR BURKETTE'S LYMPHOMA OR T-CELL NON-HODGKIN'S LYMPHOMA OR SERUM URIC ACID LEVEL GREATER THAN OR EQUAL TO 8 MG/DL AND FAILURE ON, INTOXERANCE TO, OR CONTRAINDICATION TO ORAL OR INJECTABLE ALLOPURINOL
PRIOR AUTHORIZATION GROUP DESCRIPTION
ELOXATIN

DRUG NAME
ELOXATIN

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
IN COMBO WITH 5FU & LEUCOVORIN FOR INITIAL TX OF ADVANCED COLORECTAL CANCER OR ADJUVANT TX OF STAGE III COLON CANCER FOR PATIENTS WHO HAVE UNDERGONE COMPLETE RESECTION OF THE PRIMARY TUMOR. PANCREATIC CANCER:2ND LINE THERAPY IN COMBO WITH CAPECITABINE OR 5FU. OVARIAN CANCER:AS TX FOR RECURRENCE IN PATIENTS WITH STAGE II, III OR IV EPITHELIAL OVARIAN CANCER WHO EXPERIENCED PARTIAL RESPONSES TO THEIR PRIMARY PACLITAXEL & PLATINUM-BASED CHEMO REGIMENS. ADVANCED GASTRIC CANCER. HEPATOBILIARY CANCER. RECTAL CANCER. ESOPHAGEAL CANCER. NON-HODGKINS LYMPHOMA- DIFFUSE LARGE B-CELL LYMPHOMA:AS 2ND LINE THERAPY FOR RELAPSED OR REFRACTORY DISEASE- FOLLICULAR LYMPHOMA & NODAL MARGINAL ZONE LYMPHOMA-2ND LINE THERAPY FOR REFRACTORY OR PROGRESSIVE DISEASE-GASTRIC MALT LYMPHOMA: 2ND LINE THERAPY FOR RECURRENT OR PROGRESSIVE DISEASE-MANTLE CELL LYMPHOMA:2ND LINE CHEMO FOR RELAPSED, REFRACTORY, OR PROGRESSIVE DISEASE-NON-GASTRIC MALT LYMPHOMA:2ND LINE THERAPY FOR RECURRENT (STAGE IE-II) OR PROGRESSIVE DISEASE-SPLENIC MARGINAL ZONE LYMPHOMA:2ND LINE CHEMO FOR PROGRESSIVE DISEASE. OVARIAN CANCER, EPITHELIAL OVARIAN CANCER:RECURRENT THERAPY AS A SINGLE AGENT. TESTICULAR CANCER.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST
Geisinger Health Plan - 14325
Prior Authorization Requirements

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DRUG NAME
EMEND

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
ORAL CHEMOTHERAPY REGIMEN WITH MODERATE TO HIGH EMETOGENIC POTENTIAL OR INDICATION OF POSTOPERATIVE NAUSEA/VOMITING.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST, ONCOLOGIST, SURGEON

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
MUST BE USED IN COMBINATION WITH OTHER ORAL ANTIEMETIC AGENTS WHEN USED FOR THE PREVENTION OF CHEMOTHERAPY INDUCED NAUSEA
PRIOR AUTHORIZATION GROUP DESCRIPTION

ENBREL

DRUG NAME
ENBREL

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

ADULT RA - DIAGNOSIS OF MODERATE TO SEVERE RA AND A TRIAL OF MTX OR OTHER DMARD IF MTX NOT TOLERATED OR CONTRAINDICATED. JIA - DIAGNOSIS OF JIA, A TRIAL OF NSAID AND MTX THERAPY OR OTHER DMARD IF MTX IS CONTRAINDICATED. PSORIATIC ARTHRITIS - DIAGNOSIS OF MODERATE TO SEVERE PSA AND ACTIVE PSORIATIC LESIONS OR HISTORY OF PSORIASIS AND INTOXERANCE OR FAILURE ON MTX OR SULFASALAZINE - IF THESE ARE CONTRAINDICATED THERAPY WITH AN ALTERNATIVE DMARD REQUIRED. ANKYLOSING SPONDYLITIS - DIAGNOSIS OF AS, AND FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO 2 NSAIDS. PLAQUE PSORIASIS - DIAGNOSIS OF MODERATE TO SEVERE PLAQUE PSORIASIS WITH AT LEAST 5% BSA OR AFFECTING CRUCIAL BODY AREAS SUCH AS HANDS, FEET, FACE OR GENITALS AND FAILURE ON, INTOLERANCE TO OR CONTRAINDICATION TO ONE FORMULARY TOPICAL CORTICOSTEROIDS AND AT LEAST 2 TO 3 MONTHS OF ONE FORMULARY SYSTEMIC THERAPY INCLUDING BUT NOT LIMITED TO MTX OR CYCLOSPORINE OR PHOTOTHERAPY

AGE RESTRICTIONS
MUST BE AT LEAST 18 YEARS OF AGE UNLESS TREATING JIA, THEN PATIENT MUST BE AT LEAST 2 YEARS OF AGE.

PRESCRIBER RESTRICTIONS
RHEUMATOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION

EPOGEN

DRUG NAME

EPOGEN

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

FOR NON-SURGICAL INDICATIONS: HEMOGLOBIN MUST BE LESS THAN 11GM/DL FOR NEW STARTS OR LESS THAN 12GM/DL FOR CONTINUATION OF THERAPY. DOCUMENTATION OF ADEQUATE IRON STORES W/ SERUM FERRITIN GREATER THAN 100 NG/ML OR TRANSFERRIN LEVEL SATURATION GREATER THAN 20%. TX OF SYMPTOMATIC ANEMIA OF CHRONIC RENAL INSUFFICIENCY, CHRONIC RENAL FAILURE, INCLUDING ESRD. TX OF SYMPTOMATIC ANEMIA IN AZT TREATED HIV INFECTED INDIVIDUALS - MUST HAVE ENDOGENOUS ERYTHROPOIETIN LEVELS OF 500MU/ML OR LESS AND AZT DOSES OF 4200MG/WEEK OR LESS. TX OF SYMPTOMATIC ANEMIA ASSOCIATE WITH HEP C - MUST BE ON INTERFERON OR PEGYLATED INTERFERON AND RIBIVRIN. TX OF ANEMIA IN NON-HEMATOLOGIC MALIGNANCY - MUST BE ON ANEMIA CAUSING CHEMO OR RECEIVED ANEMIA INDUCING CHEMO IN LAST 3 MONTHS. TX OF SYMPTOMATIC ANEMIA SECONDARY TO MDS - BASELINE ENDOGENOUS ERYTHROPOIETIN LEVEL OF 500MU/ML OR LESS. TX OF SYMPTOMATIC ANEMIA OF CHRONIC DISEASE - SEVERE COMORBIDITY AND IMPAIRMENTS TO ADL, EXERCISE INTOLERANCE, TACHYCARDIA AND SOB WITH MINIMAL ACTIVITY. TX OF ANEMIA IN MULTIPLE MYELOMA - DOCUMENTATION OF CHEMO OR TRANSFUSION DEPENDENCE OR RENAL INSUFFICIENCY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

3 MONTHS
OTHER CRITERIA

FOR SURGICAL INDICATIONS: HEMOGLOBIN MUST BE GREATER THAN 10GM/DL BUT LESS THAN 13GM/DL. FOR ALLOGENEIC BLOOD TRANSFUSION IN ANEMIC INDIVIDUALS UNDERGOING SURGERY IN ELECTIVE NON CARDIAC, NON-VASCULAR SURGERY WHERE ANTICIPATED BLOOD LOSS IS GREATER THAN 2 UNITS AND NEED FOR TRANSFUSION IS ANTICIPATED. TREATMENT OF ANEMIC PATIENTS WHO ARE AT HIGH RISK FOR PERI-OPERATIVE BLOOD LOSS FROM ELECTIVE, NON-CARDIAC, OR NON-VASCULAR SURGERY TO REDUCE THE NEED FOR ALLOGENIC BLOOD TRANSFUSIONS. THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.
PRIOR AUTHORIZATION GROUP DESCRIPTION
ERAXIS

DRUG NAME
ERAXIS (WATER DILUENT)

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
NON-NEUTROPENIC PATIENT WITH DX OF CANDIDEMIA OR OTHER CANDIDA INFECTION (OTHER THAN ENDOCARDITIS, OSTEOMYELITIS OR MENINGITIS).

AGE RESTRICTIONS
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS
INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION
8 WEEKS (TWO COURSES OF THERAPY)

OTHER CRITERIA
FOR A DIAGNOSIS OF ESOPHAGEAL CANDIDIASIS - FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO FLUCONAZOLE THERAPY
PRIOR AUTHORIZATION GROUP DESCRIPTION

ERBITUX

DRUG NAME
ERBITUX

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF COLORECTAL CANCER WITH DOCUMENTATION OF KRAS MUTATION NEGATIVE (WILD-TYPE), EGFR EXPRESSING, METASTATIC COLORECTAL CANCER AS DETERMINED BY FDA APPROVED TESTS AND DOCUMENTATION OF ONE OF THE FOLLOWING: USED IN COMBO WITH FOLFIRI FOR FIRST LINE TREATMENT OR MONOTHERAPY FOR EGFR-EXPRESSING METASTATIC COLORECTAL CANCER AFTER FAILURE OF BOTH IRINOTECAN AND OXALIPLATIN BASED REGIMENS OR AS AN ADJUNT IN COMBO WITH IRINOTECAN IN IRINOTECAN REFRACTORY EGFR-EXPRESSING METASTATIC COLORECTAL CANCER. DX OF HEAD AND NECK CANCER AND DOCUMENTATIO OF ONE OF THE FOLLOWING: IN COMBO WITH RADIATION THERAPY FOR FIRST LINE TREATMENT OF LOCALLY OR REGIONALLY ADVANCED SQUAMOUS CELL CARCINOMA OF THE HEAD AND NECK (SCCHN) OR IN COMBO WITH PLATINUM-BASED THERAPY WITH 5-FU FOR THE TREATMENT OF PATIENTS WITH RECURRENT LOCOREGIONAL DISEASE OR METASTATIC SQUAMOUS CELL CARCINOMA OF THE HEAD AND NECK OR AS A SINGLE AGENT IN RECURRENT OR METASTATIC SCCHN WHERE PRIOR PLATINUM-BASED CHEMO HAS FAILED.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
ERIVEDGE

DRUG NAME
ERIVEDGE

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF METASTATIC BASAL CELL CARCINOMA OR LOCALLY ADVANCED BASAL CELL CARCINOMA THAT HAS RECURRED FOLLOWING MOHS SURGERY

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ONCOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
NOT A CANDIDATE FOR SURGERY AND RADIATION. PER NCCN GUIDELINES, TREATMENT SUPPORTED BY MULTIDISCIPLINARY BOARD CONSULTATION OR A SECOND DERMATOLOGIST OR ONCOLOGIST.
PRIOR AUTHORIZATION GROUP DESCRIPTION

ESRD B VERSUS D DETERMINATION

DRUG NAME

CALCITRIOL | CUBICIN | DOXERCALCIFEROL | HECTOROL | HEPARIN SODIUM | LEVOCARNITINE | LIDOCAINE | LIDOCAINE HCL | LIDOCAINE-PRilocaine | Miacalcin | Pamidronate Disodium | Paricalcitol | Vancomycin HCL | Zemplar

COVERED USES

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.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION

ESTROGENS HRM (ORAL AND TOPICAL PATCH PRODUCTS ONLY)

DRUG NAME
CENESTIN | ESTRADIOL | ESTRADIOL-NORETHINDRONE ACETAT | ESTROPIPATE | JINTELI | MENEST | MIMVEY LO | PREMARIN | PREMPHASE | PREMPRO | VIVELLE-DOT

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION. DX OF ABNORMAL VASOMOTOR FUNCTION WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO FEMRING. DX OF VAGINAL/VULVAR ATROPHY WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OF THE FOLLOWING: ESTRACE VAGINAL CREAM, PREMARIN VAGINAL CREAM, ESTRING, VAGIFEM. DX OF POSTMENOPAUSAL OSTEOPOROSIS WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: ALENDRONATE, IBANDRONATE, RALOXIFENE. ESTROGENS FOR USE IN CANCER, PALLIATIVE CARE, OR HYPOESTROGENISM DUE TO HYPOGONADISM, CASTRATION OR PRIMARY OVARIAN FAILURE WILL BE APPROVED.
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
EXJADE

DRUG NAME
EXJADE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CHRONIC IRON OVERLOAD CAUSED BY TRANSFUSION DEPENDENT THALASSEMIA OR CHRONIC IRON OVERLOAD CAUSED BY NON-TRANSFUSION DEPENDENT THALASSEMIA

AGE RESTRICTIONS
FOR TRANSFUSION DEPENDENT THALASSEMIA: MUST BE TWO YEARS OF AGE OR OLDER. FOR NON-TRANSFUSION DEPENDENT THALASSEMIA: MUST BE 10 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
FOR TRANSFUSION DEPENDENT THALASSEMIA: DOCUMENTATION OF A SERUM FERRITIN LEVEL GREATER THAN 1000 MCG/L. CONTINUATION OF COVERAGE REQUIRES DOCUMENTATION OF A DECREASED SERUM FERRITIN FROM BASELINE. FOR NON-TRANSFUSION DEPENDENT THALASSEMIA: DOCUMENTATION OF LIC (LIVER IRON CONCENTRATION) OF GREATER THAN 5 MILLIGRAMS OF IRON PER GRAM OF DRY LIVER TISSUE WEIGHT (FE/G DW) AND SERRUM FERRITIN GREATER THAN 300 MCG/L. CONTINUATION OF COVERAGE REQUIRES DOCUMENTATION OF A DECREASED LIC FROM BASELINE AND A SERRUM FERRITIN LEVEL LESS THAN 300 MCG/L.
PRIOR AUTHORIZATION GROUP DESCRIPTION
FABRAZYME

DRUG NAME
FABRAZYME

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF FABRY DISEASE

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
METABOLIC SPECIALIST WITH EXPERIENCE TREATING FABRY DISEASE

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
FERRIPROX

DRUG NAME
FERRIPROX

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF TRANSFUSIONAL IRON OVERLOAD DUE TO THALASSEMIA SYNDROME

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO EXJADE. DOCUMENTATION OF ANC GREATER THAN 1.5 X 1000000000 (10 TO THE 9TH POWER) / L
PRIOR AUTHORIZATION GROUP DESCRIPTION
FETZIMA

DRUG NAME
FETZIMA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER

AGE RESTRICTIONS
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST TWO ANTIDEPRESSANT CLASSES.
PRIOR AUTHORIZATION GROUP DESCRIPTION

FIRAZYR

DRUG NAME

FIRAZYR

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF HEREDITARY ANGIOEDEMA SUPPORTED BY PHYSICIAN DOCUMENTATION OF RECURRENT, SELF-LIMITING NON-INFLAMMATORY SUBCUTANEOUS ANGIOEDEMA WITHOUT URTICARIA LASTING MORE THAN 12 HRS OR LARYNGEAL EDEMA OR RECURRENT, SELF-REMITTING ABDOMINAL PAIN LASTING MORE THAN 6 HRS WITHOUT CLEAR ORGANIC ETIOLOGY AND THE PRESENCE OF SPECIFIC ABNORMALITIES IN COMPLEMENT PROTEINS IN THE SETTING OF A SUGGESTIVE CLINICAL HISTORY OF EPISODIC ANGIOEDEMA WITHOUT URTICARIA.

AGE RESTRICTIONS

MUST BE AT LEAST 18 YEARS OF AGE

PRESCRIBER RESTRICTIONS

ALLERGIST, IMMUNOLOGIST, HEMATOLOGIST, OR DERMATOLOGIST

COVERAGE DURATION

6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA

DOCUMENTATION THAT FIRAZYR IS BEING USED AS A TREATMENT OF ACUTE HEREDITARY ANGIOEDEMA ATTACK. DOCUMENTATION OF CONCURRENT OR FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO PROPHYLACTIC THERAPY (ANDROGENS OR TRANEXAMIC ACID).
PRIOR AUTHORIZATION GROUP DESCRIPTION
FORTEO

DRUG NAME
FORTEO

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
PREVIOUS FRACTURE OR T SCORE (-1.5 FOR WOMEN, LESS THAN -2 FOR MEN) OR BELOW

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ENDOCRINOLOGIST OR RHEUMATOLOGIST

COVERAGE DURATION
24 MONTHS

OTHER CRITERIA
ATTEMPT OF THERAPY WITH OR CONTRAINDICATION TO BISPHOSPHONATE
DRUG NAME
FYCOMPA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PARTIAL ONSET SEIZURES

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ALTERNATIVES AND DOCUMENTATION THAT FYCOMPA IS BEING USED CONCOMITANTLY WITH AT LEAST ONE OTHER FORMULARY ANTICONVULSANT AGENT
PRIOR AUTHORIZATION GROUP DESCRIPTION
GATTEX

DRUG NAME
GATTEX

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF SHORT BOWEL SYNDROME

AGE RESTRICTIONS
MUST BE AT LEAST 18 YEARS OF AGE

PRESCRIBER RESTRICTIONS
GASTROENTEROLOGIST

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
DOCUMENTATION THAT THE MEMBER HAS BEEN DEPENDENT ON PARENTERAL NUTRITION/INTRAVENTOUS SUPPORT FOR A MINIMUM OF 12 CONSECUTIVE MONTHS CONTINUOUSLY AND THAT THE MEMBER REQUIRES PARENTERAL NUTRITION AT LEAST 3 TIMES PER WEEK.
PRIOR AUTHORIZATION GROUP DESCRIPTION

GILOTRIF

DRUG NAME
GILOTRIF

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF FIRST OR SECOND LINE TREATMENT FOR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH EGFR EXON 19 DELETIONS OR EXON 21 (L858R) SUBSTITUTION MUTATIONS AS DETECTED BY AN FDA APPROVED TEST

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
GRANIX

DRUG NAME
GRANIX

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
PREVENTION OF FEBRILE NEUTROPENIA WHEN RISK DUE TO MYELOSUPPRESSIVE CHEMO REGIMEN IS 20% OR GREATER. TO PREVENT FEBRILE NEUTROPENIA WHEN THE RISK OF DEVELOPING FEBRILE NEUTROPENIA IS LESS THAN 20% WITH THE FOLLOWING RISK FACTORS: 65 YRS OR OLDER, POOR PERFORMANCE STATUS, PREVIOUS HISTORY OF FEBRILE NEUTROPENIA, EXTENSIVE PRIOR RADIATION OF CHEMO TREATMENT, POOR NUTRITIONAL STATUS, OPEN WOUNDS OR ACTIVE INFECTION, ADVANCED CANCER.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
GROWTH HORMONE

DRUG NAME
GENOTROPIN | NORDITROPIN FLEXPRO | NORDITROPIN NORDIFLEX | NUTROPIN | NUTROPIN AQ | NUTROPIN AQ NUSPIN | OMNITROPE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
GROWTH HORMONE STIMULATION TESTS, IGF-I LEVELS, GROWTH VELOCITY CURVES

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ENDOCRINOLOGIST OR NEPHROLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
HALAVEN

DRUG NAME
HALAVEN

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF METASTATIC BREAST CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST 2 PRIOR CHEMOTHERAPEUTIC AGENTS. PRIOR THERAPY SHOULD HAVE INCLUDED AN ANTHRACYCLINE AND A TAXANE IN THE ADJUVANT OR METASTATIC SETTING
PRIOR AUTHORIZATION GROUP DESCRIPTION
HUMIRA

DRUG NAME
HUMIRA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
ADULT RA - DIAGNOSIS OF MODERATE TO SEVERE RA AND TRIAL OF MTX OR OTHER DMARD IF MTX NOT TOLERATED OR CONTRAINDICATED. JIA - DIAGNOSIS OF MODERATE TO SEVERE JIA AND A TRIAL OF ONE NSAID AND MTX THERAPY OR OTHER DMARD IF MTX IS CONTRAINDICATED. PSORIATIC ARTHRITIS - DIAGNOSIS OF MODERATE TO SEVERE PSA WITH ACTIVE PSORIATIC LESIONS OR HISTORY OF PSORIASIS AND INTOLEANCE OR FAILURE ON MTX OR SULFASALAZINE - IF THESE ARE CONTRAINDICATED THERAPY WITH AN ALTERNATIVE DMARD REQUIRED. PLAQUE PSORIASIS - A DIAGNOSIS OF MODERATE TO SEVERE PLAQUE PSORIASIS WITH AT LEAST 5% BSA OR AFFECTING CRUCIAL BODY AREAS SUCH AS HANDS, FEET, FACE OR GENITALS AND FAILURE ON, INTOLEANCE TO OR CONTRAINDICATION TO ONE FORMULARY TOPICAL CORTICOSTEROIDS AND AT LEAST 2 TO 3 MONTHS OF ONE FORMULARY SYSTEMIC THERAPY INCLUDING BUT NOT LIMITED TO MTX OR CYCLOSPORINE OR PHOTOTHERAPY. CROHN'S - A DIAGNOSIS OF CROHNS WITH FAILURE ON, INTOLEANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING (AMINOSALICYLATES, CORTICOSTEROIDS AND IMMUNOMODULATORS).

AGE RESTRICTIONS
MUST BE AT LEAST 18 YEARS OF AGE FOR THE FOLLOWING DIAGNOSES PSORIASIS, PSA, RA, AND CROHN'S. MUST BE AT LEAST 4 YEARS OF AGE FOR JIA

PRESCRIBER RESTRICTIONS
RHEUMATOLOGIST, GASTROENTEROLOGIST, DERMATOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION
OTHER CRITERIA

IN ORDER TO RECEIVE WEEKLY DOSING OF HUMIRA, MUST SHOW DOCUMENTATION OF THERAPEUTIC FAILURE ON EVERY OTHER WEEK DOSING SCHEDULE.
PRIOR AUTHORIZATION GROUP DESCRIPTION
HYDROXYZINE HRM

DRUG NAME
HYDROXYZINE HCL | HYDROXYZINE PAMOATE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION. DIAGNOSIS OF PRURITUS WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO DESLORATADINE AND LEVOCETIRIZINE. DIAGNOSIS OF ANXIETY WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: BUSPIRONE, FORMULARY SSRI, FORMULARY SNRI - FAILURES MUST BE FROM DIFFERENT CLASSES. DIAGNOSIS OF SEDATION INCLUDING PRODUCTION OF LIGHT SLEEP WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ROZEREM AND SILENOR.
PRIOR AUTHORIZATION GROUP DESCRIPTION
IMBRUVICA

DRUG NAME
IMBRUVICA

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MANTLE CELL LYMPHOMA (MCL)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLEANCE TO, OR CONTRAINDICATION TO ONE PRIOR THERAPY INCLUDING BUT NOT LIMITED TO HYPERCVAD, NORDIC REGIMEN, CALGB REGIMEN, RCHOP/RICE, RCHOP/RDHAP, BENDAMUSTINE PLUS RITUXIMAB, CHOP PLUS RITUXIMAB, CLADRIBINE PLUS RITUXIMAB, CVP PLUS RITUXIMAB, EPOCH PLUS RITUXIMAB.
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
INCIVEK

DRUG NAME
INCIVEK

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF GENOTYPE 1 CHRONIC HEPATITIS C

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 WEEK COURSE OF THERAPY PER LIFETIME

OTHER CRITERIA
MUST BE USED CONCURRENTLY WITH PEGINTERFERON ALFA AND RIBAVIRIN
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
INLYTA

DRUG NAME
INLYTA

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF ADVANCED RENAL CELL CARCINOMA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
FAILURE ON ONE PRIOR SYSTEMIC THERAPY
PRIOR AUTHORIZATION GROUP DESCRIPTION
INTUNIV

DRUG NAME
INTUNIV

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

AGE RESTRICTIONS
MUST BE BETWEEN 6 TO 17 YEARS OF AGE.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY STIMULANTS
PRIOR AUTHORIZATION GROUP DESCRIPTION
INVEGA SUSTENNA

DRUG NAME
INVEGA SUSTENNA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF SCHIZOPHRENIA

AGE RESTRICTIONS
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTED HISTORY OF POOR ADHERENCE TO ORAL MEDICATIONS AND DOCUMENTATION THAT PATIENT EDUCATION TO IMPROVE ADHERENCE HAS BEEN ATTEMPTED. FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO RISPERDAL CONSTA AND ZYPREXA RELPREVV.
PRIOR AUTHORIZATION GROUP DESCRIPTION

INVOKANA

DRUG NAME

INVOKANA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF TYPE II DIABETES MELLITUS

AGE RESTRICTIONS

MUST BE AT LEAST 18 YEARS OF AGE

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

DOCUMENTATION OF ESTIMATED GLOMERULAR FILTRATION RATE (EGFR) GREATER THAN OR EQUAL TO 45 ML/MIN. FAILURE ON, INtolerance TO, OR CONTRAINDICATION TO 2 OTHER FORMULARY ANTIDIABETIC MEDICATIONS, ONE OF WHICH MUST BE METFORMIN.
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
ISTODAX

DRUG NAME
ISTODAX

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF CUTANEOUS OR PERIPHERAL T-CELL LYMPHOMA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF DISEASE PROGRESSION WHILE ON AT LEAST ONE PRIOR SYSTEMIC THERAPY INCLUDING BUT NOT LIMITED TO CHOP REGIMENS, CHOEP, ICE, IVE, EPOCH, HYPERCVAD.
PRIOR AUTHORIZATION GROUP DESCRIPTION
ITRACONAZOLE

DRUG NAME
ITRACONAZOLE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
POSITIVE CULTURE SUBSTANTIATING DIAGNOSIS

AGE RESTRICTIONS

PREScriber restrictions

COVERAGE DURATION
REMAINder OF CONTRACT YEAR

OTHER CRITERIA
FOR ONYCHOMYCOSIS: FAILURE ON, CONTRAINDICATION TO, OR INTOlERANCE TO TERBINAFINE
PRIOR AUTHORIZATION GROUP DESCRIPTION

IVIG

DRUG NAME

BIVIGAM | CARIMUNE NF NANOFILTERED | GAMASTAN S-D | GAMMAGARD LIQUID | GAMUNEX-C | PRIVIGEN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. PRIMARY HUMORAL IMMUNODEFICIENCIES (CONGENITAL AGAMMAGLOBULINEMIA, COMMON VARIABLE IMMUNODEFICIENCY, WISKOTT-ALDRICH SYNDROME, X-LINKED IMMUNODEFICIENCY WITH HYPERIMMUNOGLOBULIN M, SEVERE COMBINED IMMUNODEFICIENCY, HYPOGAMMAGLOBULINEMIA PROVIDED FLOW CYTOMETRY AND ANAMNestic RESPONSE TO RECALL ANTIGENS TO DETERMINE EXTENT OF DEFICIENCY), IDIOPATHIC THROMBOCYTOPENIA PURPURA (ITP), B-CELL CHRONIC LYMPHOCYTIC LEUKEMIA (CLL), HIV INFECTION TO REDUCE SIGNIFICANT BACTERIAL INFECTION (HIV), CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP), DERMATOMYOSITIS AND POLYMYOSITIS, AUTOIMMUNE HEMOLYTIC ANEMIA (AHA), RELAPSING/REMITTING MULTIPLE SCLEROSIS (MS), MULTIFOCAL MOTOR NEUROPATHY (MMN).

EXCLUSION CRITERIA

USE OF IVIG FOR THE FOLLOWING INDICATIONS IS CONSIDERED INVESTIGATIONAL AND WILL NOT BE COVERED: ALZHEIMER’ S DISEASE, AMYOTROPHIC LATERAL SCLEROSIS, ATOPIC DERMATITIS, AUTISM, CHRONIC FATIGUE SYNDROME, CHRONIC MUCOCUTANEOUS CANDIDIASIS, COMPLEX REGIONAL PAIN SYNDROME, EPILEPSY, INCLUSION BODY MYOSITIS, LYME DISEASE, NEUROMYELITIS OPTICA (DEVIC’S DISEASE), OPTIC NEURITIS, PARAPROTEINEMIC DEMYElining NEUROPATHY, POST-POLIO SYNDROME, RECURRENT SPONTANEOUS MISCARRIAGE, RHEUMATIC FEVER, SECONDARY PROGRESSIVE MULTIPLE SCLEROSIS, SYSTEMIC LUPUS ERYTHEMATOSUS.

REQUIRED MEDICAL INFORMATION

ACUTE ITP: ACTIVE BLEEDING & PLATELET COUNT LESS THAN 30,000/UL OR PRE-OP TX PRIOR TO MAJOR SURGICAL PROCEDURE OR PLATELET COUNT LESS THAN 20,000/UL & AT RISK FOR INTRACEREBRAL HEMORRHAGE. CHRONIC ITP: PRIOR TX W/ CORTICOSTEROIDS & SPLENECTOMY, AND DURATION OF ILLNESS GREATER THAN 6 MONTHS, AND 10 YEARS OF AGE OR OLDER, AND NO CONCURRENT ILLNESS EXPLAINING THROMBOCYTOPENIA, AND PLATELET COUNT LESS THAN 20,000/UL. CLL: DEFINITIVE DIAGNOSIS OF CLL, AND IGG LEVEL LESS THAN 600 MG/DL, AND
HISTORY OF SERIOUS BACTERIAL INFECTION REQUIRING EITHER ORAL OR PARENTERAL ABX TX W/IN LAST 6 MONTHS. HIV: 14 YEARS OF AGE OR OLDER, AND EVIDENCE OF EITHER QUALITATIVE OR QUANTITATIVE HUMORAL IMMUNOLOGIC DEFECTS, AND CURRENT BACTERIAL INFECTIONS DESPITE APPROPRIATE ABX PROPHYLAXIS, CIDP: DEFINITIVE DIAGNOSIS OF CIDP PER AMERICAN ACADEMY OF NEUROLOGY OR MEDICAL ADVISORY COMMITTEE OF THE NEUROPATHY ASSOCIATION, REFRACTORY TO OR INTOLENT OF PREDNISONE OR AZATHIOPRINE GIVEN IN THERAPEUTIC DOSES OVER AT LEAST 3 MONTHS, NEUROLOGIC FUNCTION ASSESSMENT SCORE OF AT LEAST 3 OR GREATER ON THE RANKIN SCALE AT THE TIME OF INITIAL THERAPY. DERMATOMYOSITIS / POLYMYOSITIS: BIOPSY PROVEN DISEASE, AND ACTIVE DISEASE, AND REFRACTORY TO BOTH CORTICOSTEROID THERAPY (AT LEAST 4 MONTHS) & IMMUNOSUPPRESANTS (AT LEAST TWO OF THE FOLLOWING CYCLOSPORINE, AZATHIOPRINE, METHOTREXATE, CYCLOPHOSPHAMIDE). AHA: WARM-TYPE AUTOIMMUNE HEMOLYTIC ANEMIA WITH FAILURE OF, INTOLENTANCE TO, OR CONTRAINDICATIONS TO CORTICOSTEROIDS OR SPLENECTOMY. MS: FAILURE ON AT LEAST 2 STANDARD APPROACHES (INTERFERONS, COPAXONE) AFTER A MINIMUM TRIAL OF 3 MONTHS OR, INTOLENTANCE TO, OR CONTRAINDICATION TO THESE THERAPIES. MMN: PROGRESSIVE & SYMPTOMATIC DISEASE FOR A MINIMUM OF 2 MONTHS DIAGNOSISED WITH ELECTROPHYSICAL FINDINGS OF CONDUCTION BLOCK ON A SINGLE NERVE OR PROBABLE CONDUCTION BLOCK IN 2 OR MORE NERVES OR NORMAL SENSORY NERVE CONDUCTION IN UPPER LIMB SEGEMENTS AND NORMAL SENSORY NERVE ACTION POTENTIAL (SNAP) AMPLITUDE.

AGE RESTRICTIONS

PREScriber RESTRICTIONS

FOR CHRONIC INFLAMMATORY DemyelinATING POLYNEuROPATHY, DERMATOMYOSITIS / POLYMYOSITIS, RELAPSING/REMITTING MULTIPLE SCLEROSIS, AND MULTIFOCAL MOTOR NEUROPATHY: MUST BE PRESCRIBED BY A NEUROLOGIST OR RHEUMATOLOGIST

COVERAGE DURATION

CDIP & MS : 8 WEEKS. MULTIFOCAL MOTOR NEUROPATHY : 12 WEEKS. ALL OTHERS: 6 MONTHS.

OTHER CRITERIA

IVIG MAY BE COVERED UNDER MEDICARE PART B OR MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION. CONTINUATION OF COVERAGE WILL REQUIRE MEDICAL RECORD DOCUMENTATION OF A MEAURABLE RESPONSE OR IMPROVMENT IN SIGNS AND SYMPTOMS.
PRIOR AUTHORIZATION GROUP DESCRIPTION
IXEMPRA

DRUG NAME
IXEMPRA

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF METASTATIC OR LOCALLY ADVANCED BREAST CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF USE IN COMBO WITH CAPECITABINE FOR THE TREATMENT OF METASTATIC OR LOCALLY ADVANCED BREAST CANCER WITH RESISTANCE TO AN ANTHRACYCLINE AND A TAXANE OR CANCER THAT IS TAXANE RESISTANT AND FURTHER ANTHRACYCLINE THERAPY IS CONTRAINDICATED OR DOCUMENTATION OF USE AS A MONOTHERAPY WITH TUMORS RESISTANT OR REFRACTORY TO ANTHRACYCLINES, TAXANES AND CAPECITABINE.
DRUG NAME
JEVTANA

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF HORMONE-REFRACTORY METASTATIC PROSTATE CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF TUMOR WITHOUT NEUROENDOCRINE FEATURES AND DOCUMENTATION OF NEUTROPHIL COUNT GREATER THAN 1500 CELLS/MM(3) AND FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A DOCETAXEL-BASED REGIMEN.
PRIOR AUTHORIZATION GROUP DESCRIPTION
KADCYLA

DRUG NAME
KADCYLA

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF HER2-POSITIVE, METASTATIC BREAST CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF PREVIOUS TREATMENT WITH TRASTUZUMAB (HERCEPTIN) AND A TAXANE (PACLITAXEL OR DOCETAXEL), SEPARATELY OR IN COMBINATION. MUST HAVE EITHER RECEIVED PRIOR THERAPY FOR METASTATIC DISEASE OR DEVELOPED DISEASE RECURRENCE DURING OR WITHIN SIX MONTHS OF COMPLETING ADJUVANT.
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
KALYDECO

DRUG NAME
KALYDECO

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF CYSTIC FIBROSIS AND DOCUMENTATION OF AT LEAST ONE COPY OF G551D MUTATION IN THE CFTR GENE AS EVIDENCED BY A FDA CLEARED CF MUTATION TEST AND DOCUMENTATION THAT THE PATIENT DOES NOT CARRY THE F508 DEL MUTATION

AGE RESTRICTIONS
MUST BE 6 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS
PULMONOLOGIST

COVERAGE DURATION
2 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
Prior Authorization Requirements

Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

KETEK

DRUG NAME

KETEK

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF COMMUNITY ACQUIRED PNEUMONIA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, CONTRAINDICATION TO, OR INTOLERANCE TO AZITHROMYCIN, CLARITHROMYCIN OR ERYTHROMYCIN
PRIOR AUTHORIZATION GROUP DESCRIPTION
KINERET

DRUG NAME
KINERET

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF NEONATAL-ONSET MULTISYSTEM INFLAMMATORY DISEASE (NOMID) OR DX OF RHEUMATOID ARTHRITIS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
FOR NOMID: PRESCRIBED BY IMMUNOLOGIST, RHEUMATOLOGIST, OR ALLERGIST.
FOR RHEUMATOID ARTHRITIS: PRESCRIBED BY RHEUMATOLOGIST.

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR RHEUMATOID ARTHRITIS: TRIAL AND FAILUE WITH AT LEAST 1 PREFERRED DMARD (AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, METHOTREXATE, SULFASALAZINE, LEFLUNOMIDE, CUPRIMINE, RIDAURA) AND THAT PATIENT HAS CONTRAINDICATION/FAILURE TO PREFERRED TNF-ALPHA INHIBITORS (ENBREL OR HUMIRA). FOR NOMID: PATIENT MUST BE EVALUATED BY AN EXPERT IN A CONTRACTED CENTER OF EXCELLENCE AS CHOSEN BY THE HEALTH PLAN MEDICAL DIRECTOR IN COLLABORATION WITH THE REQUESTING PHYSICIAN.
Prior Authorization Requirements

Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
KORLYM

DRUG NAME
KORLYM

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
PREGNANCY

REQUIRED MEDICAL INFORMATION
DX OF ENDOGENOUS CUSHING'S SYNDROME AND DOCUMENTATION OF FAILED SURGICAL TREATMENT FOR CUSHING'S SYNDROME OR THAT PATIENT IS NOT A CANDIDATE FOR SURGERY. DOCUMENTATION OF A NEGATIVE PREGNANCY TEST WITHIN 14 DAYS OF INITIATING THERAPY IN WOMEN OF REPRODUCTIVE POTENTIAL

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ENDOCRINOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
THERAPEUTIC FAILURE ON, CONTRAINDICTION TO, OR INTOLERANCE TO AT LEAST TWO FORMULARY ANTI-DIABETIC ALTERNATIVES
PRIOR AUTHORIZATION GROUP DESCRIPTION
KUVAN

DRUG NAME
KUVAN

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
BASELINE BLOOD PHE LEVEL LESS THAN 450 UMOL/L.

REQUIRED MEDICAL INFORMATION
BASELINE BLOOD PHE LEVELS. FOR CONTINUATION OF THERAPY, MUST PROVIDE THE FOLLOWING BLOOD PHE LEVELS, BASELINE, 1 WEEK, 4 WEEKS AND 8 WEEKS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
METABOLIC SPECIALIST

COVERAGE DURATION
INITIALLY 2 MONTHS THEN INDEFINITE IF PATIENT IS A RESPONDER

OTHER CRITERIA
COMPLIANT WITH A PHE RESTRICTED DIET, 30% OR GREATER REDUCTION IN PHE AT WK 8 FOR INDEFINITE AUTH
PRIOR AUTHORIZATION GROUP DESCRIPTION

KYNAMRO

DRUG NAME
KYNAMRO

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF HOMOZYGIOUS FAMILIAL HYPERCHOLESTEROLEMIA THAT IS CAUSED BY MUTATIONS OF THE LDL RECEPTOR GENE

AGE RESTRICTIONS
MUST BE AT LEAST 18 YEARS OF AGE

PRESCRIBER RESTRICTIONS
HEPATOLOGIST, LIDIPOLGIST OR CARDIOLOGIST REGISTERED WITH THE KYNAMRO REMS PROGRAM

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
DOCUMENTATION OF FAILURE TO ADEQUATELY CONTROL LDL LEVELS WITH A COMBINATION OF MAXIMUM TOLERATED STATIN DOSE AND LDL APHERESIS TREATMENTS DEFINED AS GREATER THAN OR EQUAL TO 200MG/DL IN PATIENTS WITHOUT CARDIOVASCULAR DISEASE OR GREATER THAN OR EQUAL TO 160MG/DL IN PATIENTS WITH ESTABLISHED CARDIOVASCULAR DISEASE AND DOCUMENTATION THAT KYNAMRO WILL BE USED IN ADJUNCT WITH MAXIMUM TOLERATED STATIN DOSE AND DOCUMENTATION THAT KYNAMRO WILL NOT BE USED IN CONJUNCTION WITH LDL APHERESIS.
PRIOR AUTHORIZATION GROUP DESCRIPTION
LATUDA

DRUG NAME
LATUDA

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF SCHIZOPHRENIA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ATYPICAL ANTIPSYCHOTICS (OLANZAPINE, RISPERIDONE, QUETIAPINE, ZIPRASIDONE, ABILIFY) OR FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ZIPRASIDONE AND ABILIFY FOR MEMBERS WITH METABOLIC SYNDROME.
PRIOR AUTHORIZATION GROUP DESCRIPTION
LAZANDA

DRUG NAME
LAZANDA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CANCER AND OF USE TO MANAGE BREAKTHROUGH CANCER PAIN

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
MEDICAL RECORD DOCUMENTATION OF CONCOMITANT MORPHINE 60 MG/DAY OR MORE, TRANSDERMAL FENTANYL 25 MCG/H, OXYCODONE 30 MG/DAY, ORAL HYDROMORPHONE 8 MG/DAY, OR AN EQUIANALGESIC DOSE OF ANOTHER OPIOID FOR 1 WEEK OR LONGER AND FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO GENERIC FENTANYL LOZENGES.
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
LETAIRIS

DRUG NAME
LETAIRIS

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF FUNCTIONAL CLASS 2 OR 3 PULMONARY ARTERIAL HYPERTENSION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO REVATIO AND TRACLEER
PRIOR AUTHORIZATION GROUP DESCRIPTION
LEUKINE

DRUG NAME
LEUKINE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
PROPHYLAXIS DURING CHEMO REGIMENS WITH A FEBRILE NEUTROPENIA RISK LESS THAN 20% AND NO HIGH RISK FOR COMPLICATIONS, THOSE WHO ARE NEUTROPENIC BUT AFEBRILE, TO ALLOW AN INCREASE IN THE DOSE-INTENSITY OF CYTOTOXIC CHEMO BEYOND ESTABLISHED DOSE RANGES, NO RESPONSE SEEN WITHIN 45 DAYS OF TREATMENT

REQUIRED MEDICAL INFORMATION
PREVENTION OF FEBRILE NEUTROPENIA WHEN RISK DUE TO MYELOSUPPRESSIVE CHEMO REGIMEN IS 20% OR GREATER. TO PREVENT FEBRILE NEUTROPENIA WHEN THE RISK OF DEVELOPING FEBRILE NEUTROPENIA IS LESS THAN 20% WITH THE FOLLOWING RISK FACTORS: 65 YRS OR OLDER, POOR PERFORMANCE STATUS, PREVIOUS HISTORY OF FEBRILE NEUTROPENIA, EXTENSIVE PRIOR RADIATION OF CHEMO TREATMENT, POOR NUTRITIONAL STATUS, OPEN WOUNDS OR ACTIVE INFECTION,ADVANCED CANCER. PREVENTION OF FEBRILE NEUTROPENIA WHEN A PREVIOUS CYCLE RESULTED IN A NEUTROPENIC COMPLICATION AND DOSE REDUCTION WILL COMPROMISE DISEASE FREE OR OVERALL SURVIVAL OR TREATMENT OUTCOME, AS AN ADJUNCT TO ANTIBIOTICS FOR TREATMENT OF FEBRILE NEUTROPENIA WITH HIGH RISK FOR INFECTION RELATED COMPLICATIONS. FOR USE IN DOSE DENSE THERAPY, TO MOBILIZE PERIPHERAL BLOOD PROGENITOR CELL ADMINISTRATION AFTER AUTOLOGOUS PBPC TRANSPLANT, LYMPHOMA TREATED WITH CURATIVE THERAPY, LEUKEMIA OR MYELODYSPLASTIC SYNDROMES, NON-MYELOID MALIGNANCY, RADIATION THERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
Geisinger Health Plan - 14325
Prior Authorization Requirements

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION

LIDODERM

DRUG NAME
LIDOCAINE | LIDODERM

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF POST-HERPETIC NEURALGIA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, CONTRAINDICATION TO, OR INTOLERANCE TO GABAPENTIN
PRIOR AUTHORIZATION GROUP DESCRIPTION
LINZESS

DRUG NAME
LINZESS

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF IRRITABLE BOWEL SYNDROME WITH CONSTIPATION OR CHRONIC IDIOPATHIC CONSTIPATION

AGE RESTRICTIONS
MUST 6 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY CATHARTICS AND LAXATIVES
PRIOR AUTHORIZATION GROUP DESCRIPTION
LUZU

DRUG NAME
LUZU

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF TINEA PEDIS, TINEA CRURIS, OR TINEA CORPORIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
2 WEEKS

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO GENERIC FORMULARY ALTERNATIVES (CLOTRIMAZOLE, ECONAZOLE, AND/OR KETOCONAZOLE)
PRIOR AUTHORIZATION GROUP DESCRIPTION
MACROLIDES

DRUG NAME
AZITHROMYCIN | CLARITHROMYCIN | CLARITHROMYCIN ER | E.E.S. 400 | ERY-TAB | ERYTHROCIN STEARATE | ERYTHROMYCIN | ERYTHROMYCIN ETHYL SUCCINATE | PCE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
PRIOR AUTHORIZATION APPLIES ONLY IF THERE IS CONCURRENT USE OF DIGOXIN AND ONE OF THE FOLLOWING MACROLIDE ANTIBIOTICS - CLARITHROMYCIN, ERYTHROMYCIN, OR AZITHROMYCIN. IF THE MEMBER IS NOT CONCURRENTLY RECEIVING DIGOXIN, PRIOR AUTHORIZATION WILL NOT BE REQUIRED.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
1 MONTH

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ANTIBIOTIC CLASS ALTERNATIVES WHICH INCLUDE 2ND OR 3RD GENERATION CEPHALSPORINS (SUCH AS CEFACLOR OR CEPFODOXIME), PENICILLINS (SUCH AS AMOXICILLIN OR AMOXICILLIN/CLAVULANATE), OR QUINOLONES (SUCH AS CIPROFLOXACIN OR LEVOFLOXACIN) IF CONCURRENT USE OF DIGOXIN
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
MEKINIST

DRUG NAME
MEKINIST

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF UNRESECTABLE OR METASTATIC MELANOMA WITH BRAF V600E OR V600K MUTATION AS DETECTED BY AN FDA APPROVED TEST

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ONCOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
NO PRIOR THERAPEUTIC FAILURE WITH A BRAF INHIBITOR THERAPY (ZELBORAF (VEMURAFENIB) OR TAFINLAR (DABRAFENIB)) OR MEK INHIBITOR THERAPY SUCH AS MEKINIST. THE FDA APPROVED TEST FOR BRAF V600E OR V600K MUTATION IS THE THXID BRAF KIT.
DRUG NAME
MEPLOBAMATE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF ANXIETY

AGE RESTRICTIONS
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION AND WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINICATION TO TWO OF THE FOLLOWING: BUSPIRONE, PAROXETINE, ESCITALOPRAM, OR VENLAFAXINE XR.
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Prior Authorization Requirements

Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
MUSCLE RELAXANTS

DRUG NAME
CARISOPRODOL | CARISOPRODOL COMPOUND-CODEINE | CARISOPRODOL-ASPIRIN
| CHLORZOXAZONE | CYCLOBENZAPRINE HCL | METAXALONE | METHOCARBAMOL | ORPHENADRINE CITRATE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION. USE IN MUSCLE SPASTICITY WILL REQUIRE TRIAL AND FAILURE WITH TIZANIDINE. USE IN MUSCULOSKELETAL CONDITIONS WILL REQUIRE THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: FORMULARY NSAIDS OR TRAMAOL.
PRIOR AUTHORIZATION GROUP DESCRIPTION
MYOZYME

DRUG NAME
MYOZYME

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF INFANTILE ONSET POMPE DISEASE (IOPD)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
METABOLIC SPECIALIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
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Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
NAGLAZYME

DRUG NAME
NAGLAZYME

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF MUCOPOLYSACCHARIDOSIS VI (MAROTEAUX-LAMY DISEASE)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
METABOLIC SPECIALIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
NEULASTA

DRUG NAME
NEULASTA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
PROPHYLAXIS DURING CHEMO REGIMENS WITH A FEBRILE NEUTROPENIA RISK LESS THAN 20% AND NO HIGH RISK FOR COMPLICATIONS, THOSE WHO ARE NEUTROPENIC BUT AFEBRILE, TO ALLOW AN INCREASE IN THE DOSE-INTENSITY OF CYTOTOXIC CHEMO BEYOND ESTABLISHED DOSE RANGES, NO RESPONSE SEEN WITHIN 45 DAYS OF TREATMENT

REQUIRED MEDICAL INFORMATION
PREVENTION OF FEBRILE NEUTROPENIA WHEN RISK DUE TO MYELOSUPPRESSIVE CHEMO REGIMEN IS 20% OR GREATER. TO PREVENT FEBRILE NEUTROPENIA WHEN THE RISK OF DEVELOPING FEBRILE NEUTROPENIA IS LESS THAN 20% WITH THE FOLLOWING RISK FACTORS: 65 YRS OR OLDER, POOR PERFORMANCE STATUS, PREVIOUS HISTORY OF FEBRILE NEUTROPENIA, EXTENSIVE PRIOR RADIATION OF CHEMO TREATMENT, POOR NUTRITIONAL STATUS, OPEN WOUNDS OR ACTIVE INFECTION, ADVANCED CANCER. PREVENTION OF FEBRILE NEUTROPENIA WHEN A PREVIOUS CYCLE RESULTED IN A NEUTROPENIC COMPLICATION AND DOSE REDUCTION WILL COMPROMISE DISEASE FREE OR OVERALL SURVIVAL OR TREATMENT OUTCOME, AS AN ADJUNCT TO ANTIBIOTICS FOR TREATMENT OF FEBRILE NEUTROPENIA WITH HIGH RISK FOR INFECTION RELATED COMPLICATIONS. FOR USE IN DOSE DENSE THERAPY, TO MOBILIZE PERIPHERAL BLOOD PROGENITOR CELL ADMINISTRATION AFTER AUTOLOGOUS PBPC TRANSPLANT, LYMPHOMA TREATED WITH CURATIVE THERAPY, LEUKEMIA OR MYELODYSPLASTIC SYNDROMES, NON-MYELOID MALIGNANCY, RADIATION THERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
Geisinger Health Plan - 14325
Prior Authorization Requirements

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
NEUPOGEN

DRUG NAME
NEUMEGA | NEUPOGEN

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
PROPHYLAXIS DURING CHEMO REGIMENS WITH A FEBRILE NEUTROPENIA RISK LESS THAN 20% AND NO HIGH RISK FOR COMPLICATIONS, THOSE WHO ARE NEUTROPENIC BUT AFEBRILE, TO ALLOW AN INCREASE IN THE DOSE-INTENSITY OF CYTOTOXIC CHEMO BEYOND ESTABLISHED DOSE RANGES, NO RESPONSE SEEN WITHIN 45 DAYS OF TREATMENT

REQUIRED MEDICAL INFORMATION
PREVENTION OF FEBRILE NEUTROPENIA WHEN RISK DUE TO MYELOSUPPRESSIVE CHEMO REGIMEN IS 20% OR GREATER. TO PREVENT FEBRILE NEUTROPENIA WHEN THE RISK OF DEVELOPING FEBRILE NEUTROPENIA IS LESS THAN 20% WITH THE FOLLOWING RISK FACTORS: 65 YRS OR OLDER, POOR PERFORMANCE STATUS, PREVIOUS HISTORY OF FEBRILE NEUTROPENIA, EXTENSIVE PRIOR RADIATION OF CHEMO TREATMENT, POOR NUTRITIONAL STATUS, OPEN WOUNDS OR ACTIVE INFECTION,ADVANCED CANCER. PREVENTION OF FEBRILE NEUTROPENIA WHEN A PREVIOUS CYCLE RESULTED IN A NEUTROPENIC COMPLICATION AND DOSE REDUCTION WILL COMPROMISE DISEASE FREE OR OVERALL SURVIVAL OR TREATMENT OUTCOME, AS AN ADJUNCT TO ANTIBIOTICS FOR TREATMENT OF FEBRILE NEUTROPENIA WITH HIGH RISK FOR INFECTION RELATED COMPLICATIONS. FOR USE IN DOSE DENSE THERAPY, TO MOBILIZE PERIPHERAL BLOOD PROGENITOR CELL ADMINISTRATION AFTER AUTOLOGOUS PBPC TRANSPLANT, LYMPHOMA TREATED WITH CURATIVE THERAPY, LEUKEMIA OR MYELODYSPLASTIC SYNDROMES, NON-MYELOID MALIGNANCY, RADIATION THERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
NEXAVAR

DRUG NAME
NEXAVAR

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ONCOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
NEXIUM IV

DRUG NAME
NEXIUM I.V.

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINICATION TO PANTOPRAZOLE IV.
PRIOR AUTHORIZATION GROUP DESCRIPTION
NITROFURANTOIN

DRUG NAME
NITROFURANTOIN

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION AND QUANTITY LIMIT APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION. WILL APPROVE FOR UP TO 90 DAYS SUPPLY WITHIN A 12 MONTH PERIOD. CONTINUED USE OVER A 90 DAYS SUPPLY FOR DX OF UTI WILL REQUIRE CREATININE CLEARANCE GREATER THAN OR EQUAL TO 60 ML/MIN AND POSITIVE CULTURE REPORT SHOWING THAT THE BACTERIA IS ONLY SENSITIVE TO NITROFURANTOIN OR ONLY SENSITIVE TO NITROFURANTOIN AND OTHER MEDICATIONS THAT THE MEMBER IS ALLERGIC TO OR FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING FORMULARY ALTERNATIVES: AMOXICILLIN/CLAVULANIC ACID, CEFUROXIME, CEFADROXIL, CEPHALEXIN, CIPROFLOXACIN, SULFAMETHOXAZOLE/TRIMETHOPRIM, OR TRIMETHOPRIM. CONTINUED PROPHYLACTIC USE OVER A 90 DAYS SUPPLY WILL REQUIRE CREATININE CLEARANCE GREATER THAN OR EQUAL TO 60 ML/MIN AND FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING FORMULARY ALTERNATIVES: CEPHALEXIN, CIPROFLOXACIN, SULFAMETHOXAZOLE/TRIMETHOPRIM, OR TRIMETHOPRIM.
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
NOXAFIL

DRUG NAME
NOXAFIL

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF USE FOR PROPHYLAXIS OF INVASIVE ASPERGILLUS AND CANDIDA INFECTIONS IN SEVERELY IMMUNOCOMPROMISED PATIENTS (HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT) RECIPIENTS WITH GRAFT-VERSUS-HOST-DISEASE (GVHD) OR THOSE WITH HEMATOLOGIC MALIGNANCIES WITH PROLONGED NEUTROPENIA FROM CHEMOTHERAPY) OR DIAGNOSIS OF OROPHARYNGEAL CANDIDIASIS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR OROPHARYNGEAL CANDIDIASIS: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ITRACONAZOLE ORAL SOLUTION AND FLUCONAZOLE.
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
NUDEXTA

DRUG NAME
NUDEXTA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PSEUDOBULBAR AFFECT IN PATIENTS WITH AMYOTROPHIC LATERAL SCLEROSIS (ALS) OR MULTIPLE SCLEROSIS (MS).

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
NULOJIX

DRUG NAME
NULOJIX

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF RENAL TRANSPLANT

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF EPSTEIN-BARR VIRUS (EBV) SEROPOSITIVITY
PRIOR AUTHORIZATION GROUP DESCRIPTION
NUVIGIL

DRUG NAME
NUVIGIL

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME, NARCOLEPSY OR SHIFT-WORK

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR OBSTRUCTIVE SLEEP APNEA, DOCUMENTATION OF CPAP HISTORY OR STATUS.
PRIOR AUTHORIZATION GROUP DESCRIPTION
OLEPTRO

DRUG NAME
OLEPTRO ER

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER

AGE RESTRICTIONS
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ANTIDEPRESSANTS, ONE OF WHICH MUST BE TRAZODONE
PRIOR AUTHORIZATION GROUP DESCRIPTION
ONFI

DRUG NAME
ONFI

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF LENNOX-GASTAUT SYNDROME

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
NEUROLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
OPSUMIT

DRUG NAME
OPSUMIT

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF WHO FUNCTIONAL CLASS II, III, OR IV PULMONARY ARTERIAL HYPERTENSION AND NEGATIVE PREGNANCY TEST IN FEMALES OF CHILDBEARING POTENTIAL

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
CARDIOLOGIST OR PULMONOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION THAT OPSUMIT WILL BE USED IN COMBINATION WITH OR THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO SILDENAFIL AND THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TRACLEER
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
ORENCIA

DRUG NAME
ORENCIA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF RHEUMATOID ARTHRITIS MADE IN ACCORDANCE WITH THE AMERICAN COLLEGE OF RHEUMATOLOGY CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF RHEUMATOID ARTHRITIS AND DOCUMENTATION OF THE NUMBER OF SWOLLEN OR TENDER JOINTS PRIOR TO INITIATING THERAPY WITH A MINIMUM DOCUMENTED JOINT COUNT OF GREATER THAN FOUR SWOLLEN OR TENDER JOINTS BASED ON A 28 JOINT COUNT

AGE RESTRICTIONS
FOR RA - MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS
RHEUMATOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
DOCUMENTATION OF AN INADEQUATE RESPONSE TO A MINIMUM 3 MONTH TRIAL OF HUMIRA AND ENBREL
PRIOR AUTHORIZATION GROUP DESCRIPTION
ORENITRAM

DRUG NAME
ORENITRAM ER

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF WHO GROUP 1 PULMONARY ARTERIAL HYPERTENSION WITH WHO FUNCTIONAL CLASS II OR III SYMPTOMS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
CARDIOLOGIST OR PULMONOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION OF A BASELINE 6-MINUTE WALKING DISTANCE.
DOCUMENTATION THAT ORENITRAM IS NOT BEING USED IN COMBINATION WITH ENDOTHELIN RECEPTOR ANTAGONISTS (LETAIRIS, TRACLEER, OPSUMIT) OR PDE5 INHIBITORS (REVATIO OR ADCIRCA). REAUTHORIZATION WILL REQUIRE DOCUMENTATION OF AN IMPROVEMENT IN 6-MINUTE WALKING DISTANCE FROM BASELINE OR IMPROVED OR STABLE DIAGNOSIS OF WHO FUNCTIONAL CLASS AND DOCUMENTATION THAT ORENITRAM IS NOT BEING USED IN COMBINATION WITH ENDOTHELIN RECEPTOR ANTAGONISTS (LETAIRIS, TRACLEER, OPSUMIT) OR PDE5 INHIBITORS (REVATIO OR ADCIRCA).
PRIOR AUTHORIZATION GROUP DESCRIPTION
PERJETA

DRUG NAME
PERJETA

COVERED USES
ALL FDA-APPROVED AND MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF HER2 POSITIVE METASTATIC BREAST CANCER WHO HAVE NOT RECEIVED PRIOR ANTI-HER2 THERAPY OR CHEMOTHERAPY FOR METASTATIC DISEASE AND PERJETA BEING USED IN COMBINATION WITH TRASTUZUMAB AND DOCETAXEL/PACLITAXEL

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION

PICATO

DRUG NAME
PICATO

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF GREATER THAN OR EQUAL TO 4 ACTINIC KERTOSIS LESIONS WITHIN A CONTIGUOUS 25 CM SQUARED AREA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
DERMATOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO FLUOROURACIL
PRIOR AUTHORIZATION GROUP DESCRIPTION
POMALYST

DRUG NAME
POMALYST

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MULTIPLE MYELOMA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO PRIOR THERAPIES: BORTEZOMIB (VELCADE) AND LENALIDOMIDE (REVLIMID).
PRIOR AUTHORIZATION GROUP DESCRIPTION
POTIGA

DRUG NAME
POTIGA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PARTIAL ONSET SEIZURES

AGE RESTRICTIONS
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ANTICONVULSANTS
# Prior Authorization Group Description

**PROCRIT**

## Drug Name

**PROCRIT**

## Covered Uses

All medically accepted indications not otherwise excluded from Part D

## Exclusion Criteria

<table>
<thead>
<tr>
<th>Required Medical Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>For non-surgical indications: Hemoglobin must be less than 11gm/dl for new starts or less than 12gm/dl for continuation of therapy. Documentation of adequate iron stores w/ serum ferritin greater than 100 ng/ml or transferrin level saturation greater than 20%. Tx of symptomatic anemia of chronic renal insufficiency, chronic renal failure, including ESRD. Tx of symptomatic anemia in AzT treated HIV infected individuals - must have endogenous erythropoietin levels of 500mu/ml or less and AzT doses of 4200mg/week or less. Tx of symptomatic anemia of chronic disease - severe comorbidity and impairments to ADL, exercise intolerance, tachycardia and SOB with minimal activity. Tx of anemia in multiple myeloma - documentation of chemo or transfusion dependence or renal insufficiency.</td>
</tr>
</tbody>
</table>

## Age Restrictions

## Prescriber Restrictions

## Coverage Duration

3 months
OTHER CRITERIA

FOR SURGICAL INDICATIONS: HEMOGLOBIN MUST BE GREATER THAN 10GM/DL BUT LESS THAN 13GM/DL. FOR ALLOGENEIC BLOOD TRANSFUSION IN ANEMIC INDIVIDUALS UNDERGOING SURGERY IN ELECTIVE NON CARDIAC, NON-VASCULAR SURGERY WHERE ANTICIPATED BLOOD LOSS IS GREATER THAN 2 UNITS AND NEED FOR TRANSFUSION IS ANTICIPATED. TREATMENT OF ANEMIC PATIENTS WHO ARE AT HIGH RISK FOR PERI-OPERATIVE BLOOD LOSS FROM ELECTIVE, NON-CARDIAC, OR NON-VASCULAR SURGERY TO REDUCE THE NEED FOR ALLOGENIC BLOOD TRANSFUSIONS. THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.
PRIOR AUTHORIZATION GROUP DESCRIPTION
PROMACTA

DRUG NAME
PROMACTA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIC PURPURA (ITP) WITH FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR SPLENECTOMY OR DX OF SYMPTOMATIC ITP WITH BLEEDING SYMPTOMS OR A PLATELET COUNT OF LESS THAN 50,000/MICROL AND INCREASED RISK OF BLEEDING. DX OF CHRONIC HEPATITIS C AND PLAN TO INITIATE OR CONTINUE INTERFERON-BASE THERAPY AND A PLATELET COUNT OF 50,000/ML OR LESS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
FOR CHRONIC HEPATITIS C: PRESCRIBED BY GASTROENTEROLOGIST, HEMATOLOGIST, HEPATOLOGIST OR INFECTIOUS DISEASE PHYSICIAN.

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
THERAPEUTIC FAILURE ON OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS OR SPLENECTOMY
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
PROMETHAZINE HRM

DRUG NAME
PHENADOZ | PROMETHAZINE HCL | PROMETHAZINE VC | PROMETHEGAN

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION. DIAGNOSIS OF ALLERGIC CONDITIONS (PRURITUS, URTICARIA, SEASONAL OR PERENNIAL ALLERGIES) WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO DESLORATADINE AND LEVOCETIRIZINE. DIAGNOSIS OF NAUSEA AND VOMITING WILL REQUIRE DIAGNOSIS OF CANCER OR FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONDANSETRON AND PROCHLORPERAZINE. DIAGNOSIS OF MOTION SICKNESS WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO MECLIZINE. FOR USE IN SEDATION INCLUDING PRODUCTION OF LIGHT SLEEP, REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ROZEREM AND SILENOR.
Prior Authorization Requirements

Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
PROVIGIL

DRUG NAME
MODAFINIL

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME, NARCOLEPSY OR SHIFT-WORK

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDEER OF CONTRACT YEAR

OTHER CRITERIA
FOR OBSTRUCTIVE SLEEP APNEA, DOCUMENTATION OF CPAP HISTORY OR STATUS.
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
RELISTOR

DRUG NAME
RELISTOR

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
MEDICAL RECORD DOCUMENTATION OF ADVANCED ILLNESS RECEIVING PALLIATIVE CARE. CONCURRENT USE OF OPIOID THERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO LACTULOSE AND POLYETHYLENE GLYCOL 3350.
Drugs Name

REMICADE

Covered Uses

All FDA-Approved indications not otherwise excluded from Part D

Exclusion Criteria

Required Medical Information

Crohn's Disease - Diagnosis of moderate to severe Crohn's and documentation of failure on, intolerance to, or contraindication to one conventional therapy (aminosalicylates, corticosteroids, or immunomodulators) and 12 weeks of Humira therapy or diagnosis of Crohn's with active draining fistulas. RA - Diagnosis of moderate to severe RA and a failure on, intolerance to, or contraindication to 12 weeks of Enbrel and Humira therapy. Ankylosing Spondylitis - documentation of 12 weeks of Enbrel and Humira therapy. Plaque Psoriasis - Diagnosis of chronic, severe plaque psoriasis with at least 10% BSA or disease of palms or soles of feet which impairs ADL and failure on, intolerance on, or contraindication to 12 weeks of Enbrel and Humira therapy. Psoriatic Arthritis - Diagnosis of moderately to severely active PSA with history of psoriasis or active psoriatic lesions and 12 weeks of Enbrel and Humira therapy. Ulcerative Colitis - Diagnosis of moderate to severe UC and intolerance, failure on, or contraindication to two of the following (aminosalicylates, corticosteroids and immunomodulators).

Age Restrictions

Must be at least 18 years of age for the following diagnoses - RA, Ankylosing Spondylitis, Plaque Psoriasis, and Psoriatic Arthritis, must be at least 6 years of age for Chron's Disease and Ulcerative Colitis.

Prescriber Restrictions

Rheumatologist or Dermatologist or Gastroenterologist
Geisinger Health Plan - 14325
Prior Authorization Requirements

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
FOR RA, REMICADE MUST BE USED IN COMBINATION WITH METHOTREXATE.
FIRST LINE THERAPY FOR UC INCLUDES TRIALS OF TWO OF THE FOLLOWING,
CORTICOSTEROIDS, AMINOSALICYLATES, AND IMMUNOMODULATORS (6-
MERCAPTOPURINE AND AZATHIOPRINE).
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
REVATIO

DRUG NAME
REVATIO | SILDENAFIL

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
CONCOMITANT USE OF ORGANIC NITRATES

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF FUNCTIONAL CLASS 2, 3, OR 4 PULMONARY ARTERIAL HYPERTENSION.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION

REVLIMID

DRUG NAME

REVLIMID

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF MULTIPLE MYELOMA. DX OF NON-HODGKIN LYMPHOMA (NHL) RELAPSED, REFRACTORY, PROGRESSIVE DISEASE, OR MEMBERS WHO ARE NOT CANDIDATES FOR HIGH DOSE THERAPY. DX OF MYELODYSPLASTIC SYNDROMES (MDS) EITHER WITH A DELETION 5Q CYTOGENETIC ABNORMALITY WITH OR WITHOUT ADDITIONAL CYTOGENETIC ABNORMALITIES OR WITH NO DELETION 5Q CYTOGENETIC ABNORMALITY. DX OF RELAPSED, REFRACTORY, OR PROGRESSIVE MANTLE CELL LYMPHOMA WITH THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE PRIOR THERAPY INCLUDING BUT NOT LIMITED TO HYPERCVAD, NORDIC REGIMEN, CALGB REGIMEN, RCHOP/RICE, RCHOP/RDHAP, BENDAMUSTINE PLUS RITUXIMAB, CHOP PLUS RITUXIMAB, CLADRIBINE PLUS RITUXIMAB, CVP PLUS RITUXIMAB, EPOCH PLUS RITUXIMAB.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FOR MDS WITH NO DELETION 5Q CYTOGENETIC ABNORMALITY:
DOCUMENTATION OF INITIAL USE IN LOWER RISK PATIENT WITH SYMPTOMATIC ANEMIA AND SERUM ERYTHROPOIETIN LEVELS GREATER THAN 500 MU/ML AND A LOW PROBABILITY (DEFINED AS MEMBERS WHO LACK ANY OF THE FOLLOWING FEATURES: AGE LESS THAN OR EQUAL TO 60, OR THOSE WITH HYPOCELLULAR MARROW, HLA-DR 15 OR PHN CLONE POSITIVITY) OF RESPONSE TO
IMMUNOSUPPRESSIVE THERAPY OR DOCUMENTATION OF LOWER RISK PATIENT WITH SYMPTOMATIC ANEMIA AND NO RESPONSE TO INITIAL TREATMENT WITH EPOETIN ALFA OR DARBOPOETIN ALFA, HYPMETHYLATING AGENTS, OR IMMUNOSUPPRESSIVE THERAPY.
PRIOR AUTHORIZATION GROUP DESCRIPTION
RISPERDAL CONSTA

DRUG NAME
RISPERDAL CONSTA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF SCHIZOPHRENIA

AGE RESTRICTIONS
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTED HISTORY OF POOR ADHERENCE TO ORAL MEDICATIONS AND DOCUMENTATION THAT PATIENT EDUCATION TO IMPROVE ADHERENCE HAS BEEN ATTEMPTED.
PRIOR AUTHORIZATION GROUP DESCRIPTION

RITUXAN

DRUG NAME
RITUXAN

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF RHEUMATOID ARTHRITIS MADE IN ACCORDANCE WITH THE AMERICAN COLLEGE OF RHEUMATOLOGY CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF RA & DOCUMENTATION OF THE NUMBER OF SWOLLEN OR TENDER JOINTS PRIOR TO INITIATING THERAPY WITH A MINIMUM DOCUMENTED JOINT COUNT OF GREATER THAN FOUR SWOLLEN OR TENDER JOINTS BASED ON A 28 JOINT COUNT. DX OF CHRONIC LYMPHOID LEUKEMIA USED IN COMBO WITH FLUDARABINE & CYCLOPHOSPHAMIDE. DX OF MICROSCOPIC POLYARTERITIS NODOSA USED IN COMBO WITH GLUCOCORTICOIDS. DX OF NON-HODGKINS LYMPHOMA, DIFFUSE, LARGE B-CELL, CD20-POSITIVE USED IN COMBO FOR 1ST LINE TREATMENT. DX OF NON-HODGKINS LYMPHOMAS, FOLLICULAR, CD20-POSITIVE, B-CELL, IN COMBO WITH 1ST LINE CHEMO AND AS SINGLE-AGENT MAINTENANCE. DX OF NON-HODGKINS LYMPHOMA, LOW-GRADE, CD20-POSITIVE, B-CELL, STABLE OR RESPONSIVE TO PRIOR CVP (CYCLOPHOSPHAMIDE, VINCristINE, AND PREDNISONE) CHEMO. DX OF NON-HODGKINS LYMPHOMA, RELAPSED OR REFRACTORY, LOW-GRADE OR FOLLICULAR, CD20-POSITIVE, B-CELL. DX OF WEGENER'S GRANULOMATOSIS IN COMBO WITH GLUCOCORTICOIDS.

AGE RESTRICTIONS
FOR RA - MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS
FOR RA - RHEUMATOLOGIST

COVERAGE DURATION
FOR RA - ONE COURSE OF THERAPY. ALL OTHER DIAGNOSES - REMAINDER OF CONTRACT YEAR.
OTHER CRITERIA

FOR RA - DOCUMENTATION OF AN INADEQUATE RESPONSE TO A MINIMUM 3 MONTH TRIAL OF HUMIRA AND ENBREL. ONE COURSE OF THERAPY IS DEFINED AS TWO INFUSIONS GIVEN ON DAY 1 AND ANOTHER ON DAY 15. ADDITIONAL COURSES MAY BE CONSIDERED MEDICALLY NECESSARY IF AT LEAST 6 MONTHS HAS ELAPSED SINCE THE PREVIOUS TREATMENT COURSE AND DOCUMENTATION OF IMPROVEMENT
PRIOR AUTHORIZATION GROUP DESCRIPTION
RUXOLITINIB

DRUG NAME
JAKAFI

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF INTERMEDIATE OR HIGH-RISK MYELOFIBROSIS, INCLUDING PRIMARY MYELOFIBROSIS, POST-POLYCYTHEMIA VERA MYELOFIBROSIS OR POST-ESSENTIAL THROMBOCYTHEMIA MYELOFIBROSIS AND PLATELET COUNT GREATER THAN OR EQUAL TO 100 X 1000000000 (10 TO THE 9TH POWER) / L AND SPLENOMEGALY AS MEASURED BY CT, MRI, OR ULTRASOUND AND BASELINE TOTAL SYMPTOM SCORE AS MEASURED BY THE MODIFIED MYELOFIBROSIS SYMPTOM ASSESSMENT FORM (MFSAF)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
CONTINUED COVERAGE EVERY 6 MONTHS WILL REQUIRE MEDICAL RECORD DOCUMENTATION OF PLATELET COUNT GREATER THAN OR EQUAL TO 50 X 10(9) / L AND REDUCTION FROM PRETREATMENT BASELINE OF AT 35% IN SPLEEN VOLUME AS MEASURED BY CT, MRI, OR ULTRASOUND OR A 50% OR GREATER REDUCTION IN THE TOTAL SYMPTOM SCORE FROM BASELINE AS MEASURED BY THE MODIFIED MYELOFIBROSIS SYMPTOM ASSESSMENT FORM (MFSAF)
PRIOR AUTHORIZATION GROUP DESCRIPTION
SABRIL

DRUG NAME
SABRIL

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
INFANTILE SPASMS - 1 MONTH TO 2 YEARS OF AGE

PRESCRIBER RESTRICTIONS
NEUROLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR REFRACTORY COMPLEX PARTIAL SEIZURES MUST BE ON CONCOMMITANT THERAPY WITH ANOTHER SEIZURE CONTROL MEDICATION
PRIOR AUTHORIZATION GROUP DESCRIPTION
SAPHRIS

DRUG NAME
SAPHRIS

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF BIPOLAR DISORDER OR SCHIZOPHRENIA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
MEDICAL RECORD DOCUMENTATION OF TRIAL ON TWO FORMULARY ALTERNATIVES (ABILIFY, GEODON, RISPERIDONE, SEROQUEL, OR ZYPREXA).
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
SIMPONI

DRUG NAME
SIMPONI

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF RHEUMATOID ARTHRITIS AND BEING USED IN CONJUNCTION WITH METHOTREXATE OR DX OF PSORIATIC ARTHRITIS OR DX OF ANKYLOSING SPONDYLITIS OR DX OF MODERATE TO SEVERE ULCERATIVE COLITIS WITH FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO HUMIRA.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
FOR RA, PSORIATIC ARTHRITIS, AND ANKYLOSING SPONDYLITIS: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ENBREL AND HUMIRA. FOR CONTINUED THERAPY. MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.
PRIOR AUTHORIZATION GROUP DESCRIPTION

SIMPONI ARIA

DRUG NAME

SIMPONI ARIA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

FOR DX OF RHEUMATOID ARTHRITIS BEING USED IN CONJUNCTION WITH METHOTREXATE

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ENBREL AND HUMIRA. FOR CONTINUED THERAPY. MEDICAL RECORD DOCUMENTATION SHOWING MAINTENANCE OR IMPROVEMENT OF CONDITION.
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
SIMVASTATIN 40MG AND 80MG

DRUG NAME
SIMVASTATIN

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
PRIOR AUTHORIZATION APPLIES ONLY IF THERE IS CONCURRENT USE OF AMIODARONE AND THE DOSE OF SIMVASTATIN EXCEEDS 20MG/DAY. IF THE MEMBER IS NOT CONCURRENTLY RECEIVING AMIODARONE, PRIOR AUTHORIZATION WILL NOT BE REQUIRED.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO PRAVASTATIN AND ROSUVASTATIN IF CONCURRENT USE OF AMIODARONE
PRIOR AUTHORIZATION GROUP DESCRIPTION

SLEEPERS

DRUG NAME
ZALEPLON | ZOLPIDEM TARTRATE | ZOLPIDEM TARTRATE ER

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION AND QUANTITY LIMIT APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION. REQUESTS FOR GREATER THAN 90 DAYS CUMULATIVE USE WITHIN THE PAST 365 DAYS WILL REQUIRE FAILURE ON, CONTRAINDICATION TO, OR IN TOLERANCE TO ROZEREM AND SILENOR.
PRIOR AUTHORIZATION GROUP DESCRIPTION
SOMATULINE DEPOT

DRUG NAME
SOMATULINE DEPOT

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF ACROMEGALY

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
INADEQUATE RESPONSE OR CONTRAINDICATION TO SURGERY AND/OR RADIOTHERAPY
PRIOR AUTHORIZATION GROUP DESCRIPTION
SORIATANE

DRUG NAME
SORIATANE

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF SEVERE PSORIASIS WITH AT LEAST 10% BSA OR DISEASE OF PALMS OR SOLES OF FEET IMPAIERING ADL OR DOCUMENTATION OF USE AS CHEMOPREVENTION OF SKIN CANCERS IN HIGH-RISK RENAL TRANSPLANT RECIPIENTS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
FOR PSORIASIS: PRESCRIBED BY DERMATOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR PSORIASIS: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE TOPICAL CORTICOSTEROID AND AT LEAST 2 TO 3 MONTHS OF METHOTREXATE OR PHOTOTHERAPY.
PRIOR AUTHORIZATION GROUP DESCRIPTION
SPRYCEL

DRUG NAME
SPRYCEL

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF CML OR PH+ ALL

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
FOR CML - DOCUMENTATION OF THE USE OF SPRYCEL TO TREAT CHRONIC PHASE CML OR DOCUMENTATION OF THE USE OF SPRYCEL TO TREAT CML WITH RESISTANCE OR INTOLERANCE TO PRIOR THERAPY INCLUDING GLEEVEC. FOR PH+ ALL - DOCUMENTATION OF THE USE OF SPRYCEL TO TREAT PH+ ALL WITH RESISTANCE OR INTOLERANCE TO PRIOR THERAPY.
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
STELARA

DRUG NAME
STELARA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF MODERATE TO SEVERE PLAQUE PSORIASIS WITH AT LEAST 10% BSA OR DISEASE OF PALMS OR SOLES OF FEET IMPAIRING ADL

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
DERMATOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
DOCUMENTATION OF AN INADEQUATE RESPONSE TO A MINIMUM 3 MONTH TRIAL OF HUMIRA AND ENBREL OR REMICADE
PRIOR AUTHORIZATION GROUP DESCRIPTION
STIVARGA

DRUG NAME
STIVARGA

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF METASTATIC COLORECTAL CANCER OR DOCUMENTATION OF LOCALLY ADVANCED, UNRESECTABLE OR METASTATIC GASTROINTESTINAL STROMAL TUMOR (GIST).

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
FOR METASTATIC COLORECTAL CANCER: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO THREE OF THE FOLLOWING PRIOR THERAPIES (BASED ON CLINICAL TRIAL DESIGN) - FLUOROPYRIMIDINE BASED CHEMO, OXALIPLATIN BASED CHEMO, IRINOTECAN BASED CHEMO, ANTI-VEGF THERAPY (BEVACIZUMAB) OR IF KRAS WILD TYPE AN ANTI-EGFR THERAPY (CETUXIMAB OR PANITUMUMAB). FOR GIST: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO IMATINIB MESYLATE (GLEEVEC) AND SUNITINIB MALATE (SUTENT).
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
STRATTERA

DRUG NAME
STRATTERA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF ADD/ADHD

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
SULFONYLUREAS HRM

DRUG NAME
CHLORPROPAMIDE | GLYBURIDE | GLYBURIDE MICRONIZED | GLYBURIDE-METFORMIN HCL

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION AND WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINdicATION TO BOTH GLIMEPIRIDE AND GLIPIZIDE
PRIOR AUTHORIZATION GROUP DESCRIPTION

SUTENT

DRUG NAME
SUTENT

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ONCOLOGIST

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
IF DIAGNOSIS IS GASTROINTESTINAL STROMAL TUMOR THERE MUST BE A FAILURE ON, CONTRAINDICATION TO, OR INTOLERANCE TO IMATINIB
PRIOR AUTHORIZATION GROUP DESCRIPTION
SYLATRON

DRUG NAME
SYLATRON 4-PACK

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MELANOMA WITH MICROSCOPIC OR GROSS NODAL INVOLVEMENT WITHIN 84 DAYS OF DEFINITIVE SURGICAL RESECTION INCLUDING COMPLETE LYMPHADENECTOMY

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ONCOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
SYMLIN

DRUG NAME
SYMLINPEN 120 | SYMLINPEN 60

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE TO ACHIEVE DESIRED CONTROL DESPITE OPTIMAL MEALTIME INSULIN THERAPY, WHICH MAY BE WITH OR WITHOUT A CONCURRENT SULFONYLUREA AND/OR METFORMIN FOR THOSE WITH TYPE 2 DM
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
SYNRIBO

DRUG NAME
SYNRIBO

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CHRONIC OR ACCELERATED PHASE CHRONIC MYELOID LEUKEMIA (CML)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OR MORE TYROSINE KINASE INHIBITORS (GLEEVEC, SPRYCEL, TASIGNA, BOSULIF)
PRIOR AUTHORIZATION GROUP DESCRIPTION

TAFINLAR

DRUG NAME
TAFINLAR

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF UNRESECTABLE OR METASTATIC MELANOMA WITH BRAF V600E MUTATION AS DETECTED BY AN FDA APPROVED TEST

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ONCOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
NO PRIOR THERAPEUTIC FAILURE WITH A BRAF INHIBITOR THERAPY (ZELBORAF (VEMURAFENIB) OR TAFINLAR (DABRAFENIB)) OR MEK INHIBITOR THERAPY SUCH AS MEKINIST. THE FDA APPROVED TEST FOR BRAF V600E MUTATION IS THE THXID BRAF KIT.
PRIOR AUTHORIZATION GROUP DESCRIPTION

TARCEVA

DRUG NAME
TARCEVA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DOCUMENTATION OF LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH FAILURE OF 1 PRIOR CHEMOTHERAPY OR LOCALLY ADVANCED, UNRESECTABLE, OR METASTASIZED PANCREATIC CANCER IN COMBO THERAPY WITH GEMCITABINE

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
TASIGNA

DRUG NAME
TASIGNA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF NEW DIAGNOSED (NOT PREVIOUSLY TREATED) CHRONIC PHASE PH+ CML. DX OF CHRONIC OR ACCELERATED PHASE PH+ CML IN PATIENT'S RESISTENT TO, OR INTOLERANT TO PRIOR THERAPY INCLUDING GLEEVEC.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
DRUG NAME
AMITRIPTYLINE HCL | AMOXAPINE | IMIPRAMINE HCL | IMIPRAMINE PAMOATE | TRIMIPRAMINE MALEATE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION AND WILL REQUIRE TRIAL ON TWO FORMULARY ALTERNATIVES INCLUDING NOTRTRIPTYLINE AND DESIPRAMINE
PRIOR AUTHORIZATION GROUP DESCRIPTION
THIORIDAZINE HRM

DRUG NAME
THIORIDAZINE HCL

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION AND WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ATYPICAL ANTIPSYCHOTICS (OLANZAPINE, RISPERIDONE, QUETIAPINE, ZIPRASIDONE, ABILIFY)
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
TOBI

DRUG NAME
TOBI PODHALER

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF CYSTIC FIBROSIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PULMONOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Prior Authorization Requirements

Effective Date: 09/01/2014

Prior Authorization Group Description

Torisel

Drug Name
Torisel

Covered Uses
All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

Required Medical Information
DX of Advanced Renal Cell Carcinoma

Age Restrictions

Prescriber Restrictions
Oncologist

Coverage Duration
Remainder of Contract Year

Other Criteria
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
TRACLEER

DRUG NAME
TRACLEER

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF FUNCTIONAL CLASS 2, 3, OR 4 PULMONARY ARTERIAL HYPERTENSION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
TREANDA

DRUG NAME
TREANDA

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF CHRONIC LYMPHOCYTIC LEUKEMIA (CLL) AS A SINGLE AGENT FOR FIRST LINE THERAPY OR AS A SINGLE AGENT WITH OR WITHOUT RITUXIMAB FOR SECOND LINE THERAPY WITH DOCUMENTATION THAT 17P DELETION HAS BEEN TESTED AS IS NOT PRESENT. DX OF NON-HODGKIN'S LYMPHOMA AS A SECOND LINE THERAPY WITH OR WITHOUT RITUXIMAB WITH DOCUMENTATION OF DISEASE PROGRESSION DURING OR WITHIN 6 MONTHS OF TREATMENT WITH RITUXIMAB OR A RITUXIMAB-CONTAINING REGIMEN. DX OF MANTLE CELL LYMPHOMA AS A SECOND LINE THERAPY WITH OR WITHOUT RITUXIMAB WITH DOCUMENTATION OF RELAPSED OR REFRACTORY MANTLE CELL LYMPHOMA.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
TROKENDI XR

DRUG NAME
QUDEXY XR | TROKENDI XR

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINICATION TO TWO FORMULARY ALTERNATIVES, ONE OF WHICH MUST BE TOPIRAMATE.
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
TYKERB

DRUG NAME
TYKERB

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF HER2 ADVANCED OR METASTATIC BREAST CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ONCOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
MUST BE USED CONCURRENTLY WITH CAPECITABINE OR LETROZOLE. PRIOR THERAPY WITH AN ANTHRACYCLINE, A TAXANE, AND TRASTUZUMAB.
PRIOR AUTHORIZATION GROUP DESCRIPTION
TYSABRI

DRUG NAME
TYSABRI

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
COMBINATION THERAPY WITH IMMUNOSUPPRESSANTS (E.G. 6-MERCAPTOPURINE, AZATHIOPRINE, CYCLOSPORINE, METHOTREXATE) OR INHIBITORS OF TNF-A

REQUIRED MEDICAL INFORMATION
DX OF RELAPSING/REMITTING MS OR SECONDARY PROGRESSIVE MS WITH CURRENT RELAPSE, DOCUMENTATION OF TYSABRI BEING USED AS MONOTHERAPY AND THERAPEUTIC FAILURE ON, IntOLERANCE TO, OR CONTRAINDICATION TO THERAPY WITH COPAXONE, BETASERON, OR AVONEX. DX OF CROHN'S DISEASE: 18 YEARS OF AGE AND OLDER, DIAGNOSIS OF MODERATE TO SEVERE CROHN'S AND DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ADEQUATE FIRST LINE THERAPY INCLUDING ONE OF THE FOLLOWING AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, METHOTREXATE, SULFASALAZINE, LEFLUNOMIDE, CUPRIMINE, RIDAURA, AND 12 WEEKS OF HUMIRA THERAPY.

AGE RESTRICTIONS
FOR CROHN'S DISEASE - MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Prior Authorization Requirements

Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
TYVASO

DRUG NAME
TYVASO

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF FUNCTIONAL CLASS 3 PULMONARY ARTERY HYPERTENSION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: REVATIO, TRACLEER OR VENTAVIS
PRIOR AUTHORIZATION GROUP DESCRIPTION
VANDETANIB

DRUG NAME
CAPRELSA

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MEDULLARY THYROID CANCER IN PATIENTS WITH UNRESECTABLE, LOCALLY ADVANCED, OR METASTATIC DISEASE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
VECTIBIX

DRUG NAME
VECTIBIX

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF EGFR-EXPRESSING METASTATIC COLORECTAL CANCER WITH DISEASE PROGRESSION ON (OR INTOLEANCE OR CONTRAINDICATION TO) FLUOROPYRIMIDINE, OXALIPLATIN, AND IRINOTECAN CONTAINING CHEMOTHERAPY REGIMENS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF KRAS TESTING PERFORMED PRIOR TO THERAPY VERIFYING KRAS WILDTYPE (NEGATIVE)
PRIOR AUTHORIZATION GROUP DESCRIPTION

VELCADE

DRUG NAME
VELCADE

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF MULTIPLE MYELOMA. DX OF MANTLE CELL LYMPHOMA WITH DISEASE PROGRESSION AFTER FAILURE OF ONE PRIOR THERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
1 YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
VEMURAFENIB

DRUG NAME
ZELBORAF

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF UNRESECTABLE OR METASTATIC MELANOMA WITH BRAF V600E MUTATION AS DETECTED BY AN FDA APPROVED TEST

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ONCOLOGIST OR DERMATOLOGIST

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
THE FDA APPROVED TEST FOR BRAF V600E MUTATION IS THE COBAS 4800 BRAF V600 MUTATION TEST
Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
VENTAVIS

DRUG NAME
VENTAVIS

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
FOR THE TREATMENT OF PRIMARY PULMONARY HYPERTENSION (WORLD HEALTH ORGANIZATION [WHO] GROUP I) IN PATIENTS WITH NEW YORK HEART ASSOCIATION (NYHA) CLASS III SYMPTOMS WITH AN ADEQUATE TRIAL OF TRACLEER AND REVATIO OR FOR THE TREATMENT OF PRIMARY PULMONARY HYPERTENSION (WORLD HEALTH ORGANIZATION [WHO] GROUP I) IN PATIENTS WITH NEW YORK HEART ASSOCIATION (NYHA) CLASS IV SYMPTOMS WITH AN ADEQUATE TRIAL OF TRACLEER.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
VICTRELIS

DRUG NAME
VICTRELIS

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF GENOTYPE 1 CHRONIC HEPATITIS C

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
11 MONTHS

OTHER CRITERIA
MUST BE USED CONCURRENTLY WITH PEGINTERFERON ALFA AND RIBAVIRIN
PRIOR AUTHORIZATION GROUP DESCRIPTION
VIIBRYD

DRUG NAME
VIIBRYD

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINICATION TO AT LEAST TWO ANTIDEPRESSANT CLASSES, ONE OF WHICH IS BUPROPION.
PRIOR AUTHORIZATION GROUP DESCRIPTION
VIMPAT

DRUG NAME
VIMPAT

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF A DIAGNOSIS OF PARTIAL ONSET SEIZURES

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO PREFERRED ALTERNATIVE ANTICONVULSANTS
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

VOTRIENT

DRUG NAME

VOTRIENT

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF ADVANCED RENAL CELL CARCINOMA WITH CLEAR CELL OR PREDOMINANTLY CLEAR CELL HISTOLOGY OR DX OF ADVANCED RENAL CELL CARCINOMA WITH NON-CLEAR CELL HISTOLOGY OR DX OF ADVANCED SOFT TISSUE SARCOMA (STS)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

FOR DX OF ADVANCED RENAL CELL CARCINOMA WITH NON-CLEAR CELL HISTOLOGY MUST HAVE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TORISEL AND EITHER SUTENT OR NEXAVAR. FOR DX OF ADVANCED SOFT TISSUE SARCOMA MUST HAVE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE PRIOR CHEMOTHERAPY TREATMENT INCLUDING BUT NOT LIMITED TO DOXORUBICIN, IFOSFAMIDE, EPIRUBICIN, GEMCITABINE, DACARBAZINE, LIPOSOMAL DOXORUBICIN, TEMOZOLOMIDE, VINORELBINE, AD REGIMEN, AIM REGIMEN, MAID REGIMEN.
PRIOR AUTHORIZATION GROUP DESCRIPTION
VPRIV

DRUG NAME
VPRIV

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF TYPE 1 GAUCHER DISEASE WITH AT LEAST ONE OF THE FOLLOWING - ANEMIA, THROMBOCYTOPENIA, BONE DISEASE, HEPATOMEGALY OR SPLENOMEGALY

AGE RESTRICTIONS
MUST BE 4 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS
METABOLIC SPECIALIST WITH EXPERIENCE TREATING GAUCHER DISEASE

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ELELYSO IF PATIENT IS 18 YEARS OF AGE OR OLDER.
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
XELJANZ

DRUG NAME
XELJANZ

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF RHEUMATOID ARTHRITIS MADE IN ACCORDANCE WITH THE AMERICAN COLLEGE OF RHEUMATOLOGY CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF RHEUMATOID ARTHRITIS AND DOCUMENTATION OF THE NUMBER OF SWOLLEN OR TENDER JOINTS PRIOR TO INITIATING THERAPY WITH A MINIMUM DOCUMENTED JOINT COUNT OF GREATER THAN FOUR SWOLLEN OR TENDER JOINTS BASED ON A 28 JOINT COUNT OR GREATER THAN SIX SWOLLEN OR TENDER JOINTS BASED ON A 68-70 JOINT COUNT

AGE RESTRICTIONS
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS
RHEUMATOLOGIST

COVERAGE DURATION
6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO HUMIRA AND ENBREL
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
XERESE

DRUG NAME
XERESE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF COLD SORES (HERPES SIMPLEX 1 OR HERPES LABIALIS)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO VALACYCLOVIR AND FAMCICLOVIR
PRIOR AUTHORIZATION GROUP DESCRIPTION
XGEVA

DRUG NAME
XGEVA

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF BONE METASTASES RELATED TO DISEASE PROGRESSION FROM A SOLID TUMOR (E.G. BREAST, PROSTATE, THYROID). DOCUMENTATION OF TREATMENT OF ADULTS OR SKELETALLY MATURE ADOLESCENTS WITH GIANT CELL TUMOR OF BONE THAT IS UNRESECTABLE OR WHERE SURGICAL RESECTION IS LIKELY TO RESULT IN SEVERE MORBIDITY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
XOLAIR

DRUG NAME
XOLAIR

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
IGE LEVEL OF GREATER THAN 30 IU AND LESS THAN 700 IU/ML, DIAGNOSIS OF MODERATE TO SEVERE PERSISTENT ASTHMA WITH EVIDENCE OR REVERSIBLE AIRWAY DISEASE, INADEQUATE CONTROL OR INTOLERANCE DESPITE 3 MONTH TRIAL OF MEDIUM TO HIGH DOSE INHALED FLOVENT OR PULMICORT, AND SEREVENT WITH MONTELUKAST, ZYFLO OR ZAFIRLUKAST, OR COMBINATION ADVAIR OR SYMBCORT AND DOCUMENTATION OF A SPECIFIC ALLERGY REACTIVITY BY POSTIVE SKIN OR BLOOD TEST FOR A SPECIFIC IGE

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ALLERGIST OR PULMONOLOGIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
KNOWN ENVIRONMENTAL TRIGGERS HAVE BEEN ELIMINATED. REVERSIBLE AIRWAY DISEASE EVIDENCED BY GREATER THAN 12% IMPROVEMENT IN FEV1 WITH AT LEAST 200 ML INCREASE OR AT LEAST A 20% OR GREATER IMPROVEMENT IN PEF AFTER ADMINISTRATION OF ALBUTEROL.
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
XTANDI

DRUG NAME
XTANDI

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF METASTATIC CASTRATION-RESISTANT PROSTATE CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST OR UROLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO DOCETAXEL AND NO PRIOR THERAPEUTIC FAILURE WITH ZYTIGA
PRIOR AUTHORIZATION GROUP DESCRIPTION
YERVOY

DRUG NAME
YERVOY

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF UNRESECTABLE STAGE III OR IV MELANOMA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
ZALTRAP

DRUG NAME
ZALTRAP

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF METASTATIC COLORECTAL CANCER THAT IS RESISTANT TO OR HAS PROGRESSED FOLLOWING AN OXALIPLATIN CONTAINING REGIMEN AND USE IN COMBINATION WITH IRINOTECAN OR FOLFIRI (5-FLUOROURACIL, LEUCOVORIN, IRINOTECAN)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
ZAVESCA

DRUG NAME
ZAVESCA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF MILD TO MODERATE TYPE 1 GAUCHER DISEASE

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR WHOM ENZYME REPLACEMENT THERAPY IS NOT A THERAPEUTIC OPTION (I.E. BECAUSE OF CONSTRAINTS SUCH AS ALLERGY, HYPERSENSITIVITY, OR POOR VENOUS ACCESS).
PRIOR AUTHORIZATION GROUP DESCRIPTION
ZORBITIVE

DRUG NAME
ZORBITIVE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
DOCUMENTATION OF ACUTE ILLNESS DUE TO COMPLICATIONS FROM OPEN HEART OR ABDOMINAL SURGERY, MULTIPLE ACCIDENT TRAUMA, OR ACUTE RESPIRATORY FAILURE.

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF CURRENT, DAILY THERAPIES WITH PARENTERAL NUTRITION (TPN OR PPN) AND/OR ENTERAL NUTRITION SUPPORT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ENDOCRINOLOGIST OR GASTROENTEROLOGIST

COVERAGE DURATION
2 MONTHS

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
ZORTRESS

DRUG NAME
ZORTRESS

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTED KIDNEY TRANSPLANT NOT COVERED BY MEDICARE OR
DOCUMENTED LIVER TRANSPLANT NOT COVERED BY MEDICARE

AGE RESTRICTIONS
MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS
PHYSICIAN EXPERIENCED IN IMMUNOSUPPRESSIVE THERAPY AND MANAGEMENT
OF TRANSPLANT PATIENTS

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA
FOR KIDNEY TRANSPLANT: ZORTRESS BEING ADMINISTERED IN COMBINATION
WITH BASILIXIMAB (SIMULECT) INDUCTION AND CONCURRENTLY WITH REDUCED
DOSES OF CYCLOSPORINE AND CORTICOSTEROIDS. FOR LIVER TRANSPLANT:
ZORTRESS BEING ADMINISTERED NO EARLIER THAN 30 DAYS POST TRANSPLANT
WITH LOW DOSE TACROLIMUS AND CORTICOSTEROIDS.
PRIOR AUTHORIZATION GROUP DESCRIPTION
ZYKADIA

DRUG NAME
ZYKADIA

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF LOCALLY ADVANCED OR METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) THAT IS ANAPLASTIC LYMPHOMA KINASE (ALK) POSITIVE AS DETECTED BY AN FDA APPROVED TEST

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ONCOLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO XALKORI
Geisinger Health Plan - 14325
Prior Authorization Requirements
Effective Date: 09/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION
ZYTIGA

DRUG NAME
ZYTIGA

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF PROSTATE CANCER WITH EVIDENCE OF METASTATIC DISEASE AND MEMBER IS NO LONGER RESPONDING TO CASTRATION OR IS HORMONE RESISTANT

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
ONCOLOGIST OR UROLOGIST

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
DOCUMENTATION THAT PREDNISONE 5MG TWICE DAILY WILL BE ADMINISTERED CONCOMITANTLY WITH ZYTIGA.
PRIOR AUTHORIZATION GROUP DESCRIPTION
ZYVOX

DRUG NAME
ZYVOX

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DX OF VANCOMYCIN RESISTANT ENTEROCOCCUS (VRE) FAECIUM. DX OF NOSOCOMIAL PNEUMONIA CAUSED BY MRSA. DX OF COMPLICATED SKIN AND SKIN STRUCTURE INFECTIONS CAUSED BY MRSA. DX OF UNCOMPlicated SKIN AND SKIN STRUCTURE INFECTION CAUSED BY STAPHYLOCOCCUS AUREUS (METHICILLIN SUSCEPTIBLE ONLY). DX OF COMMUNITY-ACQUIRED PNEUMONIA CAUSED BY STREPTOCOCCUS PNEUMONIA (PENICILLIN SUSCEPTIBLE STRAINS ONLY) OR STAPHYLOCOCCUS AUREUS (METHICILLIN-SUSCEPTIBLE STRAINS ONLY).

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION
REMAINDER OF CONTRACT YEAR

OTHER CRITERIA