

Vantage Health Plan 2011 Prior Authorization Criteria

ACNE

Drugs

Atralin, Avita, Retin-A, Retin-A Micro, tretinoin

Covered Uses

All FDA-approved indications not otherwise excluded from Part D, keratosis follicularis (Darier's disease, Darier-White disease)

Exclusion Criteria

Cosmetic use

Required Medical Information

N/A

Age Restriction

Approve for those 12 years of age and older

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

AMPHETAMINES

Drugs

Adderall, Adderall XR, Amphetamine Salt Combo, Desoxyn, Dexedrine Spansule, dextroamphetamine, Vyvanse

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

MAOI concurrent use or within the last 14 days

Required Medical Information

Sleep studies for narcolepsy diagnosis

Age Restriction

Approve for those 3 years of age and older

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

Monitor for weight loss, decreased growth velocity in children, increased heart rate and blood pressure, appearance or worsening of aggressive behavior or hostility, sleep disturbances and long-term usefulness of the drug.

Vantage Health Plan 2011 Prior Authorization Criteria

ANTINEOPLASTIC

Drugs

Afinitor, Nexavar, Sutent, Tarceva

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Diagnosis

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

Vantage Health Plan 2011 Prior Authorization Criteria

ARANESP

Drugs

Aranesp (polysorbate)

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

CRF - transferrin saturation less than 20% and patient not receiving iron supplementation where clinically appropriate. CRF and anemia in patients with non-myeloid malignancies - hemoglobin level of the patient (not the result of a recent blood transfusion) greater than 13 g/dL. Lack of initial diagnosis of anemia (hematocrit less than 30% and/or hemoglobin less than 10 g/dL and/or symptomatic with hemoglobin 10-11g/dL).

Required Medical Information

CRF - iron status of the patient has been evaluated (serum transferrin saturation). CRF and anemia of cancer - Hemoglobin level of the patient be monitored prior to each dose when initiating therapy, for dose changes, and at regular intervals when the dose is stabilized. Hemoglobin level of the patient will be monitored prior to each dose when initiating therapy, for dose changes, and at regular intervals when the dose is stabilized. Blood pressure of the patient will be monitored throughout therapy. Patient will be monitored for the occurrence of thrombotic events.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

Initiation of therapy and/or dose changes - 6 weeks. Stable on therapy - 12 weeks.

Other Criteria

Once on therapy, compared to pretreatment baseline, the patient must show an objective clinical response (e.g., hemoglobin rise greater than 1 g/dL and/or hematocrit rise greater than 3%) to an appropriate dose/dose increase and duration of therapy.

Vantage Health Plan 2011 Prior Authorization Criteria

ARCALYST

Drugs

Arcalyst

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

6 MONTHS, FOLLOWED BY EVERY 6 MONTHS THEREAFTER

Other Criteria

ALSO REQUIRES PART B VS. D DETERMINATION

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CHANTIX

Drugs

Chantix

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Concurrent Zyban use

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 weeks initial, 12 weeks additional upon renewal

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

CIMZIA

Drugs

Cimzia, Cimzia Powder for Reconstitution

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patients are excluded if they have an active infection or are on concurrent biologic response modifier. Patient must also be assessed for the risk of hepatitis B and if appropriate, be tested.

Required Medical Information

Patient must demonstrate inadequate response to at least 1 conventional therapy for Crohn's disease (i.e., prednisone, budesonide, sulfasalazine, azathioprine, mesalamine, infliximab or adalimumab)

Age Restriction

Approve for those 18 years of age or older

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

DIFFERIN

Drugs

Differin

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Cosmetic use

Required Medical Information

N/A

Age Restriction

Approve for those 12 years of age and older

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

ENBREL

Drugs

Enbrel

Covered Uses

All FDA-approved indications not otherwise excluded from Part D, reactive arthritis, inflammatory bowel disease, arthritis

Exclusion Criteria

Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patients are excluded if they have an active infection or are on concurrent biologic response modifier. Patient must also be assessed for the risk of hepatitis B

Required Medical Information

RA/JA - patient must demonstrate inadequate response to at least 1 DMARD. Psoriasis - failure to or contraindication to phototherapy, acitretin, methotrexate, cyclosporine or azathioprine. Ankylosing Spondylitis - failure to 2 NSAIDS.

Age Restriction

Psoriasis - Approve for those 18 years of age or older

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

EPO

Drugs

Epogen, Procrit

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

CRF, Hepatitis C, elective surgery, HIV/zidovudine - transferrin saturation less than 20% and patient not receiving iron supplementation where clinically appropriate. CRF, Hepatitis C, elective surgery, HIV/zidovudine, MDS, and anemia in patients with non-myeloid malignancies - hemoglobin level of the patient (not the result of a recent blood transfusion) greater than 13 g/dL.

Required Medical Information

CRF, Hepatitis C, elective surgery, HIV/zidovudine - iron status of the patient has been evaluated (serum transferrin saturation). CRF, Hepatitis C, elective surgery, HIV/zidovudine, and anemia of cancer - Hemoglobin level of the patient be monitored prior to each dose when initiating therapy, for dose changes, and at regular intervals when the dose is stabilized. Hemoglobin level of the patient will be monitored prior to each dose when initiating therapy, for dose changes, and at regular intervals when the dose is stabilized. Blood pressure of the patient will be monitored throughout therapy. Patient will be monitored for the occurrence of thrombotic events.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

Initiation of therapy and/or dose changes - 6 weeks. Stable on therapy - 12 weeks.

Other Criteria

Once on therapy, compared to pretreatment baseline, the patient must show an objective clinical response (e.g., hemoglobin rise greater than 1 g/dL and/or hematocrit rise greater than 3%) to an appropriate dose/dose increase and duration of therapy

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GROWTH HORMONE

Drugs

Genotropin, Genotropin Miniquick, Humatrope, Norditropin Cartridge, Norditropin Nordiflex, Nutropin, Nutropin AQ, Saizen, Saizen click.easy, Serostim, Tev-Tropin

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Severe respiratory impairment or sleep apnea (Prader-Willi syndrome)

Required Medical Information

Growth hormone stimulation tests

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

6 months

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

HUMIRA

Drugs

Humira, Humira Crohn's Disease Starter Pack

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Patients are excluded if they have an active infection or are on concurrent biologic response modifier.

Required Medical Information

Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patient must also be assessed for the risk of hepatitis B and if appropriate, be tested.

Age Restriction

Rheumatoid arthritis, psoriatic arthritis, Ankylosing Spondylitis, Crohn's disease, plaque psoriasis -
Approve for those 18 years of age or older

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

RA/JA-failure to 1 DMARD. Psoriasis-failure of phototherapy, acitretin, MTX, cyclosporine, or azathioprine. Ankylosing Spondylitis-failure to 2 NSAIDs. Crohn's-failure to azathioprine, MTX, sulfasalazine, 6-mercaptopurine, or glucocorticoids.

Vantage Health Plan 2011 Prior Authorization Criteria

INCRELEX

Drugs

Increlex

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Closed epiphyses. Other secondary causes of growth failure. Pre-existing thyroid and/or nutritional deficits. Presence of active or suspected neoplasia.

Required Medical Information

Failure of a growth hormone stimulation test. Genetic testing for growth hormone gene deletion. Lab testing for neutralizing antibodies to growth hormone.

Age Restriction

Approve for those 2 years of age or older

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

Height of the patient greater than or equal to 3 standard deviations below the norm for children of the same age and gender prior to beginning Increlex therapy. Basal IGF-1 level greater than or equal to 3 standard deviations below the norm for children of the same age and gender prior to beginning Increlex therapy. Increase in height velocity of 2 cm/year within the first year of Increlex therapy.

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INFERGEN

Drugs

Infergen

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

Patient must have compensated liver disease with detectable levels of hepatitis C virus RNA in the serum

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

3 to 9 months depending on genotype and initial vs. renewal therapy

Other Criteria

2-log decrease in viral load for renewals

Vantage Health Plan 2011 Prior Authorization Criteria

INTERFERON

Drugs

Intron A

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Hypersensitivity to interferon alfa, diagnosis of autoimmune hepatitis, hepatic decompensation (Child-Pugh class B and C) before or during treatment, unstable laboratory values: neutrophils, platelets, hemoglobin, serum creatinine.

Required Medical Information

CBC, LFTs, TSH, HCV RNA viral load, HepBAG, HBV DNA, CT, MRI, or biopsy.

Age Restriction

Diagnosis other than chronic HBV: greater than or equal to 18 years old. For HBV: greater than or equal to 1 year of age

Prescriber Restriction

Oncologist or Gastroenterologist

Coverage Duration

Initially up to 3 months, continuation of therapy up to 1 year

Other Criteria

For Roferon-A: Diagnosis of hairy cell leukemia or chronic myelogenous leukemia and minimally pretreated within 1 year of diagnosis, or Diagnosis of chronic HCV. For Intron A: Diagnosis of hairy cell leukemia, or Diagnosis of malignant melanoma, or Diagnosis of follicular Non-Hodgkins lymphoma, or Diagnosis of condylomata acuminata, or Diagnosis of AIDS-related Kaposi's sarcoma, or Diagnosis of chronic hepatitis C virus (HCV).

Vantage Health Plan 2011 Prior Authorization Criteria

Istodax

Drugs

Istodax

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Primary cutaneous T-cell lymphoma (CTCL): in patients who have received at least one prior systemic therapy.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

ITRACONAZOLE

Drugs

itraconazole, Sporanox, Sporanox Pulsepak

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

LFTs, fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy)

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

1, 2, 3, or 6 months depending on the diagnosis

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

IVIG

Drugs

Carimune NF Nanofiltered, Gammagard Liquid, Gamunex, Octagam, Privigen

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

HSCT - IVIG is to be used in patients that have developed severe hypogammaglobulinemia (IgG less than 400) within the first 100 days post transplant.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

4 months- CIDP, BMT, HSCT 6 months - ITP, Kawasaki, Parvovirus B19 12 months-- remaining covered uses

Other Criteria

Kawasaki-IVIG used with high dose ASA. BMT-IVIG used in the first 100 days post BMT.
Dermatomyositis-IVIG used if corticosteroid not an option. Hyperimmunoglobulinemia E-diagnosis has to be with eczema and atopic dermatitis. RRMS-IVIG used as 2nd line treatment.

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KINERET

Drugs

Kineret

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Active infection or concurrent use of a TNF blocking agent.

Required Medical Information

Patient must demonstrate inadequate response to at least 1 DMARD.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

LIDODERM

Drugs

Lidoderm

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Sensitivity to local anesthetics of the amide type (e.g., procaine, tetracaine, benzocaine), skin is broken or inflamed where the patch is to be applied.

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

N/A

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METHYLPHENIDATES

Drugs

Concerta, Daytrana, dexamethylphenidate, Focalin, Focalin XR, Metadate CD, Metadate ER, Methylin, methylphenidate, Ritalin, Ritalin LA, Ritalin SR

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

MAOI concurrent use or within the last 14 days

Required Medical Information

Sleep studies for narcolepsy diagnosis

Age Restriction

Approved for those 6 years of age or older

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

Monitor for weight loss, decreased growth velocity in children, increased heart rate and blood pressure, appearance or worsening of aggressive behavior or hostility, sleep disturbances and long-term usefulness of the drug

Vantage Health Plan 2011 Prior Authorization Criteria

MOZOBIL

Drugs

Mozobil

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

Part B Coverage

Required Medical Information

Diagnosis, Patient's weight, concurrent treatments: used in combination with granulocyte-colony stimulating factor

Age Restriction

Approved for those patients 18 years of age or older

Prescriber Restriction

N/A

Coverage Duration

1 year

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

MULTIPLE SCLEROSIS

Drugs

Avonex, Avonex Administration Pack, Betaseron, Copaxone, Rebif, Rebif Titration Pack

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Diagnosis, drugs tried and failed, concomitant therapies

Age Restriction

Greater than or equal to 18 years old (or FDA approved age)

Prescriber Restriction

Neurologist

Coverage Duration

24 months

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

NEULASTA

Drugs

Neulasta

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Neulasta treatment within the last 14 days. Treatment of acute afebrile neutropenia.

Required Medical Information

Current and periodic monitoring of WBC count at initiation of and during therapy.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

6 months

Other Criteria

Neulasta administration will be delayed a minimum of 24 hours after the administration of cytotoxic chemotherapy.

Vantage Health Plan 2011 Prior Authorization Criteria

NEUMEGA

Drugs

Neumega

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

Patient's renal function above or below 30 mL/min for dosage adjustment. Any cardiovascular/fluid comorbidities for monitoring of fluid status (if applicable).

Age Restriction

Approved for those 18 years of age or older

Prescriber Restriction

N/A

Coverage Duration

3 months

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

NEUTROPHIL

Drugs

Leukine, Neupogen

Covered Uses

All FDA-approved indications not otherwise excluded from Part D, bone marrow transplantation failure or engraftment delay. Neutropenia AIDS associated with treatment or disease, myelodysplastic syndromes, drug-induced neutropenia.

Exclusion Criteria

Treatment of acute afebrile neutropenia. Patients not at high risk for infection-associated complications or not having prognostic factors that are predictive of poor clinical outcomes.

Required Medical Information

Current and periodic monitoring of WBC count at initiation of and during therapy.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

3 months

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

NUVIGIL

Drugs

Nuvigil

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

If diagnosis is narcolepsy require polysomnography, if diagnosis of OSAHS require polysomnography and whether patient uses a CPAP

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

OCTREOTIDE

Drugs

octreotide acetate, Sandostatin

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

ORAL FENTANYL

Drugs

Actiq, fentanyl citrate, Fentora

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

1 month for initial or titrating patients, 3 months for all others

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

ORENCIA

Drugs

ORENCIA

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Patients are excluded if they are on concurrent biologic response modifier.

Required Medical Information

Patient must be evaluated for latent TB with a PPD test and be treated if positive.

Age Restriction

Approved for those 6 years of age or older

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

Patient must demonstrate inadequate response to at least 1 DMARD or a TNF blocking agent.

Vantage Health Plan 2011 Prior Authorization Criteria

OSTEOPOROSIS

Drugs

Forteo

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Paget's disease, unexplained elevation of alkaline phosphatase, open epiphyses, bone cancer or cancer that has metastasized to the bone, prior radiation therapy involving the skeleton, hypercalcemia, treatment with Forteo for greater than or equal to 24 months, concurrent bisphosphonate therapy during treatment with Forteo

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

For diagnosis of primary osteoporosis or hypogonadal osteoporosis patient must have at least one of the following: history of osteoporotic fractures OR multiple risk factors for fracture

Vantage Health Plan 2011 Prior Authorization Criteria

Part B/D Drugs

Drugs

AccuNeb, Aminosyn 10 %, Aminosyn 3.5 %, Aminosyn 5 %, Aminosyn 7 %, Aminosyn 7 % with Electrolytes, Aminosyn 8.5 %, Aminosyn 8.5 %-Electrolytes, Aminosyn II 10 %, Aminosyn II 15%, Aminosyn II 3.5 %/Dextrose 5 %, Aminosyn II 3.5 %-Dextrose 25%, Aminosyn II 3.5% M/Dextrose 5%, Aminosyn II 3.5%-Lytes-Ca-D25W, Aminosyn II 4.25%/Dextrose 20%, Aminosyn II 4.25%-Dextrose 10%, Aminosyn II 4.25%-Dextrose 25%, Aminosyn II 4.25%-Lytes-Ca-D25, Aminosyn II 5%/Dextrose 25%, Aminosyn II 7 %, Aminosyn II 8.5 %, Aminosyn II 8.5 %-Electrolytes, Aminosyn M 3.5 %, Aminosyn-HBC 7%, Aminosyn-HF 8 %, Aminosyn-PF 10 %, Aminosyn-PF 7 % (Sulfite-Free), Anzemet, Azasan, azathioprine, CellCept, Cesamet, chorionic gonadotropin, human, Clinimix 2.75%/D5 Sulfite Free, Clinimix 4.25%/D5 Sulfite Free, Clinimix 4.25/D10 Sulfite Free, Clinimix 4.25/D20 Sulfite Free, Clinimix 4.25/D25 Sulfite Free, Clinimix 5%/D15 Sulfite Free, Clinimix 5%/D20 Sulfite Free, Clinimix 5%/D25 Sulfite Free, Clinimix E 2.75/D10 SulfiteFree, Clinimix E 2.75/D5 Sulfite Free, Clinimix E 4.25/D25 SulfiteFree, Clinimix E 4.25/D5 Sulfite Free, Clinimix E 5%/D15 Sulfite Free, Clinimix E 5%/D20 Sulfite Free, Clinimix E 5%/D25 Sulfite Free, Clinisol SF 15%, colistimethate sodium, Coly-Mycin M Parenteral, cromolyn, cyclophosphamide, cyclosporine, cyclosporine modified, DECAVAC, Emend, Engerix-B (PF), Freamine HBC 6.9 %, Freamine III 3 %-Electrolytes, Freamine III 8.5 %, Gengraf, granisetron, Granisol, Hepatamine 8%, Hepatasol 8 %, Imuran, Intralipid, Kytril, Liposyn II, Liposyn III, Myfortic, Nebupent, Neoral, Nephramine 5.4 %, Novamine 15 %, Novarel, ondansetron, ondansetron HCl, Perforomist, Pregnyl, Premasol 10 %, Premasol 6 %, Procalamine 3%, Prograf, Prosol 20%, Rapamune, Recombivax HB (PF), Renamin 6.5 %, Sandimmune, tacrolimus, tetanus toxoid, adsorbed (PF), tetanus, diphtheria toxoid ped-PF, tetanus-diphtheria toxoid-Td, Travasol 10 %, Trexall, TrophAmine 10 %, Trophamine 6%, Ventavis, Zofran, Zofran ODT

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

N/A

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Part B/D Drugs (continued)

Other Criteria

N/A

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PEGASYS

Drugs

Pegasys Convenience Pack

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

For chronic hepatitis C, patient must have compensated liver disease with detectable levels of HCV RNA in the serum. For chronic hepatitis B, patient must have a positive serum marker for HBV replication, persistently elevated aminotransferase levels greater than 2 times upper limit of normal, or signs of chronic hepatitis B on liver biopsy, or cirrhosis of the liver as evidenced by radiological or clinical data, or extrahepatic complications.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

Chronic hepatitis C - 3 to 9 months. Chronic hepatitis B - 12 months.

Other Criteria

For chronic hepatitis C, patient must have 2-log decrease in viral load for renewals.

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PEGINTRON

Drugs

PegIntron, PegIntron Redipen

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

Patient must have compensated liver disease with detectable levels of hepatitis C virus RNA in the serum

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

3 to 9 months depending on genotype and initial vs. renewal therapy

Other Criteria

2-log decrease in viral load for renewals

Vantage Health Plan 2011 Prior Authorization Criteria

PROMACTA

Drugs

Promacta

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Diagnosis other than chronic ITP. Chronic ITP diagnosis less than 3 months.

Required Medical Information

Diagnosis of chronic ITP, platelet count less than 30×10^9 per L.

Age Restriction

Greater than or equal to 18 yo (or FDA approved age)

Prescriber Restriction

Any prescriber enrolled in the Promacta CARES Program

Coverage Duration

6 months

Other Criteria

N/A

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PROVIGIL

Drugs

Provigil

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

If diagnosis is narcolepsy require polysomnography, if diagnosis of OSAHS require polysomnography and whether patient uses a CPAP

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

REMICADE

Drugs

Remicade

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Patients are excluded if they have an active infection

Required Medical Information

Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patient must also be assessed for the risk of hepatitis B and if appropriate, be tested.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

RA-fail 1 DMARD,used with MTX.Crohn's-fail 2 first-line agents unless multiple draining enterocutaneous/rectovaginal fistulae.UC-fail agents such as oral or rectal 5-ASA or glucocorticosteroids.AS-fail 2 NSAIDs. Psoriasis-candidate for systemic tx/phototherapy. Reactive AR-failure to NSAIDs or DMARDs. IBDA -fail at least 2 of following sulfasalazine, azathioprine, 6-mercaptopurine, MTX or oral steroids.

Vantage Health Plan 2011 Prior Authorization Criteria

REVATIO

Drugs

Revatio

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Concurrent nitrate therapy. PAH associated with any of the following: left heart disease, chronic thrombotic disease, embolic disease, compression of pulmonary vessels, lung diseases, hypoxemia, sarcoidosis

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

N/A

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REVLIMID

Drugs

REVLIMID

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Pregnancy

Required Medical Information

If female of child bearing potential, pregnancy excluded by 2 negative urine or serum pregnancy tests. For MM requirement of combination therapy with dexamethasone and at least one prior MM treatment. For MDS: diagnosis of anemia due to Low- or Intermediate-1-risk MDS associated with a deletion 5q cytogenetic abnormality, transfusion dependent. Instruction regarding importance and proper utilization of appropriate contraceptive methods. Monitor CBC on regular basis.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

N/A

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RIBAVIRIN

Drugs

Copegus, REBETOL, RibaPak Dose Pack, Ribasphere, ribavirin

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

History of unstable heart disease, hemoglobin less than 8.5, creatinine clearance less than 50, pregnancy, hemoglobinopathy.

Required Medical Information

Patient must have detectable levels of HCV RNA in the serum and be on an alfa interferon product concurrently.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

4 to 8 months, depending on genotype and initial vs. renewal therapy.

Other Criteria

2-log decrease in viral load for renewals

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RITUXAN

Drugs

Rituxan

Covered Uses

All FDA-approved indications not otherwise excluded from Part D, Chronic lymphocytic leukemia (CLL). Immune thrombocytopenic purpura (ITP). Waldenstrom's macroglobulinemia.

Exclusion Criteria

RA - Rituxan cannot be used concomitantly with another biologic DMARD.

Required Medical Information

Prescriber has to assess the patient for the risk of hepatitis B, and if clinically indicated, test the patient for hepatitis B infection before initiation or continuation of therapy with Rituxan.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

NHL, RA, CLL, Waldenstrom's macroglobulinemia - 12 months. ITP - 1 month.

Other Criteria

For NHL, the diagnosis must fall into one of the following categories of CD20-positive B-cell NHL: - relapsed or refractory, low-grade or follicular - previously untreated follicular, in combination with CVP chemotherapy - low grade in patients with stable disease or who achieve a partial or complete response following first-line treatment with CVP chemotherapy - diffuse large B-cell, treated first line in combination with CHOP or other anthracycline-based chemotherapy - relapsed or refractory diffuse large B-cell lymphoma. For ITP, patient has to be refractory to first line treatment with corticosteroids and/or IVIG.

Vantage Health Plan 2011 Prior Authorization Criteria

SANDOSTATIN LAR

Drugs

Sandostatin LAR Depot

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

Patient had prior therapy with sandostatin injection (not depot form) and treatment was effective and tolerated.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

SEROSTIM

Drugs

Serostim

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

BMI, patient weight.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 weeks

Other Criteria

Continuation of prescribed HIV (anti-viral) therapy

Vantage Health Plan 2011 Prior Authorization Criteria

SKELID

Drugs

Skelid

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 Months

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

SMOKING DETERRENTS

Drugs

Buproban, bupropion, Nicotrol, Nicotrol NS

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Diagnosis, drugs tried and failed, patient enrolled in any smoking cessation support program

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

3 months initially

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

SOMATULINE DEPOT

Drugs

Somatuline Depot

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

Either surgery and/or radiotherapy is not a therapeutic option for the patient or the patient has had inadequate response to surgery and/or radiotherapy

Vantage Health Plan 2011 Prior Authorization Criteria

SOMAVERT

Drugs

SOMAVERT

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

Monitor IGF-1 levels at 6 month intervals after IGF-1 levels stabilize within normal range. Monitor LFTs as recommended during therapy. Prior to initiation of therapy IGF-1 levels were above age and gender adjusted normal range. If patient has been on therapy for the past 6 months demonstration of significant decrease in IGF-1 levels required. Patients were considered for/received treatment with surgery, radiation therapy, or medical treatment for acromegaly but rejected as inappropriate or had inadequate response.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

STELARA

Drugs

Stelara

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

For the treatment of moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy.

Age Restriction

Approve for those patients 18 years of age or older

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

STERIODS, ANABOLIC

Drugs

oxandrolone

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

6 months

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

STRATTERA

Drugs

Strattera

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

MAOI concurrent use or within the last 14 days

Required Medical Information

N/A

Age Restriction

Approved for those 6 years of age or older

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

Monitor for suicidality, clinical worsening, changes in behavior, blood pressure changes, heart rate changes, weight loss, decreased growth velocity in children, sleep disturbances, liver injury

Vantage Health Plan 2011 Prior Authorization Criteria

TERBINAFINE

Drugs

Lamisil, terbinafine

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

LFTs, fungal diagnostic test (e.g., KOH preparation, positive fungal culture, or nail biopsy)

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

Two months for fingernails only, 3 months if toenail involvement

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

TESTOSTERONES

Drugs

AndroGel, testosterone cypionate, testosterone enanthate

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Female, prostate cancer, breast cancer

Required Medical Information

Before the start of testosterone therapy patient has (or patient currently has) a confirmed low testosterone level (i.e. total testosterone less than 300 ng/dL, free or bioavailable, testosterone less than 5 ng/dL) or absence of endogenous testosterone

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

THALOMID

Drugs

Thalomid

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Pregnancy

Required Medical Information

If female of child bearing potential, pregnancy excluded by ONE negative urine or serum pregnancy tests. For MM requirement of combination therapy with dexamethasone. For ENL if have moderate to severe neuritis Thalomid can not be used as monotherapy.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

Instruction regarding importance and proper utilization of appropriate contraceptive method

Vantage Health Plan 2011 Prior Authorization Criteria

TOPICAL-ULCERS

Drugs

Regranex

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

Ulcer size after 10 weeks of therapy, does ulcer have adequate blood supply, ulcer extending into subcutaneous tissue or beyond

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

3 months, then additional 2 months upon renewal

Other Criteria

N/A

Vantage Health Plan 2011 Prior Authorization Criteria

VIVAGLOBIN

Drugs

Vivaglobin

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Selective immunoglobulin A (IgA) deficiency (serum IgA less than 0.05 g/L) with known antibody against IgA. Patients with a history of anaphylactic or severe systemic response to immune globulin preparations.

Required Medical Information

N/A

Age Restriction

2 years of age or older

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

IgG and IgA levels should be obtained before the initiation of therapy. Patients should be monitored for adverse reactions.

Vantage Health Plan 2011 Prior Authorization Criteria

XENAZINE

Drugs

Xenazine

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Actively suicidal, untreated or inadequately treated depression, impaired hepatic function, current use of monoamine oxidase inhibitors or reserpine.

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

In patients who are taking reserpine, at least 20 days should lapse after stopping reserpine before initiation of Xenazine therapy.

Vantage Health Plan 2011 Prior Authorization Criteria

XOLAIR

Drugs

Xolair

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Xolair is not to be used as monotherapy.

Required Medical Information

Positive aeroallergen skin or blood test. Pre-treatment IgE level to be between 30 and 700 IU/mL

Age Restriction

12 years of age or older

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

Patient must demonstrate an inadequate response or failure to combination therapy with an inhaled corticosteroid and a long-acting inhaled beta-agonist

Vantage Health Plan 2011 Prior Authorization Criteria

ZORBTIVE

Drugs

Zorbtive

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Recently diagnosed or recurrent active neoplasia.

Required Medical Information

Tracking of patient weight for continuation/reapproval of therapy.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

Four weeks

Other Criteria

Patient is currently receiving and will continue to receive any one or a combination of the following specialized nutritional support: high complex-carbohydrate, low-fat diet, TPN, IPN, PPN, rehydration solutions, electrolyte replacement.

Vantage Health Plan 2011 Prior Authorization Criteria

Drug Index

AccuNeb	32	chorionic gonadotropin, human.....	32	Gengraf	32
Actiq.....	29	Cimzia	7	Genotropin	11
Adderall	2	Cimzia Powder for Reconst.....	7	Genotropin Miniquick.....	11
Adderall XR.....	2	Clinimix 2.75%/D5 Sulfite Free.....	32	granisetron	32
Afinitor.....	3	Clinimix 4.25%/D5 Sulfite Free.....	32	Granisol	32
Aminosyn 10 %.....	32	Clinimix 4.25/D10 Sulfite Free	32	Hepatamine 8%.....	32
Aminosyn 3.5 %.....	32	Clinimix 4.25/D20 Sulfite Free	32	Hepatasol 8 %	32
Aminosyn 5 %.....	32	Clinimix 4.25/D25 Sulfite Free	32	Humatrope	11
Aminosyn 7 %.....	32	Clinimix 5%/D15 Sulfite Free.....	32	Humira	12
Aminosyn 7 % with Electrolytes.....	32	Clinimix 5%/D20 Sulfite Free.....	32	Humira Crohn's Dis Start Pck.....	12
Aminosyn 8.5 %.....	32	Clinimix 5%/D25 Sulfite Free.....	32	Imuran.....	32
Aminosyn 8.5 %-Electrolytes	32	Clinimix E 2.75/D10 SulfiteFree	32	Increlex	13
Aminosyn II 10 %	32	Clinimix E 4.25/D25 SulfiteFree	32	Infergen.....	14
Aminosyn II 15%	32	Clinimix E 4.25/D5 SulfiteFree.....	32	Intralipid	32
Aminosyn II 3.5 %/Dextrose 5 % ...	32	Clinimix E 5%/D15 Sulfite Free	32	Intron A.....	15
Aminosyn II 3.5 %-Dextrose 25% ..	32	Clinimix E 5%/D20 Sulfite Free	32	Istodax	16
Aminosyn II 3.5% M/Dextrose 5%.	32	Clinimix E 5%/D25 Sulfite Free	32	itraconazole.....	17
Aminosyn II 3.5%-Lytes-Ca-D25W	32	Clinisol SF 15%	32	Kineret	19
Aminosyn II 4.25%/Dextrose 20% .	32	colistimethate sodium.....	32	Kytril.....	32
Aminosyn II 4.25%-Dextrose 10% .	32	Coly-Mycin M Parenteral.....	32	Lamisil.....	52
Aminosyn II 4.25%-Dextrose 25% .	32	Concerta	21	Leukine	26
Aminosyn II 4.25%-Lytes-Ca-D25 .	32	Copaxone.....	23	Lidoderm	20
Aminosyn II 5%/Dextrose 25%	32	Copegus.....	41	Liposyn II	32
Aminosyn II 7 %	32	cromolyn.....	32	Liposyn III	32
Aminosyn II 8.5 %	32	cyclophosphamide	32	METADATE CD.....	21
Aminosyn II 8.5 %-Electrolytes.....	32	cyclosporine	32	METADATE ER	21
Aminosyn M 3.5 %	32	cyclosporine modified	32	Methylin.....	21
Aminosyn-HBC 7%	32	Daytrana	21	methylphenidate.....	21
Aminosyn-HF 8 %	32	DECAVAC.....	32	Mozobil.....	22
Aminosyn-PF 10 %	32	Desoxyn.....	2	Myfortic	32
Aminosyn-PF 7 % (Sulfite-Free)	32	Dexedrine Spansule	2	Nebupent.....	32
Amphetamine Salt Combo	2	dexmethylphenidate.....	21	Neoral	32
AndroGel	53	dextroamphetamine	2	Nephramine 5.4 %	32
Anzemet.....	32	Differin	8	Neulasta	24
Aranesp (polysorbate).....	4	Emend	32	Neumega.....	25
Arcalyst.....	5	Enbrel	9	Neupogen.....	26
Atralin	1	Engerix-B (PF)	32	Nexavar.....	3
Avita.....	1	Epogen.....	10	Nicotrol.....	46
Avonex.....	23	fenfentanyl citrate.....	29	Nicotrol NS.....	46
Avonex Administration Pack	23	Fentora.....	29	Norditropin Cartridge	11
Azasan.....	32	Focalin.....	21	Norditropin Nordiflex	11
azathioprine.....	32	Focalin XR	21	Novamine 15 %	32
Betaseron	23	Forteo	31	Novarel	32
Buproban.....	46	Freamine HBC 6.9 %	32	Nutropin.....	11
bupropion HCl	46	Freamine III 3 %-Electrolytes	32	Nutropin AQ.....	11
Carimune NF Nanofiltered.....	18	Freamine III 8.5 %.....	32	Nuvigil.....	27
CellCept	32	Gammagard Liquid.....	18	Octagam.....	18
Cesamet.....	32	Gamunex	18	octreotide acetate	28
Chantix.....	6			ondansetron.....	32

Vantage Health Plan 2011 Prior Authorization Criteria

ondansetron HCl	32	Retin-A	1	tacrolimus	32
ORENCIA	30	Retin-A Micro	1	Tarceva	3
oxandrolone.....	50	Revatio	39	terbinafine	52
Pegasys Convenience Pack	34	REVLIMID	40	testosterone cypionate.....	53
PegIntron.....	35	RibaPak Dose Pack	41	testosterone enanthate	53
PegIntron Redipen	35	Ribasphere.....	41	tetanus toxoid,adsorbed (PF)	32
Perforomist.....	32	ribavirin	41	tetanus,diphtheria toxd ped-PF	32
Pregnyl	32	Ritalin	21	tetanus-diphtheria toxoids-Td	32
Premasol 10 %	32	Ritalin LA.....	21	Tev-Tropin.....	11
Premasol 6 %	32	Ritalin SR	21	Thalomid.....	54
Privigen.....	18	Rituxan	42	Travasol 10 %	32
Procalamine 3%	32	Saizen	11	tretinoin.....	1
Procrit.....	10	Saizen click.easy	11	Trexall.....	32
Prograf	32	Sandimmune.....	32	TrophAmine 10 %	32
Promacta	36	Sandostatin	28	Trophamine 6%	32
Prosol 20%	32	Sandostatin LAR Depot.....	43	Ventavis	32
Provigil.....	37	Serostim.....	11, 44	Vivaglobin	56
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Rebif.....	23	SOMAVERT	48	Xolair	58
Rebif Titration Pack.....	23	Sporanox.....	17	Zofran	32
Recombivax HB (PF).....	32	Sporanox Pulsepak	17	ZOFRAN ODT	32
Regranex	55	Stelara.....	49	Zorbtive	59
Remicade	38	Strattera	51		
Renamin 6.5 %	32	Sutent.....	3		