Medicare
Prior Authorization Requirements

Effective: 10/01/2016
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
5HT3 ANTI-NAUSEA AGENT BVD DETERMINATION

DRUG NAME
GRANISETRON HCL | ONDANSETRON HCL | ONDANSETRON ODT

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE 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
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
ABATACEPT IV

DRUG NAME
ORENCIA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
RENEWAL: RHEUMATOID ARTHRITIS/JUVENILE IDIOPATHIC ARTHRITIS: EXPERIENCED OR MAINTAINED 20% OR GREATER IMPROVEMENT IN TENDER AND SWOLLEN JOINT COUNT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: RHEUMATOLOGIST. PSORIATIC ARTHRITIS: DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: DERMATOLOGIST. CROHN’S DISEASE/ULCERATIVE COLITIS: GASTROENTEROLOGIST.

COVERAGE DURATION
INITIAL: 4 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA
INITIAL: RHEUMATOID ARTHRITIS (RA)/ JUVENILE IDIOPATHIC ARTHRITIS (JIA): PREVIOUS TRIAL WITH HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH KINERET (ANAKINRA), OR A TNF (TUMOR NECROSIS FACTOR) INHIBITOR: HUMIRA, ENBREL, CIMZIA, REMICADE, SIMPONI, OR SIMPONI ARIA.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
ABATACEPT SQ

DRUG NAME
ORENCIA | ORENCIA CLICKJECT

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
RENEWAL: RHEUMATOID ARTHRITIS: EXPERIENCED OR MAINTAINED 20% OR GREATER IMPROVEMENT IN TENDER AND SWOLLEN JOINT COUNT. NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH KINERET (ANAKINRA), OR A TNF (TUMOR NECROSIS FACTOR) INHIBITOR: HUMIRA, ENBREL, CIMZIA, REMICADE, SIMPONI, OR SIMPONI ARIA.

AGE RESTRICTIONS
18 YEARS OR OLDER.

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: RHEUMATOLOGIST.

COVERAGE DURATION
INITIAL: 4 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA
INITIAL: PREVIOUS TRIAL WITH HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENTS SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH KINERET (ANAKINRA), OR A TNF (TUMOR NECROSIS FACTOR) INHIBITOR: HUMIRA, ENBREL, CIMZIA, REMICADE, SIMPONI, OR SIMPONI ARIA.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
ABIRATERONE

DRUG NAME
ZYTIGA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ADALIMUMAB

DRUG NAME

HUMIRA | HUMIRA PEDIATRIC CROHN’S | HUMIRA PEN | HUMIRA PEN CROHN-UC-HS STARTER | HUMIRA PEN PSORIASIS-UVEITIS

COVERED USES

PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
AFATINIB DIMALEATE

DRUG NAME
GILOTRIF

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
ALECTINIB

DRUG NAME
ALECENSA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
ALIROCUMAB

DRUG NAME
PRALUENT PEN | PRALUENT SYRINGE

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS
CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST

COVERAGE DURATION
INITIAL: 6 MONTHS RENEWAL 12 MONTHS

OTHER CRITERIA
MUST HAVE AN LDL CHOLESTEROL LEVEL GREATER THAN 100MG/DL ON MAXIMAL DRUG TREATMENT FOR AT LEAST 2 MONTHS AND ONE OF THE FOLLOWING DIAGNOSES: (1) HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH) DETERMINED BY SIMON BROOME DIAGNOSTIC CRITERIA FOR HEFH OR A SCORE OF 6 OR GREATER ON THE DUTCH LIPID NETWORK CRITERIA FOR HEFH OR (2) HISTORY OF ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD) AS DOCUMENTED BY PHYSICIAN ATTESTATION. PATIENT MUST NOT HAVE CONCURRENT USE OF REPATHA OR OTHER PCSK9 AGENT. INITIAL THERAPY: FOR STATIN TOLERANT PATIENTS: MUST HAVE TAKEN ATORVASTATIN OR ROSUVASTATIN FOR AT LEAST 2 MONTHS. FOR STATIN INTOLERANT PATIENTS: DOCUMENTATION OF STATIN INTOLERANCE TO ATORVASTATIN OR ROSUVASTATIN OR STATIN THERAPY AT ANY DOSE. PATIENTS
Prior Authorization Requirements

WITH CONTRAINDICATIONS TO STATINS INCLUDING ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT OR HYPERSENSITIVITY REACTIONS WILL BE APPROVED FOR PRALUENT THERAPY WITHOUT REQUIREMENT OF DOCUMENTATION OF STATIN INTOXERANCE. DOCUMENTATION OF STATIN INTOXERANCE BY ONE OF THE FOLLOWING: (1) PHYSICIAN ATTESTATION, (2) PATIENT HAS TRIED ROSUVASTATIN OR ATORVASTATIN AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY) RENEWAL CRITERIA: RECEIVING PRIOR PRALUENT THERAPY FOR AT LEAST 6 MONTHS AND NO CLAIMS FOR REPATHA, JUXTAPID, OR KYNAMRO SINCE PRALUENT APPROVAL.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
ANAKINRA

DRUG NAME
KINERET

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
RENEWAL: RHEUMATOID ARTHRITIS: EXPERIENCED OR MAINTAINED 20% OR GREATER IMPROVEMENT IN TENDER AND SWOLLEN JOINT COUNT.

AGE RESTRICTIONS
RA: 18 YEARS OR OLDER

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: RHEUMATOID ARTHRITIS: RHEUMATOLOGIST.

COVERAGE DURATION
INITIAL: RA: 4 MOS. NOMI OR CAPS: 12 MOS. RENEWAL: 12 MOS FOR ALL DIAGNOSES.

OTHER CRITERIA
INITIAL: RHEUMATOID ARTHRITIS (RA)): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: ORENCIA, XELJANZ, OR CIMZIA.. NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH A TNF (TUMOR NECROSIS FACTOR) INHIBITOR: HUMIRA, ENBREL, CIMZIA, REMICADE, SIMPONI, OR SIMPONI ARIA.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
APREMILAST

DRUG NAME
OTEZLA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: PSORIATIC ARTHRITIS: DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: DERMATOLOGIST.

COVERAGE DURATION
INITIAL: PSORIARTIC ARTHRITIS 4 MONTHS. PSORIASIS: 5 MONTHS RENEWAL: 12 MONTHS.

OTHER CRITERIA
INITIAL: PSORIATRIC ARTHRITIS (PSA): PREVIOUS TRIAL WITH HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL WITH HUMIRA AND ONE OF THE FOLLOWING CONVENTIONAL THERAPIES SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
APREPITANT BVD DETERMINATION

DRUG NAME
EMEND

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE 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
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
ASFOTASE

DRUG NAME
STRENSIQ

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
ASPARAGINASE

DRUG NAME
ONCASPAR

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
ATEZOLIZUMAB

DRUG NAME
TECENTRIQ

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
AXITINIB

DRUG NAME
INLYTA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
TRIAL OF AT LEAST ONE SYSTEMIC THERAPY FOR THE TREATMENT OF RCC SUCH AS NEXAVAR (SORAFENIB), TORISEL (TEMSIROLIMUS), SUTENT (SUNITINIB), VOTRIENT (PAZOPANIB), OR AVASTIN (BEVACIZUMAB) IN COMBINATION WITH INTERFERON.
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
BACILLUS OF CALMETTE AND GUERIN VACCINE BVD DETERMINATION

DRUG NAME
BCG (TICE STRAIN)

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE 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 Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
BEDAQUILINE FUMARATE

DRUG NAME
SIRTURO

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
24 WEEKS

OTHER CRITERIA
SIRTURO USED IN COMBINATION WITH AT LEAST 3 OTHER ANTIBIOTICS FOR IN THE TREATMENT OF PULMONARY MULTI-DRUG RESISTANT TUBERCULOSIS.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
BELIMUMAB

DRUG NAME
BENLYSTA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
AUTOANTIBODY POSITIVE LUPUS TEST.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA
INITIAL: SELENA-SELDAI SCORE GREATER THAN OR EQUAL TO 6. RENEWAL: MAINTAIN AT LEAST A 4 POINT REDUCTION IN SELENA-SELDAI SCORE FROM BASELINE. MEMBER IS CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. NO APPROVAL FOR DIAGNOSIS OF SEVERE ACTIVE LUPUS NEPHRITIS OR SEVERE CENTRAL NERVOUS SYSTEM LUPUS OR CONCURRENT USE OF BIOLOGIC AGENTS, OR INTRAVENOUS CYCLOPHOSAMIDE.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
BELINOSTAT

DRUG NAME
BELEODAQ

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
BEVACIZUMAB

DRUG NAME
AVASTIN

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
BEXAROTENE

DRUG NAME
BEXAROTENE | TARGRETIN

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
BORTEZOMIB

DRUG NAME
VELCADE

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
BOSUTINIB

DRUG NAME
BOSULIF

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
CML: BCR-ABL MUTATIONAL ANALYSIS CONFIRMING THAT BOTH T315I AND V299L MUTATIONS ARE NOT PRESENT.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
C1 ESTERASE INHIBITOR

DRUG NAME
CINRYZE

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
HEMATOLOGIST, IMMUNOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
CABOZANTINIB

DRUG NAME
COMETRIQ

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
CABOZANTINIB S-MALATE - CABOMETYX

DRUG NAME
CABOMETYX

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PATIENT HAS RECEIVED PRIOR ANTIANGIOGENIC THERAPY (E.G., SUTENT [SUNITINIB], VOTRIENT [PAZOPANIB], INLYTA [AXITINIB], NEXAVAR [SORAFENIB])
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
CANAKINUMAB

DRUG NAME
ILARIS

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
CAPS: 4 YEARS AND OLDER. SJIA: 2 YEARS AND OLDER.

PRESCRIBER RESTRICTIONS
PRESCRIBED OR SUPERVISED BY RHEUMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
CERITINIB

DRUG NAME
ZYKADIA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
POSITIVE FOR ANAPLASTIC LYMPHOMA KINASE (ALK) FUSION ONCOGENE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
CERTOLIZUMAB PEGOL

DRUG NAME
CIMZIA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
RENEWAL: RHEUMATOID ARTHRITIS/ACTIVE PSORIATIC ARTHRITIS:
EXPERIENCED OR MAINTAINED 20% OR GREATER IMPROVEMENT IN TENDER AND
SWOLLEN JOINT COUNT. FOR ANKYLOSING SPONDYLITIS: EXPERIENCED OR
MAINTAINED IMPROVEMENT OF AT LEAST 50 PERCENT OR 2 UNITS IN THE BATH
ANKYLOSING SPONDYLITIS DISEASE ACTIVITY INDEX (BASDAI).

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: RHEUMATOID ARTHRITIS/
ANKYLOSING SPONDYLITIS: RHEUMATOLOGIST. PSORIATIC ARTHRITIS:
DERMATOLOGIST OR RHEUMATOLOGIST. CROHN'S DISEASE:
GASTROENTEROLOGIST.

COVERAGE DURATION
INITIAL: RA /PSA/AS: 4 MONTHS. CD: 12 MONTHS. RENEWAL: 12 MONTHS FOR ALL
DIAGNOSES.

OTHER CRITERIA
INITIAL: RHEUMATOID ARTHRITIS (RA)/PSORIATRIC ARTHRITIS (PSA)/: TRIAL OF
HUMIRA AND PREVIOUS TRIAL WITH ONE DMARD (DISEASE-MODIFYING
ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE,
HYDROXYCHLOROQUINE, OR SULFASALAZINE. ANKYLOSING SPONDYLITIS: TRIAL
Moda Health Plan, Inc.

Prior Authorization Requirements

OF HUMIRA. CROHN'S DISEASE (CD): PREVIOUS TRIAL WITH HUMIRA AND ONE OF THE FOLLOWING CONVENTIONAL AGENTS SUCH AS CORTICOSTEROIDS (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPOURINE, METHOTREXATE, OR MESALAMINE). NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH ANOTHER TNF INHIBITORS (HUMIRA, ENBREL, CIMZIA, REMICADE, SIMPONI, OR SIMPONI ARIA) OR ANY OTHER BIOLOGIC DMARDS (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENTS SUCH AS (ACTEMRA, KINERET, STELARA, COSENTYX, ENTYVIO, TYSABRI, ORENCIA, OR RITUXAN).
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
CLOBAZAM

DRUG NAME
ONFI

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA

TRIAL OF LAMOTRIGINE OR TOPIRAMATE. REQUESTS FOR ORAL SUSPENSION APPROVABLE IF PATIENT IS UNABLE TO SWALLOW OR IS UNDER THE AGE OF 5 YEARS.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
COBIMETINIB FUMARATE

DRUG NAME
COTELLCIC

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
CORTICOSTEROID BVD DETERMINATION

DRUG NAME
CORTISONE ACETATE | DEXAMETHASONE | HYDROCORTISONE |
METHYLPREDNISOLONE | PREDNISOLONE SODIUM PHOSPHATE | PREDNISONE

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE 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
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
CRIZOTINIB

DRUG NAME
XALKORI

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
LOCALLY ADVANCED OR METASTATIC NON SMALL CELL LUNG CANCER IS ANAPLASTIC LYMPHOMA KINASE POSITIVE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
CYCLOPHOSPHAMIDE BVD DETERMINATION

DRUG NAME
CYCLOPHOSPHAMIDE

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE 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
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
DABRAFENIB MESYLATE

DRUG NAME
TAFINLAR

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
DACLATASVIR

DRUG NAME
DAKLINZA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS
GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

COVERAGE DURATION
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

OTHER CRITERIA
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF THE PREFERRED FORMULARY ALTERNATIVE EPCLUSA OR HARVONI WHERE AN EPCLUSA OR HARVONI REGIMEN IS LISTED AS AN ACCEPTABLE REGIMEN FOR THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. NO APPROVALS FOR CONCURRENT USE OF ANY OF THESE (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER) MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, OR RIFAMPIN.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
DALFAMPRIDINE

DRUG NAME
AMPYRA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
WALKING DISABILITY SUCH AS MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS OR UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
NEUROLOGIST

COVERAGE DURATION
INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA
RENEWAL: PATIENT HAS EXPERIENCED OR MAINTAINED AT LEAST 15% IMPROVEMENT IN WALKING ABILITY.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
DARATUMUMAB

DRUG NAME
DARZALEX

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

EXCLUSION CRITERIA
CONCURRENT THERAPY WITH A PROTEASOME INHIBITOR OR AN IMMUNOMODULATORY AGENT

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
Dasatinib

DRUG NAME
SPRYCEL

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PREVIOUSLY TREATED CML REQUIRES MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS FOLLOWING BCR-ABL MUTATIONAL ANALYSIS - T315I, V299L, T315A, F317L/V/I/C.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
DICHLORPHENAMIDE

DRUG NAME
KEVEYIS

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

EXCLUSION CRITERIA
HEPATIC INSUFFICIENCY, PULMONARY OBSTRUCTION, OR A HEALTH CONDITION THAT WARRANTS CONCURRENT USE OF HIGH-DOSE ASPIRIN

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
18 YEARS AND OLDER

PRESCRIBER RESTRICTIONS
PRESCRIPTION IS WRITTEN BY OR CURRENTLY SUPERVISED BY A NEUROLOGIST

COVERAGE DURATION
INITIAL: 2 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA
RENEWAL REQUIRES THE PATIENT EXPERIENCED AT LEAST TWO FEWER ATTACKS PER WEEK FROM THEIR BASELINE
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
DICLOFENAC EPOLAMINE

DRUG NAME
FLECTOR

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
DROXIDOPA

DRUG NAME
NORTHERA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
3 MONTHS

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
ELBASVIR/GRAZOPREVIR

DRUG NAME
ZEPATIER

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.

EXCLUSION CRITERIA
MODERATE TO SEVERE LIVER IMPAIRMENT (CHILD PUGH B OR C)

REQUIRED MEDICAL INFORMATION
HCV RNA LEVEL. FOR GENOTYPE 1A : TESTING FOR NS5A RESISTANCE-
ASSOCIATED POLYMORPHISMS.

AGE RESTRICTIONS
18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS
GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN
SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A
SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY
HEALTHCARE OUTCOMES) MODEL.

COVERAGE DURATION
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.

OTHER CRITERIA
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.
NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT THE PATIENT
HAS LIFE EXPECTANCY OF LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED
COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE
RECOMMENDATIONS). APPROVAL REQUIRES THAT THE PATIENT HAS EVIDENCE
Prior Authorization Requirements

OF HEPATITIS C INFECTION (AT LEAST 1 DETECTABLE HCV RNA LEVEL) WITHIN THE PAST 6 MONTHS. A PREVIOUS TRIAL OF HARVONI OR EPCLUSA IS REQUIRED UNLESS THE PATIENT HAS STAGE 4 OR 5 CHRONIC KIDNEY DISEASE. PATIENT MUST NOT BE CONCURRENTLY TAKING ANY OF THE FOLLOWING: PHENYTOIN, CARBAMAZEPINE, RIFAMPIN, EFAVIRENZ, ATAZANAVIR, DARUNAVIR, LOPINAVIR, SAQUINAVIR, TIPRANAVIR, CYCLOSPORINE, NAFCILLIN, KETOCONAZOLE, MODAFINIL, BOSENTAN, ETRAVIRINE, ELVITEGRAVIR/COBICISTAT/EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE (STRIKILD), ATORVASTATIN AT DOSES ABOVE 20MG PER DAY OR ROSUVASTATIN AT DOSES GREATER THAN 10MG PER DAY. NO CONCURRENT USE WITH SOVALDI.
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
ELIGLUSTAT TARTRATE

DRUG NAME
CERDELGA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
ELOTUZUMAB

DRUG NAME
EMPLICITI

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
ELTROMBOPAG

DRUG NAME
PROMACTA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
INITIAL: 1 MOS. RENEWAL: CLINICAL RESPONSE: 12 MOS. MAX DOSE FOR 4 WEEKS: 1 MOS. HEP C: 12 MOS.

OTHER CRITERIA
CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIA PURPURA (ITP): INITIAL: TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY. ITP: RENEWAL: PATIENT HAS A CLINICAL RESPONSE AS DEFINED BY AN INCREASE IN PLATELET COUNT OF GREATER THAN OR EQUAL TO 50 X10^9/L (GREATER THAN OR EQUAL TO 50,000 PER UL) AT THE MAX DOSE OF 75MG PER DAY FOR 4 WEEKS. HEPATITIS C: CONCURRENT INTERFERON THERAPY.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
ENDOTHELIN RECEPTOR ANTAGONISTS

DRUG NAME
LETAIRIS | OPSUMIT | TRACLEER

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PREScriber restrictions
CARDIOLOGIST OR PULMONOLOGIST.

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
ENZALUTAMIDE

DRUG NAME
XTANDI

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
TRIAL OF ZYTIGA (ABIRATERONE ACETATE) IS REQUIRED IN PATIENTS WHO DO NOT HAVE A CONTRAINDICATION OR INTOLERANCE TO PREDNISONE.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
ERLOTINIB

DRUG NAME
TARCEVA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
ERYTHROPOIESIS STIMULATING AGENTS - EPOETIN ALFA

DRUG NAME
EPOGEN | PROCRIT

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL OFF LABEL ANEMIA IN HEPATITIS C BEING TREATED IN COMBINATION WITH RIBAVIRIN AND AN INFERFERON ALFA OR PEGINTERFERON ALFA.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
INITIAL: CHRONIC RENAL FAILURE (CRF) AND ANEMIA RELATED TO ZIDOVUDINE THERAPY REQUIRES HEMOGLOBIN LEVEL LESS THAN 10G/DL, CANCER CHEMOTHERAPY REQUIRES HEMOGLOBIN LESS THAN 11 G/DL OR HEMOGLOBIN LEVEL HAS DECREASED AT LEAST 2G/DL BELOW BASELINE, ANEMIA DUE TO CONCURRENT HEPATITIS C TREATMENT WITH RIBAVIRIN AND INTERFERON ALFA/PEGINTERFERON ALFA REQUIRES HEMOGLOBIN LESS THAN 10G/DL AND RIBAVIRIN DOSE REDUCTION (UNLESS CONTRAINDICATED), ELECTIVE NONCARDIAC OR NONVASCULAR SURGERY REQUIRES HEMOGLOBIN LESS THAN 13G/DL RENEWAL: CRF HEMOGLOBIN LEVELS LESS THAN 10 G/DL IF NOT ON DIALYSIS AND LESS THAN 11 G/DL IF ON DIALYSIS OR HEMOGLOBIN HAS REACHED 11 G/DL IF ON DIALYSIS AND DOSE REDUCTION/INTERUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS OR HEMOGLOBIN HAS REACHED 10 G/DL IF NOT ON DIALYSIS AND DOSE REDUCTION/INTERUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CANCER CHEMOTHERAPY OR ANEMIA DUE TO CONCURRENT HEPATITIS C TREATMENT WITH RIBAVIRIN AND INTERFERON ALFA/PEGINTERFERON ALFA OR ANEMIA DUE TO ZIDOVUDINE THERAPY REQUIRES HEMOGLOBIN LEVELS BETWEEN 10 AND 12 G/DL.

AGE RESTRICTIONS
Prior Authorization Requirements

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
ANEMIA FROM MYELOSUPPRESSIVE CHEMO/CKD W/O DIALYSIS/ZIDOVUDINE: 12 MOS. SURGERY: 1 MO. HEP C: 6 MOS.

OTHER CRITERIA
ALL INDICATIONS: TRIAL OF PROCRIT. PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
ERYTHROPOIESIS STIMULATING AGENTS - MIRCERA

DRUG NAME
MIRCERA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

CHRONIC RENAL FAILURE: INITIAL: HEMOGLOBIN LEVELS LESS THAN 10 G/DL
RENEWAL: HEMOGLOBIN LEVELS LESS THAN 10 G/DL IF NOT ON DIALYSIS AND
LESS THAN 11 G/DL IF ON DIALYSIS OR HEMOGLOBIN HAS REACHED 11 G/DL IF ON
DIALYSIS AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE
NEED FOR BLOOD TRANSFUSIONS OR HEMOGLOBIN HAS REACHED 10 G/DL IF NOT
ON DIALYSIS AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE
NEED FOR BLOOD TRANSFUSIONS.

AGE RESTRICTIONS

PREScriber restrictions

COVERAGE DURATION

ANEMIA DUE TO CKD WITH OR WITHOUT DIALYSIS: 12 MONTHS.

OTHER CRITERIA

TRIAL OF PROCRIT. PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A
PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ETANERCEPT

DRUG NAME
ENBREL

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

EXCLUSION CRITERIA
PATIENT IS NOT CURRENTLY TAKING KINERET (ANAKINRA) OR ORENCIA (ABATACEPT).

REQUIRED MEDICAL INFORMATION
INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECT THE HANDS, FEET, OR GENITAL AREA. RENEWAL: RHEUMATOID ARTHRITIS/JUVENILE IDIOPATHIC ARTHRITIS/PSORIATIC ARTHRITIS: EXPERIENCED OR MAINTAINED 20 PERCENT OR GREATER IMPROVEMENT IN TENDER OR SWOLLEN JOINT COUNT WHILE ON THERAPY. ANKYLOSING SPONDYLITIS: EXPERIENCED OR MAINTAINED IMPROVEMENT OF AT LEAST 50 PERCENT OR 2 UNITS IN THE BATH ANKYLOSING SPONDYLITIS DISEASE ACTIVITY INDEX (BASDAI). PLAQUE PSORIASIS: ACHIEVED OR MAINTAINED CLEAR OR MINIMAL DISEASE OR A DECREASE IN PSORIASIS AREA AND SEVERITY INDEX (PASI) OF AT LEAST 50% OR MORE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: RHEUMATOLOGIST. PSORIATIC ARTHRITIS: DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: DERMATOLOGIST.

COVERAGE DURATION
INITIAL: RA /PJIA: 3 MONTHS. PSA/AS/PSO: 4 MONTHS. RENEWAL: 12 MONTHS FOR ALL DIAGNOSES.
OTHER CRITERIA

Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
EVEROLIMUS

DRUG NAME
AFINITOR | AFINITOR DISPERZ

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
ADVANCED RENAL CELL CARCINOMA (RCC): TRIAL OF OR CONTRAINDICATION TO SUTENT OR NEXAVAR.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

EVOLOCUMAB

DRUG NAME

REPATHA PUSHTRONEX | REPATHA SURECLICK | REPATHA SYRINGE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

HEFH OR ASCVD: 18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST

COVERAGE DURATION

INITIAL: 6 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

FOR HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH) OR Atherosclerotic Cardiovascular Disease (ASCVD): MUST HAVE LDL LEVEL GREATER THAN 100MG/DL ON MAXIMAL DRUG TREATMENT (MDT) FOR AT LEAST 2 MOS AND ONE OF THE FOLLOWING: (1) HEFH DETERMINED BY SIMON BROOME DIAGNOSTIC (SBD) CRITERIA OR A SCORE OF 6 OR GREATER ON THE DUTCH LIPID NETWORK (DLN) CRITERIA OR (2) ASCVD AS SUBSTANTIATED BY PHYSICIAN ATTESTATION. FOR HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HOFH): LDL LEVEL GREATER THAN 100MG/DL ON MDT FOR AT LEAST 2 MOS AND HOFH DETERMINED BY ONE OF THE FOLLOWING: 1) SBD CRITERIA, 2) A SCORE OF 8 OR GREATER ON THE DLN CRITERIA, OR 3) A CLINICAL DIAGNOSIS BASED ON A HISTORY OF AN UNTREATED LDL-C CONCENTRATION GREATER THAN 500 MG/DL TOGETHER WITH EITHER XANTHOMA BEFORE 10 YEARS OF AGE, OR EVIDENCE OF
Prior Authorization Requirements

HEFH IN BOTH PARENTS. NO CONCURRENT USE OF OTHER PCSK9 INHIBITORS.
INITIAL THERAPY: FOR STATIN TOLERANT PTS: MUST HAVE TRIED MAXIMALLY TOLERATED DOSE OF HIGH INTENSITY STATIN SUCH AS ATORVASTATIN OR ROSUVASTATIN. FOR STATIN INTOLERANT PTS WITH HEFH OR ASCVD: ONE OF THE FOLLOWING MUST BE MET: PHYSICIAN ATTESTATION OF STATIN INTOLERANCE (INCLUDING BUT NOT LIMITED TO MYOPATHY), OR PATIENT HAS TRIED ROSUVASTATIN OR ATORVASTATIN AT ANY DOSE. PTS WITH CONTRAINdicATIONS TO STATINS INCLUDING ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT OR HYPERSENSITIVITY REACTIONS WILL BE APPROVED FOR REPATHA THERAPY WITHOUT DOCUMENTED STATIN INTOLERANCE. FOR STATIN INTOLERANT PTS WITH HOFH: MUST BE ON MAX TOLERATED LIPID-LOWERING THERAPY INCLUDING ONE OF THE FOLLOWING: EZETIMIBE, NIacin, BILE ACID SEQUESTRANT, LDL APHERESIS, LOMITAPIDE OR MIpomerSEN. QUALIFIERS MUST PROVIDE DOCUMENTATION OF STATIN INTOLERANCE TO ONE OF THE FOLLOWING: A HIGH INTENSITY STATIN (ROSUVASTATIN OR ATORV) OR OTHER STATIN THERAPY AT ANY DOSE. STATIN INTOLERANT PATIENTS MUST BE ON MAXIMAL LIPID-LOWERING MEDICATION (NON-STATIN THERAPY) FOR AT LEAST 2 MONTHS WITH DOCUMENTATION OF STATIN INTOLERANCE TO ATORVASTATIN OR ROSUVASTATIN OR STATIN THERAPY AT ANY DOSE. DOCUMENTATION OF STATIN INTOLERANCE INCLUDES: (1) PHYSICIAN ATTESTATION, OR (2) PATIENT HAS TRIED ROSUVASTATIN OR ATORVASTIN AND HAS EXPERIENCED SKELETAL MUSCLE RELATED EVENTS (E.G. MYOPATHY). RENEWAL CRITERIA: RECEIVING PRIOR REPATHA THERAPY FOR AT LEAST 6 MONTHS AND NOT ON CONCURRENT THERAPY WITH OTHER PCSK9 INHIBITORS, MIpomerSEN, OR LOMITapIDE.
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
FENTANYL NASAL SPRAY

DRUG NAME
LAZANDA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
CANCER: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION (SUCH AS MORPHINE SULFATE SR, OXYCODONE SR, OR FENTANYL). EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE (1) IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT (SUCH AS MORPHINE SULFATE IR, OXYCODONE/ASPIRIN, OXYCODONE/ACETAMINOPHEN, CODEINE/ACETAMINOPHEN, HYDROMORPHONE, OR MEPERIDINE) OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES AND TRIAL OR CONTRAINDICATION TO GENERIC FENTANYL CITRATE LOZENGE.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
FENTANYL TRANSMUCOSAL AGENTS - FENTANYL CITRATE

DRUG NAME
FENTANYL CITRATE

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
CANCER: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE
OPIOID PAIN MEDICATION (SUCH AS MORPHINE SULFATE SR, OXYCODONE SR, OR
FENTANYL). EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE (1)
IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT (SUCH AS MORPHINE SULFATE IR,
OXYCODONE/ASPIRIN, OXYCODONE/ACETAMINOPHEN,
CODEINE/ACETAMINOPHEN, HYDROMORPHONE, OR MEPERIDINE) OR MEMBER
HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
GEFITINIB

DRUG NAME
IRESSA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
GLYCEROL PHENYL BUTYRATE

DRUG NAME
RAVICTI

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PREScriber restrictions

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
TRIAL OF OR CONTRAINDICATION TO SODIUM PHENYL BUTYRATE (BUPHENYL).
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
GOLIMUMAB IV

DRUG NAME
SIMPONI ARIA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
RHEUMATOID ARTHRITIS. RENEWAL: AT LEAST 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT.

AGE RESTRICTIONS
18 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: RHEUMATOLOGIST.

COVERAGE DURATION
INITIAL: 4 MOS RENEWAL: 12 MOS

OTHER CRITERIA
INITIAL: PREVIOUS TRIAL HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENT: ORENCIA, XELJANZ, OR CIMZIA. NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH ORENCIA OR KINERET.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
GOLIMUMAB SQ

DRUG NAME
SIMPONI

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
RENEWAL: ACTIVE RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS: MAINTAINED OR EXPERIENCED GREATER THAN 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT. ANKYLOSING SPONDYLITIS: MAINTAINED OR EXPERIENCED GREATER THAN 20% IMPROVEMENT IN ANKYLOSING SPONDYLITIS (ASAS20) CRITERIA.

AGE RESTRICTIONS
18 YEARS OR OLDER

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: RHEUMATOLOGIST. PSORIATIC ARTHRITIS: DERMATOLOGIST OR RHEUMATOLOGIST. ULCERATIVE COLITIS: GASTROENTEROLOGIST.

COVERAGE DURATION
INITIAL: RA/PSA/AS: 4 MONTHS. UC: 12 MONTHS RENEWAL: 12 MONTHS FOR ALL DIAGNOSES.

OTHER CRITERIA
INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: ORENCIA, XELJANZ, OR CIMZIA. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL WITH
Prior Authorization Requirements

HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: CIMZIA OR OTEZLA. ANYKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL WITH HUMIRA ULCERATIVE COLITIS (UC): PREVIOUS TRIAL WITH HUMIRA AND ONE OF THE FOLLOWING CONVENTIONAL AGENTS SUCH AS CORTICOSTEROIDS (I.E., BUDESONIDE, METHYL PREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH ORENCIA OR KINERET.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
HEPATITIS B VACCINE BVD DETERMINATION

DRUG NAME
ENGEX-B ADULT | ENGEX-B PEDIATRIC-ADOLESCENT | RECOMBIVAX HB

COVERED USES

THIS DRUG MAY BE COVERED UNDER MEDICARE 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
HIGH RISK DRUGS IN THE ELDERLY - ANTI-INFECTIVE

DRUG NAME
NITROFURANTOIN | NITROFURANTOIN MONO-MACRO

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
TRIAL OF (UNLESS CONTRAINDICATED) OF SULFAMETHOXAZOLE/TRIMETHOPRIM (TMP-SMX) OR TRIMETHOPRIM.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS -
BENZTROPINE_TRIHEXYPHENIDYL

DRUG NAME
BENZTROPINE MESYLATE | TRIHEXYPHENIDYL HCL

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.
PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - HYDROXYZINE

DRUG NAME
HYDROXYZINE HCL | HYDROXYZINE PAMOATE

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. SEASONAL/PERENNIAL ALLERGIC RHINITIS.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PREScriber restrictions

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: TRIAL OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE. ANXIETY: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - BUSPIRONE, PAROXETINE, DULOXETINE, OR VENLAFAXINE.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - PROMETHAZINE

DRUG NAME
PHENADOZ | PROMETHAZINE HCL | PROMETHEGAN

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: TRIAL OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE. MOTION SICKNESS: TRIAL OR CONTRAINDICATION TO MECLIZINE.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - BARBITURATE COMBINATIONS

DRUG NAME
ASCOMP WITH CODEINE | BUTALB-ACETAMINOPH-CAFF-CODEIN | BUTALB-CAFF-ACETAMINOPH-CODEIN | BUTALBITAL COMPOUND-CODEINE | BUTALBITAL-ACETAMINOPHEN | BUTALBITAL-ACETAMINOPHEN-CAFFE | BUTALBITAL-ASPIRIN-CAFFEINE | TENCON | ZEBUTAL

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
6 MONTHS

OTHER CRITERIA
PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - CARDIOVASCULAR

DRUG NAME
GUANFACINE HCL

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
HYPERTENSION: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - BENAZEPRL, BENAZEPRL/HYDROCHLOROTHIAZIDE, CAPTOPRIL, CAPTOPRIL/HYDROCHLOROTHIAZIDE, ENALAPRIL, ENALAPRIL/HYDROCHLOROTHIAZIDE, FOSINOPRIL, FOSINOPRIL/HYDROCHLOROTHIAZIDE, L LISINOPRIL, L LISINOPRIL/HYDROCHLOROTHIAZIDE, QUINAPRIL, QUINAPRIL/HYDROCHLOROTHIAZIDE, RAMIPRIL, MOEXIPRIL, MOEXIPRIL/HYDROCHLOROTHIAZIDE, PERINDOPRIL ERBUMINE, QUINAPRIL, QUINAPRIL/HYDROCHLOROTHIAZIDE, TRANDOLAPRIL, TRANDOLAPRIL/VERAPAMIL, LOSARTAN, LOSARTAN/HYDROCHLOROTHIAZIDE, IRBESARTAN, IRBESARTAN/HYDROCHLOROTHIAZIDE, OLMESARTAN, OLMESARTAN/HYDROCHLOROTHIAZIDE,
Prior Authorization Requirements

OLEMSARTAN/AMILODIPINE/HYDROCHLOROTHIAZIDE, VALSARTAN, VALSARTAN/HYDROCLOROTHIAZIDE, DILTIAZEM HCL, DILTIAZEM SUSTAINED RELEASE, VERAPAMIL, VERAPAMIL SUSTAINED RELEASE, ATENOLOL, ATENOLOL/HCLORTHALIDONE, BISOPROLOL, BISOPROLOL/HYDROCHLOROTHIAZIDE, CARVEDILOL, METOPROLOL TARTRATE, NADOLOL, ACEBUTOLOL, BETAXOLOL, LABETAOL, METOPROLOL SUCCINATE, METOPROLOL/HYDROCHLOROTHIAZIDE, PINDOLOL, PROPRANOLOL, PROPRANOLOL/HYDROCHLOROTHIAZIDE, SOTALOL, TIMOLOL MALEATE.
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - CENTRAL NERVOUS SYSTEM - THIORIDAZINE

DRUG NAME
THIORIDAZINE HCL

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
65 YEARS AND OLDER: SCHIZOPHRENIA - PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER. PRIOR AUTHORIZATION APPLIES TO NEW START ONLY
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - DIGOXIN

DRUG NAME
DIGITEK | DIGOX | DIGOXIN | LANOXIN

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DIGOXIN LEVEL

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
APPROVAL FOR MEMBERS STABLE ON DOSES GREATER THAN 125 MCG PER DAY WITH DOCUMENTED THERAPEUTIC DIGOXIN LEVEL TAKEN WITHIN THE PAST YEAR.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - ESTROGEN

DRUG NAME
COMBIPATCH | DUAVEE | ESTRADIOL | ESTRADIOL-NORETHINDRONE ACETAT | ESTROPIPATE | MENEST | MIMVEY | MIMVEY LO | PREMARIN | PREMPHASE | PREMPRO

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS LABELED AS HIGH RISK FOR PATIENTS 65 YEARS AND OLDER.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - SULFONYLUREAS

DRUG NAME
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
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PREScriBER RESTRICTIONS

Coverage Duration
12 MONTHS

OTHER CRITERIA
TRIAL OF GLIMEPIRIDE, GLIPIZIDE, OR PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS LABELED AS HIGH RISK FOR PATIENTS 65 YEARS AND OLDER
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - NON-BENZODIAZEPINE

DRUG NAME
ESZOPICLONE | 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
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
TRIAL OF SILENOR AND ROZEREM OR PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS LABELED AS HIGH RISK FOR PATIENTS 65 YEARS AND OLDER
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - SKELETAL MUSCLE RELAXANTS

DRUG NAME
CARISOPRODOL | CHLORZOXAZONE | CYCLOBENZAPRINE HCL | METAXALL | METAXALONE | METHOCARBAMOL

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
HIGH RISK DRUGS IN THE ELDERLY - TCA

DRUG NAME
AMITRIPTYLINE HCL | CLOMIPRAMINE HCL | DOXEPIN HCL | IMIPRAMINE HCL | IMIPRAMINE PAMOATE | PERPHENAZINE-AMITRIPTYLINE | SURMONTIL | TRIMIPRAMINE MALEATE

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. MIGRAINE HEADACHE AND POST-HERPETIC NEURALGIA.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
APPLIES TO MEMBERS 65 YEARS AND OLDER FOR THE FOLLOWING: MIGRAINE PROPHYLAXIS: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - PROPRANOLOL, TIMOLOL, TOPIRAMATE, VALPROIC ACID, OR DIVALPROEX. DEPRESSION: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - PAROXETINE, SERTRALINE, VENLAFAXINE, DULOXETINE, CITALOPRAM, ESCITALOPRAM, FLUOXETINE, OR TRAZODONE. POSTHERPERTIC NEURALGIA: TRIAL OR CONTRAINDICATION TO GABAPENTIN OR PREGABALIN. PRIOR AUTHORIZATION APPLIES TO NEW START ONLY.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
HYDROXYPROGESTERONE CAPROATE-DELALUTIN GENERIC

DRUG NAME
HYDROXYPROGESTERONE CAPROATE

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
IBRUTINIB

DRUG NAME
IMBRUVICA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
IDELALISIB

DRUG NAME
ZYDELIIG

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
IMATINIB MESYLATE

DRUG NAME
IMATINIB MESYLATE

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
ALL DIAGNOSIS: 12 MONTHS. ADJUVANT GIST TREATMENT (TWICE DAILY DOSE): 36 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
IMIQUIMOD - ALDARA

DRUG NAME
IMIQUIMOD

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. MOLLUSCUM CONTAGIOSUM, AND LETIGO MALIGNA.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: ACTINIC KERATOSIS, MOLLUSCUM CONTAGIOSUM: DERMATOLOGIST ONLY. SUPERFICIAL BASAL CELL CARCINOMA/LETIGO MALIGNA: DERMATOLOGIST OR ONCOLOGIST ONLY.

COVERAGE DURATION
4 MONTHS

OTHER CRITERIA
EXTERNAL GENITAL WARTS: TRIAL OF OR CONTRAINDICATION TO PODOFILOX (CONDYLOX) 0.5% TOPICAL SOLUTION. ACTINIC KERATOSIS BRAND DRUG REQUEST: TRIAL OF GENERIC IMIQUIMOD 5% CREAM. SUPERFICIAL BASAL CELL CARCINOMA: LESS THAN 2CM IN SIZE AND NOT ON THE FACE. MOLLUSCUM CONTAGIOSUM LIMITED TO THE FACE.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
IMMUNE GLOBULIN BVD DETERMINATION

DRUG NAME
CARIMUNE NF NANOFILTERED | FLEBOGAMMA DIF | GAMASTAN S-D | GAMMAGARD LIQUID | GAMMAPLEX | OCTAGAM | PRIVIGEN

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE 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
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
IMMUNOSUPPRESSANT BVD DETERMINATION

DRUG NAME
ASTAGRAF XL | AZATHIOPRINE | AZATHIOPRINE SODIUM | CELLCEPT |
CYCLOSPORINE | CYCLOSPORINE MODIFIED | ENVARSUS XR | GENGRAF |
MYCOPHENOLATE MOFETIL | MYCOPHENOLIC ACID | NULOJIX | PROGRAF |
RAPAMUNE | SIROLIMUS | TACROLIMUS | ZORTRESS

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE 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
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
INFLIXIMAB

DRUG NAME
REMICADE

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
INITIAL: PLACER PSORIASIS: MODERATE TO SEVERE PLACER PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECT THE HANDS, FEET, OR GENITAL AREA. RENEWAL: RHEUMATOID/PSORIATIC ARTHRITIS: MAINTAINED OR EXPERIENCED GREATER THAN 20% IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT. PLACER PSORIASIS: MAINTAINED OR EXPERIENCED PASI OF GREATER THAN 50% OR SIGNIFICANT IMPROVEMENT IN QUALITY OF LIFE OBSERVED BY PHYSICIAN AND PATIENT. ANKYLOSING SPONDYLISTIS: MAINTAINED OR EXPERIENCED IMPROVEMENT OF AT LEAST 50%, OR 2 UNITS (SCALE OF 1-10), IN THE BATH ANKYLOSING SPONDYLISTIS DISEASE ACTIVITY INDEX (BASDAI) OR IMPROVEMENT OF AT LEAST 20% IN THE ASSESSMENT IN ANKYLOSING SPONDYLISTIS (ASAS20) CRITERIA.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLISTIS: RHEUMATOLOGIST. PSORIATIC ARTHRITIS: DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: DERMATOLOGIST. CROHN’S DISEASE/ULCERATIVE COLITIS: GASTROENTEROLOGIST.

COVERAGE DURATION
CD/UC: 8 MO. OTHER INDICATIONS INITIAL: 4 MO RENEWAL: 12 MO
OTHER CRITERIA

INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: ORENCIA, XELJANZ, OR CIMZIA.

PSORIATRIC ARTHRITIS (PSA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: CIMZIA OR OTEZLA. ANKYLOSING SPONDYLITIS: HUMIRA FOLLOWED BY CIMZIA. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: COSENTYX OR OTEZLA.

CROHNS DISEASE (CD): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY CIMZIA. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY SIMPONI. NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH KINERET (ANAKINRA), ORENCIA (ABATACEPT), ACTEMRA (TOCILIZUMAB) OR ANOTHER TNF (TUMOR NECROSIS FACTOR) INHIBITOR: HUMIRA, ENBREL, CIMZIA, REMICADE, SIMPONI, OR SIMPONI ARIA.
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
INFUSIBLE DRUG BVD DETERMINATION

DRUG NAME
ABELCET | ACYCLOVIR SODIUM | ADRUCIL | AMBISOME | AMPHOTERICIN B | BLEOMYCIN SULFATE | DOXORUBICIN HCL LIPOSOME | FLUOROURACIL | GANCICLOVIR SODIUM | IFOSFAMIDE | METHOTREXATE | REMODULIN

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE 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
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
INTERFERON ALFA-2B

DRUG NAME
INTRON A

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
FOR HEPATITIS C INDICATION GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST). FOR OTHER FDA APPROVED INDICATIONS, NO REQUIREMENT.

COVERAGE DURATION
INITIAL HEP C AND ALL OTHER DX: 6 MOS. RENEWAL HEP C AND ALL DX: 6 MOS.

OTHER CRITERIA
CRITERIA APPLIES TO NEW STARTS ONLY. DURATION LIMITATION OF 1 YEAR OF THERAPY EXCEPT 18 MONTHS FOR FOLLICULAR LYMPHOMA. FOR HEPATITIS C INDICATION REQUIRES A TRIAL OF PEGINTERFERON ALFA 2A OR PEGINTERFERON ALFA 2B. HEP C: DRUG MUST BE USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDIATED. TRIAL OF OR CONTRAINDICATION TO PEGINTERFERON ALFA-2A OR PEGINTERFERON ALFA-2B. GENOTYPE 1, 2, 3, 4, 5, OR 6.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
IPILIMUMAB

DRUG NAME
YERVOY

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL: UNRESECTABLE/METASTATIC MELANOMA: 3 MO ADJUVANT MELANOMA: 6 MO RENEWAL: ADJUVANT MELANOMA: 6 MO

OTHER CRITERIA

RENEWAL FOR ADJUVANT MELANOMA: NO EVIDENCE OF DISEASE RECURRENCE (DEFINED AS THE APPEARANCE OF ONE OR MORE NEW MELANOMA LESIONS: LOCAL, REGIONAL OR DISTANT METASTASIS)
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

IVACAFTOR

DRUG NAME
KALYDECO

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

EXCLUSION CRITERIA
HOMOZYGOUS FOR F508DEL MUTATION IN CFTR GENE.

REQUIRED MEDICAL INFORMATION
CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.

AGE RESTRICTIONS
6 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
IVACAFTOR - GRANULE PACKETS

DRUG NAME
KALYDECO

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

EXCLUSION CRITERIA
F508DEL MUTATION IN CFTR GENE.

REQUIRED MEDICAL INFORMATION
CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS. PATIENT WEIGHT.

AGE RESTRICTIONS
2 YEARS OF AGE TO 5 YEARS OF AGE

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
IXAZOMIB

DRUG NAME
NINLARO

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
IXEKIZUMAB

DRUG NAME
TALTZ AUTOINJECTOR | TALTZ SYRINGE

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PLAQUE PSORIASIS: ACHIEVED OR MAINTAINED CLEAR OR MINIMAL DISEASE OR A DECREASE IN PSORIASIS AREA AND SEVERITY INDEX (PASI) OF AT LEAST 50% OR MORE

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PLAQUE PSORIASIS (PSO): THERAPY PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST

COVERAGE DURATION
INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA
INITIAL PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: COSENTYX OR OTEZLA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
LEDIPASVIR-SOFOSBUVIR

DRUG NAME
HARVONI

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
HCV RNA LEVEL.

AGE RESTRICTIONS
18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: GASTROENTEROLOGIST,
INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT
OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO
(EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

COVERAGE DURATION
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

OTHER CRITERIA
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT PATIENT HAS
LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED
COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE
RECOMMENDATION). HCV RNA LEVEL WITHIN PAST 6 MONTHS. PATIENT IS NOT
CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE,
PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN,
Moda Health Plan, Inc.

Prior Authorization Requirements

RIFAPENTINE, ROSUVASTATIN, SIMEPREVIR, SOFOSBUVIR (AS A SINGLE AGENT), STRIBILD (ELVITAGRAVIR/COBICISTAT/EMTRICITABINE /TENOFOVIR), OR TIPRANAVIR/RITONAVIR.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
LENALIDOMIDE

DRUG NAME
REVLIMID

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
LENVATINIB MESYLATE

DRUG NAME
LENVIMA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
LIDOCAINE

DRUG NAME
LIDOCAINE

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL COVERAGE CONSIDERATION FOR DIABETIC NEUROPATHY OR CANCER PAIN.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
LOMITAPIDE

DRUG NAME
JUXTAPID

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
USE IN COMBINATION WITH OTHER LIPID LOWERING TREATMENTS SUCH AS A STATIN (EXAMPLE: SIMVASTATIN, ATORVASTATIN), FENOFIBRATE, NIACIN, ETC.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
LUMACAFTOR-IVACAFTOR

DRUG NAME
ORKAMBI

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS. BASELINE FEV1.

AGE RESTRICTIONS
12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT

COVERAGE DURATION
INITIAL: 6 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA
INITIAL: BASELINE FEV1 OF AT LEAST 40 PERCENT. NOT CONCURRENTLY TAKING KALYDECO THERAPY. RENEWAL: MAINTAINED OR IMPROVEMENT IN FEV1 OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS OR IMPROVEMENT IN BODY MASS INDEX (BMI).
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
MEPOLIZUMAB

DRUG NAME
NUCALA

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

EXCLUSION CRITERIA
CONCURRENT USE OF XOLAIR

REQUIRED MEDICAL INFORMATION
BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE LAST 6 WEEKS OR GREATER THAN OR EQUAL TO 300 CELLS/MCL WITHIN THE LAST 12 MONTHS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY MEDICINE

COVERAGE DURATION
INITIAL 24 WEEKS. RENEWAL 12 MONTHS

OTHER CRITERIA
INITIAL THERAPY: PATIENT CURRENTLY TREATED WITH A MAXIMALLY TOLERATED DOSE OF INHALED CORTICOSTEROIDS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION WHICH INCLUDES ANY OF THE FOLLOWING: LONG-ACTING INHALED BETA2-AGONIST, LONG-ACTING MUSCARINIC ANTAGONIST, A LEUKOTRIENE RECEPTOR ANTAGONIST, THEOPHYLLINE, OR ORAL CORTICOSTEROID. RENEWAL REQUIRES DOCUMENTATION THAT THE PATIENT HAS EXPERIENCED AT LEAST A 25 PERCENT REDUCTION IN ASTHMA EXACERBATIONS (FOR EXAMPLE, HOSPITALIZATIONS, URGENT OR EMERGENT
Prior Authorization Requirements

CARE VISITS, USE OF RESCUE MEDICATIONS, ETC.) FROM BASELINE AND A
REDUCTION IN ORAL CORTICOSTEROID DOSE (IF THE PATIENT WAS ON A
MAINTENANCE REGIMEN OF ORAL CORTICOSTEROIDS AT THE INITIATION OF
TREATMENT).
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
METHOTREXATE BVD DETERMINATION

DRUG NAME
METHOTREXATE | TREXALL

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE 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 Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
METHYLNALTREXONE

DRUG NAME
RELISTOR

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
ADVANCED ILLNESS: CONSTIPATION DUE TO OPIOIDS CHRONIC NON-CANCER PAIN: HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
6 MONTHS FOR PATIENTS RECEIVING PALLIATIVE CARE, 12 MONTHS FOR CHRONIC NON-CANCER PAIN.

OTHER CRITERIA
ADVANCED ILLNESS (OR TERMINAL ILLNESS): PATIENT IS RECEIVING PALLIATIVE CARE. CHRONIC NON-CANCER PAIN: HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS, PREVIOUS TRIAL (UNLESS CONTRAINDICATED) WITH MOVANTIK.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
MIFEPRISTONE

DRUG NAME
KORLYM

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
MIPOMERSEN

DRUG NAME
KYNAMRO

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

EXCLUSION CRITERIA
PATIENT IS CONCURRENTLY RECEIVING LDL APHERESIS.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
USE IN COMBINATION WITH A STATIN (EXAMPLE: SIMVASTATIN, ATORVASTATIN), BILE ACID SEQUESTRANT FENOFIBRATE OR NIACIN.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
MODAFINIL AND ARMODAFINIL - NUVIGIL

DRUG NAME
ARMODAFINIL

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PREScriber RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
NARCOLEPSY: TRIAL OF AT LEAST ONE OF THE FOLLOWING (UNLESS ALL ARE CONTRAINDICATED): AMPHETAMINE-DEXTROAMPHETAMINE IR, DEXTROAMPHETAMINE SULFATE IR, DEXTROAMPHETAMINE SULFATE ER, METHYLPHENIDATE IR OR METHYLPHENIDATE ER.
PRIOR AUTHORIZATION GROUP DESCRIPTION
NATALIZUMAB

DRUG NAME
TYSABRI

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
CROHNS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST.

OVERAGE DURATION
MULTIPLE SCLEROSIS: 12 MONTHS. CROHNS DISEASE: 6 MONTHS. RENEWAL: CROHNS: 12 MONTHS.

OTHER CRITERIA
MULTIPLE SCLEROSIS: TRIAL OF ONE OF THE FOLLOWING PREFERRED AGNETS FOR MULTIPLE SCLEROSIS: COPAXONE, REBIF, AVONEX, PLEGIRIDY, TEDFIDERA, OR AUBAGIO. CROHNS DISEASE: TRIAL OF A HUMIRA FOLLOWED BY CIMZIA. NOT APPROVED FOR PATINETS ON CONCURRENT THERAPY WITH A TNF (TUMOR NECROSIS FACTOR) INHIBITOR: ENBREL, CIMZIA, REMICADE, SIMPONI, OR SIMPONI ARIA.
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
NEBULIZER BVD DETERMINATION

DRUG NAME
ACETYLCYSTEINE | ALBUTEROL SULFATE | BETHKIS | CROMOLYN SODIUM | IPRATROPIUM BROMIDE | IPRATROPIUM-ALBUTEROL | NEBUPENT | PULMOZYME | TOBRAMYCIN | TYVASO | VIRAZOLE

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE 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
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
NETUPITANT-PALOSETRON BVD DETERMINATION

DRUG NAME
AKYNZEO

COVERED USES
THIS DRUG MAY BE COVERED UNDER MEDICARE 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
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
NILOTINIB

DRUG NAME
TASIGNA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PREVIOUSLY TREATED CML REQUIRES MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS FOLLOWING BCR-ABL MUTATIONAL ANALYSIS - T315I, Y253H, E255K/V, F359V/C/I.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
NINTEDANIB ESYLATE

DRUG NAME
OFEV

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-
RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION
OF SURGICAL LUNG BIOPSY AND HRCT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
NOT APPROVED FOR PATIENTS WITH OTHER KNOWN CAUSES OF INTERSTITIAL
LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR
BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS,
RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS
OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV)
INFECTION, VIRAL HEPATITIS, AND CANCER. NOT APPROVED IF PATIENT HAS NOT
OBTAINED LIVER FUNCTION TESTS.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
NIVOLUMAB

DRUG NAME
OPDIVO

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
MELANOMA: OPDIVO IS NOT APPROVED FOR COMBINATION THERAPY WITH TAFINLAR OR ZELBORAF.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
OBETICHOLIC ACID

DRUG NAME
OCALIVA

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

EXCLUSION CRITERIA
PATIENTS WITH COMPLETE BILIARY OBSTRUCTION.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
OLAPARIB

DRUG NAME
LYNPARZA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
OMACETAXINE

DRUG NAME
SYNRIBO

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
INDUCTION: 3 MONTHS. POST INDUCTION/RENEWAL: 3 TO 12 MONTHS

OTHER CRITERIA
CML INDUCTION THERAPY: TRIAL OF OR CONTRAINDICATION TO AT LEAST TWO OF THE FOLLOWING GLEEVEC, SPRYCEL, TASIGNA, BOSULIF, OR ICLUSIG. DETERMINATION FOR THERAPY LENGTH OF APPROVAL THAT IS NOT INDUCTION THERAPY WILL DEPEND ON THE PATIENTS HEMATOLOGIC RESPONSE (DEFINED AS ABSOLUTE NEUTROPHIL COUNT (ANC) GREATER THAN OR EQUAL TO 1.5 X 10^9/L AND PLATELETS GREATER THAN OR EQUAL TO 100 X 10^9/L AND NO BLOOD BLASTS OR BONE MARROW BLASTS LESS THAN 5%). IF MEETS HEMATOLOGIC RESPONSE CRITERIA APPROVAL WILL BE 12 MONTHS. IF HEMATOLOGIC RESPONSE CRITERIA IS NOT MET APPROVAL WILL BE FOR 3 MONTHS.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
OMALIZUMAB

DRUG NAME
XOLAIR

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA FOR ASTHMA: PATIENT MEETS THE CRITERIA OF MODERATE TO SEVERE ASTHMA, POSITIVE SKIN PRICK OR RAST TEST, FEV1 LESS THAN 80%, DEMONSTRATED INADEQUATELY CONTROLLED SYMPTOMS ON INHALED CORTICOSTEROIDS AND SECOND ASTHMA CONTROLLER, BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30IU/ML. RENEWAL CRITERIA FOR ASTHMA: PATIENT REDUCED EXACERBATIONS BY AT LEAST 25% FROM BASELINE, REDUCTION IN ORAL OR INHALED CORTICOSTEROID USE FROM BASELINE

AGE RESTRICTIONS
CIU (CHRONIC IDIOPATHIC URTICARIA): 12 YEARS OF AGE OR OLDER. ASTHMA: 6 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A SPECIALIST IN ALLERGY OR PULMONARY MEDICINE.

COVERAGE DURATION
INITIAL: ASTHMA: 12 MONTHS, CIU: 6 MONTHS, RENEWAL: 12 MONTHS.

OTHER CRITERIA
FOR CIU: TRIAL OF A HIGH DOSE H1 ANTI-HISTAMINE (LEVOCETIRIZINE) FOR AT LEAST 2 WEEKS AND STILL EXPERIENCES HIVES ON MOST DAYS OF THE WEEK.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
OMBITASVIR-PARITAPREVIR-RITONAVIR

DRUG NAME
TECHNIVIE

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.

EXCLUSION CRITERIA
CIRRHOSIS, MODERATE OR SEVERE LIVER IMPAIRMENT (CHILD-PUGH B OR C)

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS
GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

COVERAGE DURATION
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

OTHER CRITERIA
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE. NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT THE PATIENT HAS A LIFE EXPECTANCY OF LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATIONS). APPROVAL REQUIRES THAT THE PATIENT HAS EVIDENCE OF HEPATITIS C INFECTION (AT LEAST 1 DETECTABLE HCV RNA LEVEL) WITHIN THE PAST 6 MONTHS. THE PATIENT MUST HAVE HAD A PREVIOUS TRIAL OF
Moda Health Plan, Inc.

Prior Authorization Requirements

HARVONI OR EPCLUSA. MUST BE USED CONCURRENTLY WITH RIBAVIRIN UNLESS THE PATIENT IS TREATMENT NAIVE AND HAS A CONTRAINDICATION TO RIBAVIRIN. THE PATIENT MUST NOT BE CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER): ALFUZOSIN, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, RIFAMPIN, ERGOTAMINE DIHYDROERGOTAMINE, ERGONOVINE, METHYLERGONOVINE, ETHINYL Estradiol-CONTAINING MEDICATIONS (SUCH AS COMBINED ORAL CONTRACEPTIVES, NUVARING, ORTHO EVRA OR XULANE TRANSDERMAL PATCH SYSTEM), LOVASTATIN, SIMVASTATIN, PIMOZIDE, EFAVIRENZ (ATRIPLA, SUSTIVA), SILDENAFIL (DOSE OF 20MG AND/OR DOSED TID FOR PAH), TRIAZOLAM, ORAL MIDAZOLAM, LOPINAVIR/RITONAVIR, RILPIVIRINE, SALMETEROL.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
OMBITASVIR-PARITAPREVIR-RITONAVIR-DASABUVIR

DRUG NAME
VIEKIRA PAK

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.

EXCLUSION CRITERIA
DECOMPENSATED CIRRHOSIS, SEVERE LIVER IMPAIRMENT (CHILD-PUGH C).

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS
GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

COVERAGE DURATION
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

OTHER CRITERIA
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT THE PATIENT HAS A LIFE EXPECTANCY OF LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATIONS). APPROVAL REQUIRES THAT THE PATIENT HAS EVIDENCE OF HEPATITIS C INFECTION (AT LEAST ONE DETECTABLE HCV RNA LEVEL) WITHIN THE PAST 6 MONTHS. APPROVAL REQUIRES THAT THE PATIENT HAS AN
Prior Authorization Requirements

INABILITY TO TOLERATE HARVONI OR EPCLUSA. CONCURRENT RIBAVIRIN USE IS REQUIRED WHEN RECOMMENDED BY AASLD/IDSA. PATIENTS WITH GENOTYPE 1B WITH OR WITHOUT CIRRHOSIS (TREATMENT NAÏVE AND TREATMENT EXPERIENCED): APPROVAL FOR FULL 12 WEEKS. PATIENTS WITH GENOTYPE 1A WHO DO NOT HAVE CIRRHOSIS (TREATMENT NAIVE AND TREATMENT EXPERIENCED): APPROVAL FOR FULL 12 WEEKS. PATIENTS WITH GENOTYPE 1A WITH CIRRHOSIS (TREATMENT NAÏVE AND TREATMENT EXPERIENCED): APPROVAL FOR FULL 24 WEEKS. PATIENT MUST NOT BE CONCURRENTLY TAKING ANY OF THE FOLLOWING: ALFUZOSIN, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, GEMFIBROZIL, RIFAMPIN, ERGOTAMINE DIHYDROERGOTAMINE, ERGONOVINE, METHYLERGONOVINE, ETHINYL ESTRADIOL-CONTAINING MEDICATIONS (SUCH AS COMBINED ORAL CONTRACEPTIVES, NUVARING, ORTHO EVRA OR XULANE TRANSDERMAL PATCH SYSTEM), LOVASTATIN, SIMVASTATIN, PIMOZIDE, EFAVIRENZ, SILDENAFIL, TRIAZOLAM, ORAL MIDAZOLAM, DARUNAVIR/RITONAVIR, LOPINAVIR/RITONAVIR, RILPIVIRINE, SALMETEROL.
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
OPIOID DEPENDENCY AGENTS

DRUG NAME
BUPRENORPHINE HCL | BUPRENORPHINE-NALOXONE | ZUBSOLV

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

EXCLUSION CRITERIA
PATIENT CURRENTLY TAKING OPIOID ANALGESICS.

REQUIRED MEDICAL INFORMATION
PSYCHOSOCIAL COUNSELING

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBING PHYSICIAN MUST BE CERTIFIED TO PRESCRIBE BUPRENORPHINE FOR OPIOID DEPENDENCE.

COVERAGE DURATION
BUPRENORPHINE: 1 WEEK. RENEWAL: 6 MOS. BUPRENOR/NALOX: 6 MOS

OTHER CRITERIA
CONTINUATION OF THERAPY WITH BUPRENORPHINE: CONTRAINDICATION OR UNABLE TO TOLERATE NALOXONE IN COMBINATION WITH BUPRENORPHINE.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
OSIMERTINIB MESYLATE

DRUG NAME
TAGRISSO

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

EXCLUSION CRITERIA
CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
PALBOCICLIB

DRUG NAME
IBRANCE

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
PANOBINOSTAT

DRUG NAME
FARYDAK

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
PARATHYROID HORMONE

DRUG NAME
NATPARA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
PAZOPANIB

DRUG NAME
VOTRIENT

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

DRUG NAME
ADCIRCA | SILDENAFIL | SILDENAFIL CITRATE

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
CARDIOLOGIST OR PULMONOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
REQUEST FOR ADCIRCA REQUIRE TRIAL OR CONTRAINDICATION TO REVATIO.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
PEG-INTERFERON ALFA-2A

DRUG NAME
PEGASYS | PEGASYS PROCLICK

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTIONS
N/A

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST).

COVERAGE DURATION
HEP B: 48 WEEKS HEP C: CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.

OTHER CRITERIA
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE. HEPATITIS C: CONCURRENT USE OF RIBAVIRIN IS REQUIRED (UNLESS CONTRAINDIANTED).
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
PEG-INTERFERON ALFA-2B

DRUG NAME
PEGINTRON

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTIONS
N/A

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST).

COVERAGE DURATION
HEP B: 48 WEEKS HEP C: CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.

OTHER CRITERIA
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE. HEPATITIS C: CONCURRENT USE OF RIBAVIRIN IS REQUIRED (UNLESS CONTRAINDICATED).
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
PEG-INTERFERON ALFA-2B-SYLATRON

DRUG NAME
SYLATRON

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
CRITERIA APPLIES TO NEW STARTS ONLY. DURATION LIMITATION OF 5 YEARS OF THERAPY.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
PEMBROLIZUMAB

DRUG NAME
KEYTRUDA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
NO CONCURRENT REQUESTS FOR YERVOY, TAFINLAR, OR ZELBORAF.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
PIMAVANSEIRIN

DRUG NAME
NUPLAZID

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
18 YEARS OR OLDER

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, GERIATRICIAN, OR A BEHAVIOURAL HEALTH SPECIALIST (SUCH AS A PSYCHIATRIST)

COVERAGE DURATION
INITIAL: 12 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA
RENEWAL REQUIRES THAT THE PATIENT HAS EXPERIENCED AN IMPROVEMENT IN PSYCHOSIS SYMPTOMS FROM BASELINE AND DEMONSTRATES A CONTINUED NEED FOR TREATMENT
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
PIRFENIDONE

DRUG NAME
ESBRIET

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
PATIENT WITH USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
NOT APPROVED FOR PATIENTS WITH KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, AND CANCER). NOT APPROVED IF THE PATIENT HAS NOT OBTAINED LIVER FUNCTION TESTS. NOT APPROVED IF THE PATIENT CURRENTLY SMOKE CIGARETTES.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
POMALIDOMIDE

DRUG NAME
POMALYST

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
PONATINIB

DRUG NAME
ICLUSIG

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
PRAMLINTIDE

DRUG NAME
SYMLINPEN 120 | SYMLINPEN 60

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
TYPE I OR TYPE II DIABETES: REQUIRING INSULIN OR CONTINUOUS INSULIN INFUSION (INSULIN PUMP) FOR GLYCEMIC CONTROL

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
QUININE SULFATE

DRUG NAME
QUININE SULFATE

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
RABIES VACCINE BVD DETERMINATION

DRUG NAME
IMOVAX RABIES VACCINE | RABAVERT

COVERED USES

THIS DRUG MAY BE COVERED UNDER MEDICARE 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

PRESCRIBERRestrictions

COVERAGE DURATION

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
RAMUCIRUMAB

DRUG NAME
CYRAMZA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
REGORAFENIB

DRUG NAME
STIVARGA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
FOR KRAS WILD TYPE COLORECTAL CANCER, TRIAL OR CONTRAINDICATION TO ANTI-EGFR THERAPY SUCH AS ERBITUX OR VECTIBIX. FOR COLORECTAL CANCER, TRIAL OR CONTRAINDICATION TO ANTI-VEGF THERAPY SUCH AS AVASTIN OR ZALTRAP AND A FLUOROPYRMIDINE-, OXAPLATIN- AND IRINOTECAN-BASED CHEMOTHERAPY SUCH AS FOLFOX, FOLFIRI,CAPEOX, INFUSIONAL 5-FU/LV OR CAPECITABINE, AND FOLFOXIRI. FOR GIST, A TRIAL OR CONTRAINDICATION TO GLEEVEC AND SUTENT IS REQUIRED.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
RIFAXIMIN

DRUG NAME
XIFAXAN

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
TRAVELERS DIARRHEA: 12 YEARS OR OLDER.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
TRAVELERS DIARRHEA: 1 FILL IN 1 MONTH. HEPATIC ENCEPHALOPATHY OR IBS WITH DIARRHEA: 12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
RIOCIGUAT

DRUG NAME
ADEMPAS

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
TRIAL OF OR CONTRAINDICATION TO A PHOSPHODIESTERASE-5 (PDE-5) INHIBITOR SUCH AS REVATIO OR ADCIRCA.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
RITUXIMAB

DRUG NAME
RITUXAN

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
RENEWAL: ACTIVE RHEUMATOID ARTHRITIS: GREATER THAN 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: RHEUMATOLOGIST. FOR NHL OR CLL: ONCOLOGIST.

COVERAGE DURATION
RA: INITIAL: 4 MO. RENEWAL: 12 MO NHL: 1 YEAR. CLL: 6 MO. WG, MPA: 1 MO

OTHER CRITERIA
INITIAL: RHEUMATOID ARTHRITIS: PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: ORENCIA, XELJANZ, OR CIMZIA. NON HODGKIN'S LYMPHOMA/CHRONIC LYMPHOCYTIC LEUKEMIA: USED IN COMBINATION WITH CHEMOTHERAPY. WEGNER'S GRANULOMATOSIS/MICROSCOPIC POLYANGIITIS: CONCURRENT GLUCOCORTICOID USE. NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH KINERET (ANAKINRA), ORENCIA (ABATACEPT), ACTEMRA (TOCILIZUMAB) OR ANOTHER TNF BLOCKER (ENBREL, CIMZIA, REMICADE, SIMPONI, OR SIMPONI ARIA).
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
RUXOLITINIB

DRUG NAME
JAKAFI

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
RENEWAL: IMPROVEMENT OR MAINTENANCE OF SYMPTOM IMPROVEMENT SUCH AS A 50% OR GREATER REDUCTION IN TOTAL SYMPTOM SCORE ON THE MODIFIED MYELOFIBROSIS SYMPTOM ASSESSMENT FORM (MFSAF) V2.0 OR 50% OR GREATER REDUCTION IN PALPABLE SPLEEN LENGTH, OR REDUCTION OF 35% OR GREATER FROM BASELINE SPLEEN VOLUME AFTER 6 MONTHS OF THERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
SACUBITRIL/VALSARTAN

DRUG NAME
ENTRESTO

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

EXCLUSION CRITERIA
CONCURRENT USE OF ANGIOTENSIN-CONVERTING ENZYME INHIBITORS [ACEI] (BENAZEPRIL, CAPTOPRIL, ENALAPRIL, FOSINOPRIL, LISINOPRIL, MOEXIPRIL, PERINDOPRIL, QUINAPRIL, RAMIPRIL, TRANDOLAPRIL) OR ANGIOTENSIN II RECEPTOR BLOCKERS [ARB] (SUCH AS OLMESARTAN, VALSARTAN, CANDESARTAN, IRBESARTAN, LOSARTAN, TELMISARTAN). PRIOR HISTORY OF ANGIOEDEMA RELATED TO ACEI OR ARB THERAPY.

REQUIRED MEDICAL INFORMATION
LEFT VENTRICULAR EJECTION FRACTION (LVEF)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
MUST HAVE LEFT VENTRICULAR EJECTION FRACTION (LVEF) OF 40% OR LESS. PREVIOUS HEART FAILURE TREATMENT WITH ONE OF THE FOLLOWING: AN ANGIOTENSIN-CONVERTING ENZYME INHIBITORS [ACEI] (SUCH AS BENAZEPRIL, CAPTOPRIL, ENALAPRIL, FOSINOPRIL, LISINOPRIL, MOEXIPRIL, PERINDOPRIL, QUINAPRIL, RAMIPRIL, TRANDOLAPRIL) OR AN ANGIOTENSIN II RECEPTOR BLOCKERS [ARB] (SUCH AS OLMESARTAN, VALSARTAN, CANDESARTAN, IRBESARTAN, LOSARTAN, TELMISARTAN).
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
SEBELIPASE ALFA

DRUG NAME
KANUMA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

BLOOD TEST OR DRIED BLOOD SPOT TEST INDICATING LOW OR ABSENT
LYSOSOMAL ACID LIPASE DEFICIENCY (LAL) ENZYME ACTIVITY, OR A GENETIC
TEST INDICATING THE PRESENCE OF ALTERED LIPA GENE(S)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
SECUKINUMAB

DRUG NAME
COSENTYX (2 SYRINGES) | COSENTYX PEN (2 PENS)

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECT THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PLAQUE PSORIASIS: ACHIEVED OR MAINTAINED CLEAR OR MINIMAL DISEASE OR A DECREASE IN PSORIASIS AREA AND SEVERITY INDEX (PASI) OF AT LEAST 50% OR MORE. PSORIATIC ARTHRITIS (PSA): RENEWAL: PATIENT HAS EXPERIENCED OR MAINTAINED A 20% OR GREATER IMPROVEMENT IN TENDER JOINT COUNT OR SWOLLEN JOINT COUNT WHILE ON THERAPY. ANKYLOSING SPONDYLITIS: RENEWAL CRITERIA: PATIENT HAS EXPERIENCED OR MAINTAINED AN IMPROVEMENT OF AT LEAST 50% OR 2 UNITS (SCALE OF 1–10) IN THE BATH ANKYLOSING SPONDYLITIS DISEASE ACTIVITY INDEX (BASDAI).

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PSO: THERAPY PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSA: RHEUMATOLOGIST OR DERMATOLOGIST. ANKYLOSING SPONDYLITIS: RHEUMATOLOGIST.

COVERAGE DURATION
INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS FOR ALL DIAGNOSES.
Prior Authorization Requirements

OTHER CRITERIA
INITIAL PSO: PREVIOUS TRIAL WITH HUMIRA AND ONE OF THE FOLLOWING CONVENTIONAL THERAPIES SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. INITIAL PSA: PREVIOUS TRIAL WITH HUMIRA AND AT LEAST ONE OF THE FOLLOWING DMARDS (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENTS SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. INITIAL ANKYLOSING SPONDYLITIS: PREVIOUS TRIAL WITH HUMIRA.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
SELEXIPAG

DRUG NAME
UPTRAVI

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
DOCUMENTED CONFIRMATORY PAH DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PREVIOUS OR CURRENT TREATMENT WITH A PHOSPHODIESTERASE-5 INHIBITOR (E.G., REVATIO [SILDENAFIL] OR ADCIRCA [TADALAFIL]) AND AN ENDOTHELIN RECEPTOR ANTAGONIST (E.G., TRACLEER [BOSENTAN], LETAIRIS [AMBRISENTAN]) OR OPSUMIT [MACITENTAN], OR A CONTRAINDICATION TO ALL OF THESE AGENTS.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
SILTUXIMAB

DRUG NAME
SYLVANT

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
SIMEPREVIR

DRUG NAME
OLYSIO

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
HCV RNA LEVEL OR VIRAL LOAD. FOR ALL GENOTYPE 1A: NS3 80K POLYMORPHISM LAB TEST AT BASELINE.

AGE RESTRICTIONS
18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (FOR EXAMPLE HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

COVERAGE DURATION
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE

OTHER CRITERIA
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE. NO APPROVAL FOR PATIENTS WITH DECOMPENSATED CIRRHOSIS. COMBINATION REGIMEN OF SOVALDI AND OLYSIO FOR GENOTYPE 1 WILL BE APPROVED IF THE PATIENT HAS TRIED EPCLUSA OR HARVONI AS LONG AS THE PATIENT HAS NOT FAILED A PRIOR COURSE OF THERAPY WITH ANY HCV PROTEASE INHIBITOR (SUCH AS INCIVEK, OLYSIO, OR VICTRELIS) (I.E., HAS NOT ACHIEVED A SUSTAINED
Prior Authorization Requirements

VIROLOGIC RESPONSE). APPROVAL FOR SOVALDI AND OLYSIO IS FOR 24 WEEKS FOR PATIENTS WITH CIRRHOSIS OR 12 WEEKS FOR PATIENTS WITHOUT CIRRHOSIS, EXCEPT A 24-WEEK APPROVAL FOR ANY PATIENT WITH PREVIOUS FAILURE OF A NS5A INHIBITOR-CONTAINING REGIMEN. PATIENT MUST NOT BE TAKING ANY OF THE FOLLOWING INTERACTING MEDICATIONS: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ERYTHROMYCIN (DOES NOT INCLUDE TOPICAL FORMULATIONS), CLARITHROMYCIN, TELITHROMYCIN, ITIRACONAZOLE, KETOCONAZOLE, POSACONAZOLE, FLUCONAZOLE (DOES NOT INCLUDE TOPICAL FORMULATIONS), VORICONAZOLE, DEXAMETHASONE, CISAPRIDE, CYCLOSPORINE, ROSUVASTATIN DOSE ABOVE 10MG, ATORVASTATIN DOSE ABOVE 40MG, OR ANY OF THE FOLLOWING HIV MEDICATIONS: COBICISTAT-CONTAINING MEDS (E.G., STRIBILD), DELAVIRDINE, ETRAVIRINE, NEVIRAPINE, EFAVIRENZ, OR ANY HIV PROTEASE INHIBITOR (ATAZANAVIR, FOSAMPRENAVIR, LOPINAVIR, INDINAVIR, NELFINAVIR, SAQUINAVIR, TIPRANAVIR/RIPTONAVIR, DARUNAVIR/RIPTONAVIR). PATIENT MUST ALSO NOT BE TAKING AMIODARONE IF ON A COMBINATION REGIMEN OF SOVALDI AND OLYSIO.
PRIOR AUTHORIZATION GROUP DESCRIPTION

SOFOBUVIR

DRUG NAME
SOVALDI

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.

EXCLUSION CRITERIA
PATIENT WITH END STAGE RENAL DISEASE OR REQUIRES DIALYSIS.

REQUIRED MEDICAL INFORMATION
FOR ALL GENOTYPE 1 PATIENTS USING OLYSIO AND SOVALDI AND HAVE GENOTYPE 1A: NS3 80K POLYMORPHISM LAB TEST AT BASELINE.

AGE RESTRICTIONS
18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

COVERAGE DURATION
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

OTHER CRITERIA
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. FOR PATIENTS ON SOVALDI PLUS DAKLINZA REGIMENS THERE WILL BE NO APPROVALS FOR CONCURRENT USE WITH ANY OF THESE (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER) MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, OR RIFAMPIN. REQUESTS FOR SOVALDI IN COMBINATION WITH DAKLINZA OR OLYSIO WILL REQUIRE THAT THE PATIENT ALSO MEETS ALL CRITERIA FOR CONCURRENT AGENT (DAKLINZA OR OLYSIO).
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
SOFOSBUVIR/VELPATASVIR

DRUG NAME
EPCLUSA

COVERED USES
PA CRITERIA: PENDING CMS APPROVAL

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
SOMATROPIN - GROWTH HORMONE

DRUG NAME
GENOTROPIN | NORDITROPIN FLEXPRO | SAIZEN

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
GROWTH HORMONE FAILURE DUE TO CHRONIC RENAL INSUFFICIENCY (CRI-CKD).

EXCLUSION CRITERIA
ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES, GROWTH FAILURE DUE TO
CHRONIC RENAL INSUFFICIENCY (CRI) IF PATIENT HAS HAD A RENAL
TRANSPLANT, OR GROWTH FAILURE WITH CLOSED EPIPHYSES FOR PEDIATRIC
PATIENTS.

REQUIRED MEDICAL INFORMATION
INDUCTION - PATIENT'S HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW
THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER.
RENEWAL: GROWTH VELOCITY AND/OR TARGET HEIGHT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: ENDOCRINOLOGIST. FOR GROWTH
HORMONE FAILURE DUE TO CRI: NEPHROLOGIST.

COVERAGE DURATION
12 MONTHS.

OTHER CRITERIA
FOR GROWTH FAILURE DUE TO (CRI): PATIENT HAS NOT UNDERGONE A RENAL
TRANSPLANT. RENEWAL: GROWTH VELOCITY OF 2 CM OR MORE COMPARED WITH
WHAT WAS OBSERVED FROM THE PREVIOUS YEAR AND/OR PATIENT HAS NOT
REACHED 50TH PERCENTILE FOR TARGET HEIGHT FOLLOWING GROWTH
HORMONE THERAPY.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
SOMATROPIN - SEROSTIM

DRUG NAME
SEROSTIM

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

EXCLUSION CRITERIA
ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES

REQUIRED MEDICAL INFORMATION
HIV/WASTING: MEETS CRITERIA OF WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, OR 7.5% OVER 6 MONTHS, OR 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN) AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, 23% (WOMEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BMI LESS THAN 18.5 KG PER METER SQUARED.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH:
GASTROENTEROLOGIST/NUTRITIONAL SUPPORT SPECIALIST (SBS) OR INFECTIOUS DISEASE SPECIALIST.

COVERAGE DURATION
HIV/AIDS: 3 MONTHS.

OTHER CRITERIA
HIV/WASTING: CURRENTLY ON ANTIRETROVIRAL THERAPY. IF CURRENTLY ON GROWTH HORMONE, PATIENT HAS SHOWN CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT OR IF NOT ON GROWTH HORMONE, PATIENT HAS HAD INADEQUATE RESPONSE TO PREVIOUS THERAPY. (I.E. EXERCISE TRAINING, NUTRITIONAL SUPPLEMENTS, APPETITE STIMULANTS OR ANABOLIC STEROIDS).
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
SONIDEGIB

DRUG NAME
ODOMZO

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
BASELINE SERUM CREATINE KINASE (CK) AND SERUM CREATININE LEVELS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
SORAFENIB TOSYLATE

DRUG NAME
NEXAVAR

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
SUNITINIB MALATE

DRUG NAME
SUTENT

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
GASTROINTESTINAL STROMAL TUMORS (GIST): TRIAL OF OR CONTRAINDICATION TO GLEEVEC.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
TASIMELTEON

DRUG NAME
HETLIOZ

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
TEDUGlutide

DRUG NAME
GATTEX

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS
18 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PATIENT IS DEPENDENT ON INTRAVENOUS PARENTERAL NUTRITION DEFINED AS REQUIRING PARENTERAL NUTRITION AT LEAST THREE TIMES PER WEEK.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
TERIFLUNOMIDE

DRUG NAME
AUBAGIO

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
TRIAL OF OR CONTRAINDICATION TO AN AGENT INDICATED FOR THE TREATMENT OF MULTIPLE SCLEROSIS (COPAXONE, REBIF, TECFIDERA).
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
TERIPARATIDE

DRUG NAME
FORTEO

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

EXCLUSION CRITERIA
GREATER THAN 24 MONTHS OF THERAPY.

REQUIRED MEDICAL INFORMATION
A PATIENT WITH EITHER A DIAGNOSIS OF SEVERE OSTEOPOROSIS (T-SCORE LESS THAN -2.5 WITH FRAGILITY FRACTURE) OR A T SCORE EQUAL TO OR LESS THAN -2.5 AND MULTIPLE RISK FACTORS FOR FRACTURE (E.G. HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS), OR FAILED AN ADEQUATE TRIAL OF BISPHOSPHONATES, IS INTOLERANT, OR HAS A CONTRAINDICATION TO BISPHOSPHONATES.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
TESTOSTERONE

DRUG NAME
ANDRODERM | ANDROGEL | TESTOSTERONE | TESTOSTERONE CYPIONATE | TESTOSTERONE ENANTHATE

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
MALE HYPOGONADISM CONFIRMED BY EITHER: 1) LAB CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL OF LESS THAN 300 NG/DL OR 2) A LOW TOTAL SERUM TESTOSTERONE LEVEL AS INDICATED BY A LAB RESULT WITH A REFERENCE RANGE OBTAINED WITHIN 90 DAYS, OR 3) A FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 50 NG/L.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
LIFETIME OF MEMBERSHIP IN PLAN

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
TETRABENAZINE

DRUG NAME
TETRABENAZINE

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
NEUROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
THALIDOMIDE

DRUG NAME
THALOMID

COVERED USES
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
ADDITIONAL COVERAGE CONSIDERATION FOR ANEMIA DUE TO
MYELODYSPLASTIC SYNDROME AND WALDENSTROM'S MACROGLOBULINEMIA.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
TOCILIZUMAB IV

DRUG NAME
ACTEMRA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
RENEWAL: RHEUMATOID ARTHRITIS/POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS/SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS: EXPERIENCED OR MAINTAINED 20 PERCENT IMPROVEMENT IN TENDER OR SWOLLEN JOINT COUNT WHILE ON THERAPY.

AGE RESTRICTIONS
JIA, SJI: 2 YEARS AND OLDER

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: RHEUMATOLOGIST.

COVERAGE DURATION
INITIAL: RA: 7 MONTHS. PJIA: 5 MONTHS. SJIA: 12 MONTHS RENEWAL: 12 MONTHS FOR ALL DIAGNOSES.

OTHER CRITERIA
INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: ORENCIA, XELJANZ, OR CIMZIA. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY ORENCIA. NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH KINERET (ANAKINRA), ORENCIA (ABATACEPT), ACTEMRA (TOCILIZUMAB) OR ANOTHER TNF (TUMOR NECROSIS FACTOR) INHIBITORS: HUMIRA, ENBREL, CIMZIA, REMICADE, SIMPONI, OR SIMPONI ARIA.
PRIOR AUTHORIZATION GROUP DESCRIPTION
TOCILIZUMAB SQ

DRUG NAME
ACTEMRA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
FOR RHEUMATOID ARTHRITIS. RENEWAL: AT LEAST 20% IMPROVEMENT OR MAINTENANCE IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: RHEUMATOLOGIST.

COVERAGE DURATION
INITIAL: 7 MONTHS  RENEWAL: 12 MONTHS

OTHER CRITERIA
INITIAL: RHEUMATOID ARTHRITIS (RA): TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: ORENCIA, XELJANZ, OR CIMZIA. NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH KINERET (ANAKINRA), ORENCIA (ABATACEPT), ACTEMRA (TOCILIZUMAB) OR ANOTHER TNF (TUMOR NECROSIS FACTOR) INHIBITORS: HUMIRA, ENBREL, CIMZIA, REMICADE, SIMPONI, OR SIMPONI ARIA.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TOFACITINIB

DRUG NAME
XELJANZ | XELJANZ XR

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
RENEWAL: RHEUMATOID ARTHRITIS: EXPERIENCED OR MAINTAINED 20 PERCENT IMPROVEMENT IN TENDER OR SWOLLEN JOINT COUNT WHILE ON THERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: RHEUMATOLOGIST.

COVERAGE DURATION
RA: INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS.

OTHER CRITERIA
RHEUMATOID ARTHRITIS INITIAL: PREVIOUS TRIAL WITH HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TOPICAL TRETINOIN

DRUG NAME
TRETINOIN | TRETINOIN MICROSPHERE

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

EXCLUSION CRITERIA
WRINKLES, PHOTOAGING, MELASMA.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
BRAND TRETINON WILL REQUIRE TRIAL OF GENERIC TOPICAL TRETINOIN.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
TOTAL PARENTARAL NUTRITION AGENT BVD DETERMINATION

DRUG NAME

AMINO ACIDS | AMINOSYN II | AMINOSYN II WITH ELECTROLYTES | AMINOSYN M | AMINOSYN WITH ELECTROLYTES | AMINOSYN-HBC | AMINOSYN-PF | AMINOSYN-RF | CLINIMIX | CLINIMIX E | CLINISOL | DEXTROSE IN WATER | FREAMINE HBC | HEPATAMINE | INTRALIPID | NEPHRAMINE | NUTRILIPID | PREMASOL | PROCALAMINE | PROSOL | TRAVASOL | TROPHAMINE

COVERED USES

THIS DRUG MAY BE COVERED UNDER MEDICARE 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
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
TRAMETINIB DIMETHYL SULFOXIDE

DRUG NAME
MEKINIST

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
TRASTUZUMAB

DRUG NAME
HERCEPTIN

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
BREAST CANCER, METASTATIC BREAST CANCER, GASTRIC CANCER: HER2 POSITIVE

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
B VS D COVERAGE CONSIDERATION.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
TREPROSTINIL DIOLAMINE

DRUG NAME
ORENITRAM ER

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED OR IN CONSULTATION WITH A CARDIOLOGIST OR A PULMONOLOGIST.

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
TRIFLURIDINE/TIPIRACIL

DRUG NAME
LONSURF

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
USTEKINUMAB

DRUG NAME
STELARA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECT THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PSORIATIC ARTHRITIS: EXPERIENCED OR MAINTAINED 20 PERCENT IMPROVEMENT IN TENDER OR SWOLLEN JOINT COUNT WHILE ON THERAPY. PLAQUE PSORIASIS: ACHIEVED OR MAINTAINED CLEAR OR MINIMAL DISEASE OR A DECREASE IN PSORIASIS AREA AND SEVERITY INDEX (PASI) OF AT LEAST 50% OR MORE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS
PRESCRIBED BY OR IN CONSULTATION WITH: PSORIATIC ARTHRITIS: DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: DERMATOLOGIST.

COVERAGE DURATION
INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA
INITIAL: PSORIATRIC ARTHRITIS (PSA): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY ONE OF THE FOLLOWING AGENTS: CIMZIA, OR OTEZLA. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY ONE OF THE FOLLOWING AGENTS: COSENTYX OR OTEZLA.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
VANDETANIB

DRUG NAME
CAPRELSA

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
CRITERIA APPLIES TO NEW STARTS ONLY.
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
VEMURAFENIB

DRUG NAME
ZELBORAF

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
BRAFV600E MUTATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
PRIOR AUTHORIZATION GROUP DESCRIPTION
VENETOCLAX

DRUG NAME
VENCLEXTA | VENCLEXTA STARTING PACK

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

EXCLUSION CRITERIA
NONE

REQUIRED MEDICAL INFORMATION
NONE

AGE RESTRICTIONS
NONE

PRESCRIBER RESTRICTIONS
NONE

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
NONE
Moda Health Plan, Inc.

Prior Authorization Requirements

EFFECTIVE DATE: 10/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION
VISMODEGIB

DRUG NAME
ERIVEDGE

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA