Prior Authorization Requirements

Effective: 01/01/2014

Updated 11/2013

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ABILIFY MAINTENA

DRUG NAME

ABILIFY MAINTENA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF SCHIZOPHRENIA

AGE RESTRICTIONS

MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ABRAXANE

DRUG NAME

ABRAXANE

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FOR BREAST CANCER - DOCUMENTATION OF FAILURE OF COMBINATION CHEMOTHERAPY FOR METASTATIC DISEASE OR RELAPSE WITHIN 6 MONTHS OF ADJUVANT CHEMOTHERAPY AND DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ANTHRACYCLINE AND DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO STANDARD PACLITAXEL THERAPY. FOR NSCLC - DOCUMENTATION OF ABRAXANE USED AS FIRST-LINE TREATMENT IN COMBINATION WITH CARBOPLATIN WHO ARE NOT CANDIDATES FOR CURATIVE SURGERY OR RADIATION THERAPY.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ACTEMRA

DRUG NAME

ACTEMRA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

FOR JIA - MUST BE 2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

RHEUMATOLOGIST

COVERAGE DURATION

6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA

FOR RA: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO HUMIRA AND ENBREL OR REMICADE. FOR JIA: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO HUMIRA AND ENBREL.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ACTIQ

DRUG NAME

FENTANYL CITRATE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DOCUMENTATION OF USE TO MANAGE BREAKTHROUGH CANCER PAIN IN PATIENTS WITH CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

AFINITOR

DRUG NAME

AFINITOR

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST OR NEPHROLOGIST OR UROLOGIST

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

FOR RENAL CELL CARCINOMA: THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO SUTENT OR NEXAVAR. FOR BREAST CANCER: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO PREVIOUS ENDOCRINE THERAPY TREATMENT AND AFINITOR MUST BE USED IN COMBINATION WITH AN AROMATASE INHIBITOR. FOR RENAL ANGIOMYOLIPOMA AND TUBUEROUS SCLEROSIS COMPLEX/SPORADIC LYMPHANGIOLEIOMYMATOSIS: AT LEAST ONE

Geisinger Health Plan - 14325
Prior Authorization Requirements

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ALDURAZYME

DRUG NAME

ALDURAZYME

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF HURLER FORM OF MPS I OR HURLER-SCHEIE FORM OF MPS I OR SCHEIE FORM OF MPS WITH MODERATE TO SEVERE SYMPTOMS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

METABOLIC SPECIALIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ALINIA

DRUG NAME

ALINIA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

AMPYRA

DRUG NAME

AMPYRA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

NEUROLOGIST

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

CONCOMITANT THERAPY ON BETASERON, COPAXONE, OR AVONEX WITH DEMONSTRATED IMPROVEMENT IN TIMED 25 FT GAIT TEST

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ANTIPARKINSON AGENT HRM

DRUG NAME

BENZTROPINE MESYLATE | TRIHEXYPHENIDYL HCL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ARALAST

DRUG NAME

ARALAST NP

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF PANACINAR EMPHYSEMA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ARANESP

DRUG NAME

ARANESP

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

3 MONTHS

Geisinger Health Plan - 14325
Prior Authorization Requirements

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ARRANON

DRUG NAME

ARRANON

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FOR RELAPSED OR REFRACTORY LYMPHOBLASTIC LEUKEMIA - DOCUMENTATION OF FAILURE TO RESPOND TO OR RELAPSE FOLLOWING TREATMENT WITH A MINIMUM OF 2 CHEMOTHERAPY REGIMENS

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ARZERRA

DRUG NAME

ARZERRA

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF CHRONIC LYMPHOCYTIC LEUKEMIA (CLL)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO CAMPATH AND FLUDARABINE OR RITUXAN

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

AUBAGIO

DRUG NAME

AUBAGIO

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF RELAPSING FORM OF MULTIPLE SCLEROSIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

NEUROLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO BETASERON AND COPAXONE

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

AVASTIN

DRUG NAME

AVASTIN

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

BONIVA IV

DRUG NAME

BONIVA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF OSTEOPOROSIS IN POSTMENOPAUSAL WOMEN

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

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Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

BOSULIF

DRUG NAME

BOSULIF

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OF THE FOLLOWING PRIOR THERAPIES GLEEVEC, SPRYCEL, OR TASIGNA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

BUPROPION 24 HR

DRUG NAME

APLENZIN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DOCUMENTATION OF A DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER OR SEASONAL AFFECTIVE DISORDER.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO BUPROPION XL.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

BUTRANS

DRUG NAME

BUTRANS

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY OPIOIDS, ONE OF WHICH MUST BE MORPHINE SULFATE ER.

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Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

BVD ONLY

DRUG NAME

ABELCET | ACYCLOVIR SODIUM | ADRIAMYCIN | ALBUTEROL SULFATE | AMBISOME | AMINOSYN II | AMINOSYN M | AMINOSYN-HBC | AMINOSYN-PF | AMPHOTERICIN B | ANZEMET | AZASAN | AZATHIOPRINE | AZATHIOPRINE SODIUM | BLEOMYCIN SULFATE | CELLCEPT | CLADRIBINE | CLINISOL | CROMOLYN SODIUM | CYCLOSPORINE | CYCLOSPORINE MODIFIED | CYTARABINE | DEXTROSE IN WATER | DOXIL | ENGERIX-B | FLUOROURACIL | FOSCARNET SODIUM | GANCICLOVIR SODIUM | GENGRAF | GRANISETRON HCL | GRANISOL | HAVRIX | HERCEPTIN | IFOSFAMIDE | IMOVAX RABIES VACCINE | INTRALIPID | IPRATROPIUM-ALBUTEROL | KEPIVANCE | LIPOSYN III | METHOTREXATE | MITOMYCIN | MYCOPHENOLATE MOFETIL | MYFORTIC | NEBUPENT | ONDANSETRON HCL | ONDANSETRON ODT | PREMASOL | PROGRAF | PROSOL | PULMOZYME | RABAVERT | RAPAMUNE | RECOMBIVAX HB | SIMULECT | TACROLIMUS | TETANUS TOXOID ADSORBED | TOBI | TRAVASOL | TROPHAMINE | VAQTA | VINBLASTINE SULFATE | VINCRISTINE SULFATE

COVERED USES

THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CEREZYME

DRUG NAME

CEREZYME

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

METABOLIC SPECIALIST WITH EXPERIENCE TREATING GAUCHER DISEASE

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ELELYSO

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CIMZIA

DRUG NAME

CIMZIA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF CHROHN'S DISEASE OR RHEUMATOID ARTHRITIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CINRYZE

DRUG NAME

CINRYZE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ALLERGIST, IMMUNOLOGIST, HEMATOLOGIST OR DERMATOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CLOLAR

DRUG NAME

CLOLAR

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF RELAPSED OR REFRACTORY ACUTE LYMPHOBLASTIC LEUKEMIA

AGE RESTRICTIONS

1 TO 21 YEARS OF AGE

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO PRIOR TREATMENT REGIMENS

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CLOMIPRAMINE HRM

DRUG NAME

CLOMIPRAMINE HCL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

COMETRIQ

DRUG NAME

COMETRIQ

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PROGRESSIVE METASTATIC MEDULLARY THYROID CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CORTICOSTEROID B VERSUS D DETERMINATION

DRUG NAME

A-HYDROCORT | CORTISONE ACETATE | DEXAMETHASONE | DEXAMETHASONE SODIUM PHOSPHATE | HYDROCORTISONE | METHYLPREDNISOLONE | METHYLPREDNISOLONE ACETATE | METHYLPREDNISOLONE SOD SUCC | PREDNISOLONE SODIUM PHOSPHATE | PREDNISONE | SOLU-MEDROL | VERIPRED 20

COVERED USES

THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CRESTOR 10MG, 20MG, 40MG

DRUG NAME

CRESTOR

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO THE EQUIPOTENT DOSE OF ATORVASTATIN.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CRESTOR 5MG

DRUG NAME

CRESTOR

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO 2 EQUIPOTENT HMG COA REDUCTASE INHIBITORS, ONE OF WHICH MUST BE ATORVASTATIN.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CRIZOTINIB

DRUG NAME

XALKORI

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

THE FDA APPROVED TEST TO MAKE ALK POSITIVE DETERMINATION IS THE VYSIS ALK BREAK-APART FISH PROBE KIT

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CYCLOSET

DRUG NAME

CYCLOSET

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF TYPE 2 DIABETES MELLITUS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO ORAL FORMULARY ALTERNATIVES.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

CYPROHEPTADINE HRM

DRUG NAME

CYPROHEPTADINE HCL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

DACOGEN

DRUG NAME

DACOGEN

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO VIDAZA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

DALIRESP

DRUG NAME

DALIRESP

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF COPD ASSOCIATED WITH CHRONIC BRONCHITIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

CONCOMITANT USE OF, FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO SPIRIVA AND ONE LONG ACTING BETA AGONISTS.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ELAPRASE

DRUG NAME

ELAPRASE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF HUNTER'S SYNDROME (MPS II)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

METABOLIC SPECIALIST WITH EXPERIENCE TREATING MPS II

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ELELYSO

DRUG NAME

ELELYSO

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

METABOLIC SPECIALIST WITH EXPERIENCE TREATING GAUCHER DISEASE

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ELIDEL

DRUG NAME

ELIDEL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF ATOPIC DERMATITIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

DERMATOLOGIST OR ALLERGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ELITEK

DRUG NAME

ELITEK

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

1 COURSE OF THERAPY (5 DAYS)

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ELOXATIN

DRUG NAME

ELOXATIN

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

Geisinger Health Plan - 14325
Prior Authorization Requirements

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

EMEND

DRUG NAME

EMEND

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST, ONCOLOGIST, SURGEON

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

MUST BE USED IN COMBINATION WITH OTHER ORAL ANTIEMETIC AGENTS WHEN USED FOR THE PREVENTION OF CHEMOTHERAPY INDUCED NAUSEA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ENBREL

DRUG NAME

ENBREL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

RHEUMATOLOGIST OR DERMATOLOGIST

COVERAGE DURATION

6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

EPOGEN

DRUG NAME

EPOGEN

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

3 MONTHS

Geisinger Health Plan - 14325
Prior Authorization Requirements

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ERAXIS

DRUG NAME

ERAXIS (ALCOHOL DILUENT)

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION

8 WEEKS (TWO COURSES OF THERAPY)

OTHER CRITERIA

FOR A DIAGNOSIS OF ESOPHAGEAL CANDIDIASIS - FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO FLUCONAZOLE THERARPY

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ERBITUX

DRUG NAME

ERBITUX

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ERIVEDGE

DRUG NAME

ERIVEDGE

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST OR DERMATOLOGIST

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

NOT A CANDIDATE FOR SURGERY AND RADIATION. PER NCCN GUIDELINES, TREATMENT SUPPORTED BY MULTIDISCIPLINARY BOARD CONSULTATION OR A SECOND DERMATOLOGIST OR ONCOLOGIST.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ESRD B VERSUS D DETERMINATION

DRUG NAME

CALCITRIOL | CUBICIN | HECTOROL | HEPARIN SODIUM | LEVOCARNITINE | LIDOCAINE | LIDOCAINE HCL | LIDOCAINE-PRILOCAINE | MIACALCIN | PAMIDRONATE DISODIUM | VANCOMYCIN HCL | ZEMPLAR

COVERED USES

THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ESTROGENS HRM (ORAL AND TOPICAL PATCH PRODUCTS ONLY)

DRUG NAME

CENESTIN | ESTRADIOL | ESTRADIOL-NORETHINDRONE ACETAT | ESTROPIPATE | JINTELI | MENEST | PREMARIN | PREMPHASE | PREMPRO | VIVELLE-DOT

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

EXJADE

DRUG NAME

EXJADE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

FABRAZYME

DRUG NAME

FABRAZYME

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF FABRY DISEASE

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

METABOLIC SPECIALIST WITH EXPERIENCE TREATING FABRY DISEASE

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

FERRIPROX

DRUG NAME

FERRIPROX

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF TRANSFUSIONAL IRON OVERLOAD DUE TO THALASSEMIA SYNDROME

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO EXJADE. DOCUMENTATION OF ANC GREATER THAN 1.5 X 1000000000 (10 TO THE 9TH POWER) / L

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

FORTEO

DRUG NAME

FORTEO

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ENDOCRINOLOGIST OR RHEUMATOLOGIST

COVERAGE DURATION

24 MONTHS

OTHER CRITERIA

ATTEMPT OF THERAPY WITH OR CONTRAINDICATION TO BISPHOSPHONATE

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

GILENYA

DRUG NAME

GILENYA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF A RELAPSING FORM OF MULTIPLE SCLEROSIS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

NEUROLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO INTERFERON DISEASE MODIFYING THERAPY (BETASERON, AVONEX, OR REBIF) AND COPAXONE.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

GROWTH HORMONE

DRUG NAME

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

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

GROWTH HORMONE STIMULATION TESTS, IGF-I LEVELS, GROWTH VELOCITY CURVES

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ENDOCRINOLOGIST OR NEPHROLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

HALAVEN

DRUG NAME

HALAVEN

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF METASTATIC BREAST CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

HUMIRA

DRUG NAME

HUMIRA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

RHEUMATOLOGIST, GASTROENTEROLOGIST, DERMATOLOGIST

COVERAGE DURATION

6 MONTHS INITIAL AND 1 YEAR CONTINUATION

Geisinger Health Plan - 14325
Prior Authorization Requirements

OTHER CRITERIA

IN ORDER TO RECEIVE WEEKLY DOSING OF HUMIRA, MUST SHOW DOCUMENTATION OF THERAPEUTIC FAILURE ON EVERY OTHER WEEK DOSING SCHEDULE.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

HYDROXYZINE HRM

DRUG NAME

HYDROXYZINE HCL | HYDROXYZINE PAMOATE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ICLUSIG

DRUG NAME

ICLUSIG

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF CHRONIC PHASE, ACCELERATED PHASE, OR BLAST PHASE CHRONIC MYELOID LEUKEMIA (CML) OR PHILADELPHIA CHROMOSOME POSITIVE ACUTE LYMPHOBLASTIC LEUKEMIA (PH+ALL)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

DOCUMENTATION OF RESISTANCE OR INTOLERANCE TO ONE PRIOR TYROSINE KINASE INHIBITOR THERAPY OR DOCUMENTATION OF CML CELL MUTATION T3151

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

INCIVEK

DRUG NAME

INCIVEK

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF GENOTYPE 1 CHRONIC HEPATITIS C

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 WEEK COURSE OF THERAPY PER LIFETIME

OTHER CRITERIA

MUST BE USED CONCURRENTLY WITH PEGINTERFERON ALFA AND RIBAVIRIN

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

INLYTA

DRUG NAME

INLYTA

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF ADVANCED RENAL CELL CARCINOMA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

FAILURE ON ONE PRIOR SYSTEMIC THERAPY

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

INTUNIV

DRUG NAME

INTUNIV

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

AGE RESTRICTIONS

MUST BE BETWEEN 6 TO 17 YEARS OF AGE.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY STIMULANTS

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

INVEGA SUSTENNA

DRUG NAME

INVEGA SUSTENNA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF SCHIZOPHRENIA

AGE RESTRICTIONS

MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ISTODAX

DRUG NAME

ISTODAX

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF CUTANEOUS OR PERIPHERAL T-CELL LYMPHOMA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ITRACONAZOLE

DRUG NAME

ITRACONAZOLE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

POSITIVE CULTURE SUBSTANTIATING DIAGNOSIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FOR ONYCHOMYCOSIS: FAILURE ON, CONTRAINDICATION TO, OR INTOLERANCE TO TERBINAFINE

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

IVIG

DRUG NAME

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

COVERED USES

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

EXCLUSION CRITERIA

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

REQUIRED MEDICAL INFORMATION

ACUTE ITP: ACTIVE BLEEDING & PLATELET COUNT LESS THAN 30,000/UL OR PRE-OP TX PRIOR TO MAJOR SURGICAL PROCEDURE OR PLATELET COUNT LESS THAN 20,000/UL & AT RISK FOR INTRACEREBRAL HEMORRHAGE. CHRONIC ITP: PRIOR TX W/ CORTICOSTEROIDS & SPLENECTOMY, AND DURATION OF ILLNESS GREATER THAN 6 MONTHS, AND 10 YEARS OF AGE OR OLDER, AND NO CONCURRENT ILLNESS EXPLAINING THROMBOCYTOPENIA, AND PLATELET COUNT LESS THAN 20,000/UL. CLL: DEFINITIVE DIAGNOSIS OF CLL, AND IGG LEVEL LESS THAN 600 MG/DL, AND

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Prior Authorization Requirements

HISTORY OF SERIOUS BACTERIAL INFECTION REQUIRING EITHER ORAL OR PARENTERAL ABX TX W/IN LAST 6 MONTHS. HIV: 14 YEARS OF AGE OR OLDER, AND EVIDENCE OF EITHER QUALITATIVE OR QUANTITATIVE HUMORAL IMMUNOLOGIC DEFECTS, AND CURRENT BACTERIAL INFECTIONS DESPITE APPOPRIATE ABX PROPHYLAXIS, CIDP: DEFINITIVE DIGANOSIS OF CIDP PER AMERICAN ACADEMY OF NEUROLOGY OR MEDICAL ADVISORY COMMITTEE OF THE NEUROPATHY ASSOCIATION, REFRACTORY TO OR INTOLERANT OF PREDNISONE OR AZATHIOPRINE GIVEN IN THERAPEUTIC DOSES OVER AT LEAST 3 MONTHS, NEUROLOGIC FUNCTION ASSESSMENT SCORE OF AT LEAST 3 OR GREATER ON THE RANKIN SCALE AT THE TIME OF INITIAL THERAPY. DERMATOMYOSITIS / POLYMYOSITIS: BIOPSY PROVEN DISEASE, AND ACTIVE DISEASE, AND REFRACTORY TO BOTH CORTICOSTEROID THERAPY (AT LEAST 4 MONTHS) & IMMUNOSUPPRESANTS (AT LEAST TWO OF THE FOLLOWING CYCLOSPORINE, AZATHIOPRINE, METHOTREXATE, CYCLOPHOSPHAMIDE). AHA: WARM-TYPE AUTOIMMUNE HEMOLYTIC ANEMIA WITH FAILURE OF, INTOLERANCE TO, OR CONTRAIDICATIONS TO CORTICOSTEROIDS OR SPLENECTOMY. MS: FAILURE ON AT LEAST 2 STANDARD APPROACHES (INTERFERONS, COPAXONE) AFTER A MINIMUM TRIAL OF 3 MONTHS OR, INTOLERANCE TO, OR CONTRAINDICATION TO THESE THERAPIES. MMN: PROGRESSIVE & SYMPTOMATIC DISEASE FOR A MINIMUM OF 2 MONTHS DIAGNOSISED WITH ELECTROPHYSICAL FINDINGS OF CONDUCTION BLOCK ON A SINGLE NERVE OR PROBABLE CONDUCTION BLOCK IN 2 OR MORE NERVES OR NORMAL SENSORY NERVE CONDUCTION IN UPPER LIMB SEGEMENTS AND NORMAL SENSORY NERVE ACTION POTENTIAL (SNAP) AMPLITUDE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

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

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

IXEMPRA

DRUG NAME

IXEMPRA

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF METASTATIC OR LOCALLY ADVANCED BREAST CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

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Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

JEVTANA

DRUG NAME

JEVTANA

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF HORMONE-REFRACTORY METASTATIC PROSTATE CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

DOCUMENTATION OF TUMOR WIHTOUT NEUROENDOCRINE FEATURES AND DOCUMENTATION OF NEUTROPHIL COUNT GREATER THAN 1500 CELLS/MM(3) AND FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A DOCETAXEL-BASED REGIMEN.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

KADCYLA

DRUG NAME

KADCYLA

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF HER2-POSITIVE, METASTATIC BREAST CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

DOCUMENTATION OF PREVIOUS TREATMENT WITH TRASTUZUMAB (HERCEPTIN) AND A TAXANE (PACLITAXEL OR DOCETAXEL), SEPARATELY OR IN COMBINATION. MUST HAVE EITHER RECEIVED PRIOR THERAPY FOR METASTATIC DISEASE OR DEVELOPED DISEASE RECURRENCE DURING OR WITHIN SIX MONTHS OF COMPLETING ADJUVANT.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

KALYDECO

DRUG NAME

KALYDECO

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

MUST BE 6 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

PULMONOLOGIST

COVERAGE DURATION

2 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA

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Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

KETEK

DRUG NAME

KETEK

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF COMMUNITY ACQUIRED PNEUMONIA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, CONTRAINDICATION TO, OR INTOLERANCE TO AZITHROMYCIN, CLARITHROMYCIN OR ERYTHROMYCIN

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

KINERET

DRUG NAME

KINERET

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

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Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

KORLYM

DRUG NAME

KORLYM

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

PREGNANCY

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ENDOCRINOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

THERAPEUTIC FAILURE ON, CONTRAINDICATION TO, OR INTOLERANCE TO AT LEAST TWO FORMULARY ANTI-DIABETIC ALTERNATIVES

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

KUVAN

DRUG NAME

KUVAN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

BASELINE BLOOD PHE LEVEL LESS THAN 450 UMOL/L.

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

METABOLIC SPECIALIST

COVERAGE DURATION

INITIALLY 2 MONTHS THEN INDEFINITE IF PATIENT IS A RESPONDER

OTHER CRITERIA

COMPLIANT WITH A PHE RESTRICTED DIET, 30% OR GREATER REDUCTION IN PHE AT WK 8 FOR INDEFINITE AUTH

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Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

LATUDA

DRUG NAME

LATUDA

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF SCHIZOPHRENIA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ATYPICAL ANTIPSYCHOTICS (OLANZAPINE, RISPERIDONE, QUETIAPINE, ZIPRASIDONE, ABILIFY) OR FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ZIPRASIDONE AND ABILIFY FOR MEMBERS WITH METABOLIC SYNDROME.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

LAZANDA

DRUG NAME

LAZANDA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CANCER AND OF USE TO MANAGE BREAKTHROUGH CANCER PAIN

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

MEDICAL RECORD DOCUMENTATION OF CONCOMITANT MORPHINE 60 MG/DAY OR MORE, TRANSDERMAL FENTANYL 25 MCG/H, OXYCODONE 30 MG/DAY, ORAL HYDROMORPHONE 8 MG/DAY, OR AN EQUIANALGESIC DOSE OF ANOTHER OPIOID FOR 1 WEEK OR LONGER AND FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO GENERIC FENTANYL LOZENGES.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

LETAIRIS

DRUG NAME

LETAIRIS

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF FUNCTIONAL CLASS 2 OR 3 PULMONARY ARTERIAL HYPERTENSION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO REVATIO AND TRACLEER

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

LEUKINE

DRUG NAME

LEUKINE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

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

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

Geisinger Health Plan - 14325
Prior Authorization Requirements

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

LIDODERM

DRUG NAME

LIDODERM

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF POST-HERPETIC NEURALGIA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, CONTRAINDICTION TO, OR INTOLERANCE TO GABAPENTIN

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

LINZESS

DRUG NAME

LINZESS

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF IRRITABLE BOWEL SYNDROME WITH CONSTIPATION OR CHRONIC IDIOPATHIC CONSTIPATION

AGE RESTRICTIONS

MUST 6 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY CATHARTICS AND LAXATIVES

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

LOMOTIL

DRUG NAME

DIPHENOXYLATE-ATROPINE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION AND WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO LOPERAMIDE

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

MACROLIDES

DRUG NAME

AZITHROMYCIN | CLARITHROMYCIN | CLARITHROMYCIN ER | E.E.S. 400 | ERY-TAB | ERYTHROCIN STEARATE | ERYTHROMYCIN | ERYTHROMYCIN ETHYLSUCCINATE | PCE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

1 MONTH

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ANTIBIOTIC CLASS ALTERNATIVES WHICH INCLUDE 2ND OR 3RD GENERATION CEPHALSPORINS (SUCH AS CEFACLOR OR CEFPODOXIME), PENICILLINS (SUCH AS AMOXICILLIN OR AMOXICILLIN/CLAVULANATE), OR QUINOLONES (SUCH AS CIPROFLOXACIN OR LEVOFLOXACIN) IF CONCURRENT USE OF DIGOXIN

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

MEKINIST

DRUG NAME

MEKINIST

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST OR DERMATOLOGIST

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

MEPROBAMATE HRM

DRUG NAME

MEPROBAMATE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ANXIETY

AGE RESTRICTIONS

ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

MUSCLE RELAXANTS

DRUG NAME

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

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

MYOZYME

DRUG NAME

MYOZYME

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF INFANTILE ONSET POMPE DISEASE (IOPD)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

METABOLIC SPECIALIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

NAGLAZYME

DRUG NAME

NAGLAZYME

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF MUCOPOLYSACCHARIDOSIS VI (MAROTEAUX-LAMY DISEASE)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

METABOLIC SPECIALIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

NEULASTA

DRUG NAME

NEULASTA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

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

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

Geisinger Health Plan - 14325
Prior Authorization Requirements

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

NEUPOGEN

DRUG NAME

NEUMEGA | NEUPOGEN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

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

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

Geisinger Health Plan - 14325
Prior Authorization Requirements

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

NEXAVAR

DRUG NAME

NEXAVAR

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

NEXIUM IV

DRUG NAME

NEXIUM I.V.

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO PANTOPRAZOLE IV.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

NITROFURANTOIN

DRUG NAME

NITROFURANTOIN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

NOXAFIL

DRUG NAME

NOXAFIL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FOR OROPHARYNGEAL CANDIDIASIS: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ITRACONAZOLE ORAL SOLUTION AND FLUCONAZOLE.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

NUEDEXTA

DRUG NAME

NUEDEXTA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

NULOJIX

DRUG NAME

NULOJIX

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DOCUMENTATION OF RENAL TRANSPLANT

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

DOCUMENTATION OF EPSTEIN-BARR VIRUS (EBV) SEROPOSITIVITY

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

NUVIGIL

DRUG NAME

NUVIGIL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FOR OBSTRUCTIVE SLEEP APNEA, DOCUMENTATION OF CPAP HISTORY OR STATUS.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

OLEPTRO

DRUG NAME

OLEPTRO ER

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DOCUMENTATION OF A DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER

AGE RESTRICTIONS

MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ANTIDEPRESSANTS, ONE OF WHICH MUST BE TRAZODONE

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ONFI

DRUG NAME

ONFI

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF LENNOX-GASTAUT SYNDROME

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

NEUROLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ONTAK

DRUG NAME

ONTAK

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF PERSISTENT OR RECURRENT/RELAPSING CUTANEOUS T-CELL LYMPHOMA (CTCL) EXPRESSING THE CD25 COMPONENT OF THE IL-2 RECEPTOR

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ORENCIA

DRUG NAME

ORENCIA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

FOR RA - MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

RHEUMATOLOGIST

COVERAGE DURATION

6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA

DOCUMENTATION OF AN INADEQUATE RESPONSE TO A MINIMUM 3 MONTH TRIAL OF HUMIRA AND ENBREL

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

PERJETA

DRUG NAME

PERJETA

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

PICATO

DRUG NAME

PICATO

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

DERMATOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO FLUOROURACIL

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

POMALYST

DRUG NAME

POMALYST

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF MULTIPLE MYELOMA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO PRIOR THERAPIES: BORTEZOMIB (VELCADE) AND LENALIDOMIDE (REVLIMID).

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

POTIGA

DRUG NAME

POTIGA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PARTIAL ONSET SEIZURES

AGE RESTRICTIONS

MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ANTICONVULSANTS

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

PROCRIT

DRUG NAME

PROCRIT

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

3 MONTHS

Geisinger Health Plan - 14325
Prior Authorization Requirements

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

PROMACTA

DRUG NAME

PROMACTA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

THERAPEUTIC FAILURE ON OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS OR SPLENECTOMY

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

PROMETHAZINE HRM

DRUG NAME

PHENADOZ | PROMETHAZINE HCL | PROMETHAZINE VC | PROMETHEGAN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

PROVIGIL

DRUG NAME

MODAFINIL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FOR OBSTRUCTIVE SLEEP APNEA, DOCUMENTATION OF CPAP HISTORY OR STATUS.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

RELISTOR

DRUG NAME

RELISTOR

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

MEDICAL RECORD DOCUMENTATION OF ADVANCED ILLNESS RECEIVING PALLIATIVE CARE. CONCURRENT USE OF OPIOD THERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO LACTULOSE AND POLYETHYLENE GLYCOL 3350.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

REMICADE

DRUG NAME

REMICADE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

CROHN'S DISEASE- DIAGNOSIS OF MODERATE TO SEVERE CROHN'S AND DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY (AMINOSALICYLATES, CORTICOSTEROIDS, OR IMMUNOMODULATORS) AND 12 WEEKS OF HUMIRA THERAPY OR DIAGNOSIS OF CROHN'S WITH ACTIVE DRAINING FISTULAS. RA - DIAGNOSIS OF MODERATE TO SEVERE RA AND A FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO 12 WEEKS OF ENBREL AND HUMIRA THERAPY. ANKYLOSING SPONDYLITIS - DOCUMENTATION OF 12 WEEKS OF ENBREL AND HUMIRA THERAPY. PLAQUE PSORIASIS - DIAGNOSIS OF CHRONIC, SEVERE PLAQUE PSORIASIS WITH AT LEAST 10% BSA OR DISEASE OF PALMS OR SOLES OF FEET WHICH IMPAIRS ADL AND FAILURE ON, INTOLERANCE ON, OR CONTRAINDICATION TO 12 WEEKS OF ENBREL AND HUMIRA THERAPY. PSORIATIC ARTHRITIS - DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE PSA WITH HISTORY OF PSORIASIS OR ACTIVE PSORIATIC LESIONS AND 12 WEEKS OF ENBREL AND HUMIRA THERAPY. ULCERATIVE COLITIS - DIAGNOSIS OF MODERATE TO SEVERE UC AND INTOLERANCE, FAILURE ON, OR CONTRAINDICATION TO TWO OF THE FOLLOWING (AMINOSALICYLATES, CORTICOSTEROIDS AND IMMUNOMODULATORS).

AGE RESTRICTIONS

MUST BE AT LEAST 18 YEARS OF AGE FOR THE FOLLOWING DIAGNOSES - RA, ,ANKYLOSING SPONDYLITIS, PLAQUE PSORIASIS, AND PSORIATIC ARTHRITIS, MUST BE AT LEAST 6 YEARS OF AGE FOR CHRON'S DISEASE AND ULCERATIVE COLITIS.

PRESCRIBER RESTRICTIONS

RHEUMATOLOGIST OR DERMATOLOGIST OR GASTROENTEROLOGIST

Geisinger Health Plan - 14325
Prior Authorization Requirements

COVERAGE DURATION

6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA

FOR RA, REMICADE MUST BE USED IN COMBINATION WITH METHOTREXATE. FIRST LINE THERAPY FOR UC INCLUDES TRIALS OF TWO OF THE FOLLOWING, CORTICOSTEROIDS, AMINOSALICYLATES, AND IMMUNOMODULATORS (6-MERCAPTOPURINE AND AZATHIOPRINE).

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

REVATIO

DRUG NAME

REVATIO | SILDENAFIL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

CONCOMITANT USE OF ORGANIC NITRATES

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

REVLIMID

DRUG NAME

REVLIMID

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

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Prior Authorization Requirements

IMMUNOSUPPRESSIVE THERAPY OR DOCUMENTATION OF LOWER RISK PATIENT WITH SYMPTOMATIC ANEMIA AND NO RESPONSE TO INITIAL TREATMENT WITH EPOETIN ALFA OR DARBOPOETIN ALFA, HYPOMETHYLATING AGENTS, OR IMMUNOSUPPRESSIVE THERAPY.

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Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

RISPERDAL CONSTA

DRUG NAME

RISPERDAL CONSTA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF SCHIZOPHRENIA

AGE RESTRICTIONS

MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

DOCUMENTED HISTORY OF POOR ADHERENCE TO ORAL MEDICATIONS AND DOCUMENTATION THAT PATIENT EDUCATION TO IMPROVE ADHERENCE HAS BEEN ATTEMPTED.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

RITUXAN

DRUG NAME

RITUXAN

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

FOR RA - MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

FOR RA - RHEUMATOLOGIST

COVERAGE DURATION

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

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Prior Authorization Requirements

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

RUXOLITINIB

DRUG NAME

JAKAFI

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST OR HEMATOLOGIST

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

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

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Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SABRIL

DRUG NAME

SABRIL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

INFANTILE SPASMS - 1 MONTH TO 2 YEARS OF AGE

PRESCRIBER RESTRICTIONS

NEUROLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FOR REFRACTORY COMPLEX PARTIAL SEIZURES MUST BE ON CONCOMMITANT THERAPY WITH ANOTHER SEIZURE CONTROL MEDICATION

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Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SAPHRIS

DRUG NAME

SAPHRIS

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF BIPOLAR DISORDER OR SCHIZOPHRENIA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

MEDICAL RECORD DOCUMENTATION OF TRIAL ON TWO FORMULARY ALTERNATIVES (ABILIFY, GEODON, RISPERIDONE,SEROQUEL, OR ZYPREXA).

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Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SIMPONI

DRUG NAME

SIMPONI

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SIMVASTATIN 40MG AND 80MG

DRUG NAME

SIMVASTATIN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO PRAVASTATIN AND ROSUVASTATIN IF CONCURRENT USE OF AMIODARONE

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SLEEPERS

DRUG NAME

ZALEPLON | ZOLPIDEM TARTRATE | ZOLPIDEM TARTRATE ER

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SOMATULINE DEPOT

DRUG NAME

SOMATULINE DEPOT

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF ACROMEGALY

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

INADEQUATE RESPONSE OR CONTRAINDICATION TO SURGERY AND/OR RADIOTHERAPY

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SORIATANE

DRUG NAME

SORIATANE

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

FOR PSORIASIS: PRESCRIBED BY DERMATOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FOR PSORIASIS: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ONE TOPICAL CORTICOSTEROID AND AT LEAST 2 TO 3 MONTHS OF METHOTREXATE OR PHOTOTHERAPY.

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Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SPRYCEL

DRUG NAME

SPRYCEL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF CML OR PH+ ALL

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

FOR CML - DOCUMENTATION OF THE USE OF SPRYCEL TO TREAT CHRONIC PHASE CML OR DOCUMENTATION OF THE USE OF SPRYCEL TO TREATE CML WITH RESISTANCE OR INTOLERANCE TO PRIOR THERAPY INCLUDING GLEEVEC. FOR PH+ ALL - DOCUMENTATION OF THE USE OF SPRYCEL TO TREAT PH+ ALL WITH RESISTANCE OR INTOLERANCE TO PRIOR THERAPY.

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Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

STELARA

DRUG NAME

STELARA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

DERMATOLOGIST

COVERAGE DURATION

6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA

DOCUMENTATION OF AN INADEQUATE RESPONSE TO A MINIMUM 3 MONTH TRIAL OF HUMIRA AND ENBREL OR REMICADE

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

STIVARGA

DRUG NAME

STIVARGA

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DOCUMENTATION OF METASTATIC COLORECTAL CANCER OR DOCUMENTATION OF LOCALLY ADVANCED, UNRESTECTABLE OR METASTATIC GASTROINTESTINAL STROMAL TUMOR (GIST).

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

FOR METASTATIC COLORECTAL CANCER: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO THREE OF THE FOLLOWING PRIOR THERAPIES (BASED ON CLINICAL TRIAL DESIGN) - FLUOROPYRIMIDINE BASED CHEMO, OXALIPLATIN BASED CHEMO, IRINOTECAN BASED CHEMO, ANTI-VEGF THERAPY (BEVACIZUMAB) OR IF KRAS WILD TYPE AN ANTI-EGFR THERAPY (CETUXIMAB OR PANITUMUMAB). FOR GIST: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO IMATINIB MESYLATE (GLEEVEC) AND SUNITINIB MALATE (SUTENT).

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Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

STRATTERA

DRUG NAME

STRATTERA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF ADD/ADHD

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SULFONYLUREAS HRM

DRUG NAME

CHLORPROPAMIDE | GLYBURIDE | GLYBURIDE MICRONIZED | GLYBURIDE-METFORMIN HCL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SUTENT

DRUG NAME

SUTENT

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

IF DIAGNOSIS IS GASTROINTESTINAL STROMAL TUMOR THERE MUST BE A FAILURE ON, CONTRAINDICATION TO, OR INTOLERANCE TO IMATINIB

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Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SYLATRON

DRUG NAME

SYLATRON 4-PACK

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST OR DERMATOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SYMLIN

DRUG NAME

SYMLINPEN 120 | SYMLINPEN 60

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE TO ACHIEVE DESIRED CONTROL DESPITE OPTIMAL MEALTIME INSULIN THERAPY, WHICH MAY BE WITH OR WITHOUT A CONCURRENT SULFONYLUREA AND/OR METFORMIN FOR THOSE WITH TYPE 2 DM

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

SYNRIBO

DRUG NAME

SYNRIBO

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CHRONIC OR ACCELERATED PHASE CHRONIC MYELOID LEUKEMIA (CML)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OR MORE TYROSINE KINASE INHIBITORS (GLEEVEC, SPRYCEL, TASIGNA, BOSULIF)

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TAFINLAR

DRUG NAME

TAFINLAR

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST OR DERMATOLOGIST

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TARCEVA

DRUG NAME

TARCEVA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TASIGNA

DRUG NAME

TASIGNA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TCA

DRUG NAME

AMITRIPTYLINE HCL | AMOXAPINE | IMIPRAMINE HCL | IMIPRAMINE PAMOATE | TRIMIPRAMINE MALEATE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION AND WILL REQUIRE TRIAL ON TWO FORMULARY ALTERNATIVES INCLUDING NOTRTIPTYLINE AND DESIPRAMINE

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

THIORIDAZINE HRM

DRUG NAME

THIORIDAZINE HCL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

ONLY APPLIES TO MEMBERS 65 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

PRIOR AUTHORIZATION APPLIES ONLY TO MEMBERS 65 YEARS OF AGE AND OLDER WHO WILL BE EVALUATED FOR APPROPRIATE USE OF HIGH RISK MEDICATION AND WILL REQUIRE FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ATYPICAL ANTIPSYCHOTICS (OLANZAPINE, RISPERIDONE, QUETIAPINE, ZIPRASIDONE, ABILIFY)

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TOBI

DRUG NAME

TOBI PODHALER

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CYSTIC FIBROSIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PULMONOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TORISEL

DRUG NAME

TORISEL

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF ADVANCED RENAL CELL CARCINOMA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TRACLEER

DRUG NAME

TRACLEER

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TREANDA

DRUG NAME

TREANDA

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TYKERB

DRUG NAME

TYKERB

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DOCUMENTATION OF A DIAGNOSIS OF HER2 ADVANCED OR METASTATIC BREAST CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

MUST BE USED CONCURRENTLY WITH CAPECITABINE OR LETROZOLE. PRIOR THERAPY WITH AN ANTHRACYCLINE, A TAXANE, AND TRASTUZUMAB.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TYSABRI

DRUG NAME

TYSABRI

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

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

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

TYVASO

DRUG NAME

TYVASO

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF FUNCTIONAL CLASS 3 PULMONARY ARTERY HYPERTENSION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: REVATIO, TRACLEER OR VENTAVIS

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

VANDETANIB

DRUG NAME

CAPRELSA

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF MEDULLARY THYROID CANCER IN PATIENTS WITH UNRESECTABLE, LOC ALLY ADVANCED, OR METASTATIC DISEASE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

VECTIBIX

DRUG NAME

VECTIBIX

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

DOCUMENTATION OF KRAS TESTING PERFORMED PRIOR TO THERAPY VERIFYING KRAS WILDTYPE (NEGATIVE)

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

VELCADE

DRUG NAME

VELCADE

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

1 YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

VEMURAFENIB

DRUG NAME

ZELBORAF

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST OR DERMATOLOGIST

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

THE FDA APPROVED TEST FOR BRAF V600E MUTATION IS THE COBAS 4800 BRAF V600 MUTATION TEST

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

VENTAVIS

DRUG NAME

VENTAVIS

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PULMONOLOGIST OR CARDIOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

VICTRELIS

DRUG NAME

VICTRELIS

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF GENOTYPE 1 CHRONIC HEPATITIS C

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

11 MONTHS

OTHER CRITERIA

MUST BE USED CONCURRENTLY WITH PEGINTERFERON ALFA AND RIBAVIRIN

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

VIIBRYD

DRUG NAME

VIIBRYD

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST TWO ANTIDEPRESSANT CLASSES, ONE OF WHICH IS BUPROPION.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

VIMPAT

DRUG NAME

VIMPAT

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DOCUMENTATION OF A DIAGNOSIS OF PARTIAL ONSET SEIZURES

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO PREFERRED ALTERNATIVE ANTICONVULSANTS

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

VOTRIENT

DRUG NAME

VOTRIENT

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

VPRIV

DRUG NAME

VPRIV

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

MUST BE 4 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

METABOLIC SPECIALIST WITH EXPERIENCE TREATING GAUCHER DISEASE

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ELELYSO IF PATIENT IS 18 YEARS OF AGE OR OLDER.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

XELJANZ

DRUG NAME

XELJANZ

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

RHEUMATOLOGIST

COVERAGE DURATION

6 MONTHS INITIAL AND 1 YEAR CONTINUATION

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO HUMIRA AND ENBREL

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

XGEVA

DRUG NAME

XGEVA

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

XOLAIR

DRUG NAME

XOLAIR

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ALLERGIST OR PULMONOLOGIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

KNOWN ENVIRONMENTAL TRIGGERS HAVE BEEN ELIMINATED. REVERSIBLE AIRWAY DISEASE EVIDENCED BY GREATER THAN 12% IMPROVEMENT IN FEV1 WITH AT LEAST 200 ML INCREASE OR AT LEAST A 20% OR GREATER IMPROVEMENT IN PEF AFTER ADMINISTRATION OF ALBUTEROL.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

XTANDI

DRUG NAME

XTANDI

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DOCUMENTATION OF METASTATIC CASTRATION-RESISTANT PROSTATE CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST OR UROLOGIST

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO DOCETAXEL AND NO PRIOR THERAPEUTIC FAILURE WITH ZYTIGA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

YERVOY

DRUG NAME

YERVOY

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF UNRESECTABLE STAGE III OR IV MELANOMA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ZALTRAP

DRUG NAME

ZALTRAP

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

HEMATOLOGIST OR ONCOLOGIST

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ZAVESCA

DRUG NAME

ZAVESCA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DX OF MILD TO MODERATE TYPE 1 GAUCHER DISEASE

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

FOR WHOM ENZYME REPLACEMENT THERAPY IS NOT A THERAPEUTIC OPTION (I.E. BECAUSE OF CONSTRAINTS SUCH AS ALLERGY, HYPERSENSITIVITY, OR POOR VENOUS ACCESS).

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ZORBTIVE

DRUG NAME

ZORBTIVE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

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

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ENDOCRINOLOGIST OR GASTROENTEROLOGIST

COVERAGE DURATION

2 MONTHS

OTHER CRITERIA

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ZORTRESS

DRUG NAME

ZORTRESS

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DOCUMENTED KIDNEY TRANSPLANT NOT COVERED BY MEDICARE OR DOCUMENTED LIVER TRANSPLANT NOT COVERED BY MEDICARE

AGE RESTRICTIONS

MUST BE 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

PHYSICIAN EXPERIENCED IN IMMUNOSUPPRESSIVE THERAPY AND MANAGEMENT OF TRANSPLANT PATIENTS

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA

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

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ZYTIGA

DRUG NAME

ZYTIGA

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PROSTRATE CANCER WITH EVIDENCE OF METASTATIC DISEASE AND MEMBER IS NO LONGER RESPONDING TO CASTRATION OR IS HORMONE RESISTANT

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ONCOLOGIST OR UROLOGIST

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

DOCUMENTATION THAT PREDNISONE 5MG TWICE DAILY WILL BE ADMINISTERED CONCOMITANTLY WITH ZYTIGA.

Geisinger Health Plan - 14325
Prior Authorization Requirements

Effective Date: 01/01/2014

PRIOR AUTHORIZATION GROUP DESCRIPTION

ZYVOX

DRUG NAME

ZYVOX

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION

REMAINDER OF CONTRACT YEAR

OTHER CRITERIA