

# **Prior Authorization Requirements**

**Effective: 09/01/2014**

**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**ABILIFY MAINTENA**

**DRUG NAME**

**ABILIFY MAINTENA**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DIAGNOSIS OF SCHIZOPHRENIA**

**AGE RESTRICTIONS**

**MUST BE 18 YEARS OF AGE OR OLDER**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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.**

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**Geisinger Health Plan - 14326  
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**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**ACTEMRA**

**DRUG NAME**

**ACTEMRA**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

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

**PRESCRIBER RESTRICTIONS**

**RHEUMATOLOGIST**

**COVERAGE DURATION**

**6 MONTHS INITIAL AND 1 YEAR CONTINUATION**

**OTHER CRITERIA**

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

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**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**ACTEMRA SUBQ**

**DRUG NAME**

**ACTEMRA**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**MUST BE 18 YEARS OF AGE OR OLDER**

**PRESCRIBER RESTRICTIONS**

**RHEUMATOLOGIST**

**COVERAGE DURATION**

**6 MONTHS INITIAL AND 1 YEAR CONTINUATION**

**OTHER CRITERIA**

**FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A MINIMUM 3 MONTH TRIAL OF HUMIRA AND ENBREL.**

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**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.**

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**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**ADEMPAS**

**DRUG NAME**

**ADEMPAS**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**CARDIOLOGIST OR PULMONOLOGIST**

**COVERAGE DURATION**

**6 MONTHS**

**OTHER CRITERIA**

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

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**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**AFINITOR**

**DRUG NAME**

**AFINITOR | AFINITOR DISPERZ**

**COVERED USES**

**ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**ONCOLOGIST OR NEPHROLOGIST OR UROLOGIST**

**COVERAGE DURATION**

**3 MONTHS**

**OTHER CRITERIA**

**FOR RENAL CELL CARCINOMA: THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO 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 TUBEROUS SCLEROSIS COMPLEX/SPORADIC LYMPHANGIOLEIOMYMATOSIS: AT LEAST ONE**

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



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**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**

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**Geisinger Health Plan - 14326  
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**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
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**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**

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**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.**

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**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**APTIOM**

**DRUG NAME**

**APTIOM**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DIAGNOSIS OF PARTIAL ONSET SEIZURES**

**AGE RESTRICTIONS**

**MUST BE 18 YEARS OF AGE OR OLDER**

**PRESCRIBER RESTRICTIONS**

**NEUROLOGIST**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**ARALAST**

**DRUG NAME**

**ARALAST NP | PROLASTIN C**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DX OF PANACINAR EMPHYSEMA**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**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**

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**Geisinger Health Plan - 14326**  
**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.**

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**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**ARRANON**

**DRUG NAME**

**ARRANON**

**COVERED USES**

**ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**HEMATOLOGIST OR ONCOLOGIST**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**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**

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**Geisinger Health Plan - 14326  
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**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**ASPARAGINASE**

**DRUG NAME**

**ERWINAZE**

**COVERED USES**

**ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**HEMATOLOGIST OR ONCOLOGIST**

**COVERAGE DURATION**

**6 MONTHS**

**OTHER CRITERIA**

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**Geisinger Health Plan - 14326  
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**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**AUBAGIO**

**DRUG NAME**

**AUBAGIO**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DIAGNOSIS OF RELAPSING FORM OF MULTIPLE SCLEROSIS**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**NEUROLOGIST**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**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**

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**Geisinger Health Plan - 14326  
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**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**BONIVA IV**

**DRUG NAME**

**BONIVA**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DX OF OSTEOPOROSIS IN POSTMENOPAUSAL WOMEN**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

**INTOLERANCE TO ORAL BIPHOSPHONATES OR INABILITY TO REMAIN IN AN UPRIGHT POSITION FOR A MINIMUM OF 30-60 MINUTES AFTER INGESTION OR DISRUPTION OF THE 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 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**

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**Geisinger Health Plan - 14326  
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**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**BRINTELLIX**

**DRUG NAME**

**BRINTELLIX**

**COVERED USES**

**ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER**

**AGE RESTRICTIONS**

**MUST BE AT LEAST 18 YEARS OF AGE**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

**DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST TWO ANTIDEPRESSANT CLASSES.**

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**Geisinger Health Plan - 14326  
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**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**BUPROPION 24 HR**

**DRUG NAME**

**ALENZIN**

**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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**BUTRANS**

**DRUG NAME**

**BUTRANS**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**BVD ONLY**

**DRUG NAME**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**CINRYZE**

**DRUG NAME**

**CINRYZE**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DX OF HEREDITARY ANGIOEDEMA WITH DOCUMENTATION OF RECURRENT, SELF-LIMITING NON-INFLAMMATORY SUBCUTANEOUS ANGIOEDEMA WITHOUT URTICARIA LASTING MORE THAN 12 HOURS OR LARNGEAL EDEMA OR RECURRENT SELF-REMITTING 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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

Effective Date: 09/01/2014

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**CLOMIPRAMINE HRM**

**DRUG NAME**

**CLOMIPRAMINE HCL**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**AGE RESTRICTIONS**

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

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**  
**CORTICOSTEROID B VERSUS D DETERMINATION**

**DRUG NAME**

**A-HYDROCORT | CORTISONE ACETATE | DEXAMETHASONE | DEXAMETHASONE  
SODIUM PHOSPHATE | HYDROCORTISONE | KENALOG-10 | KENALOG-40 |  
METHYLPREDNISOLONE | METHYLPREDNISOLONE ACETATE |  
METHYLPREDNISOLONE SOD SUCC | PREDNISOLONE SODIUM PHOSPHATE |  
PREDNISONE | SOLU-MEDROL | TRIAMCINOLONE ACETONIDE | VERIPRED 20**

**COVERED USES**

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

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**OTHER CRITERIA**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

Effective Date: 09/01/2014

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**CYCLOSET**

**DRUG NAME**

**CYCLOSET**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DIAGNOSIS OF TYPE 2 DIABETES MELLITUS.**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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).**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**DUAVEE**

**DRUG NAME**

**DUAVEE**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DOCUMENTATION OF AN INTACT UTERUS. DOCUMENTATION OF USE FOR ABNORMAL VASOMOTOR FUNCTION OR PREVENTION OF POSTMENOPAUSAL OSTEOPOROSIS**

**AGE RESTRICTIONS**

**AGE LESS THAN 75 YEARS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

**FOR ABNORMAL VASOMOTOR FUNCTION: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO FEMRING. FOR PREVENTION OF POSTMENOPAUSAL OSTEOPOROSIS: FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO OF THE FOLLOWING: ALENDRONATE, IBANDRONATE, RALOXIFENE, RISEDRONATE.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**ELAPRASE**

**DRUG NAME**

**ELAPRASE**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DX OF HUNTER'S SYNDROME (MPS II)**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**METABOLIC SPECIALIST WITH EXPERIENCE TREATING MPS II**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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))**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**



**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**ERAXIS**

**DRUG NAME**

**ERAXIS (WATER DILUENT)**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**18 YEARS OF AGE OR OLDER**

**PRESCRIBER RESTRICTIONS**

**INFECTIOUS DISEASE SPECIALIST**

**COVERAGE DURATION**

**8 WEEKS (TWO COURSES OF THERAPY)**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

Effective Date: 09/01/2014

**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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**ESRD B VERSUS D DETERMINATION**

**DRUG NAME**

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

**COVERED USES**

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

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**OTHER CRITERIA**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**ESTROGENS HRM (ORAL AND TOPICAL PATCH PRODUCTS ONLY)**

**DRUG NAME**

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

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**AGE RESTRICTIONS**

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

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**EXJADE**

**DRUG NAME**

**EXJADE**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

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

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**3 MONTHS**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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  $1.5 \times 10^{10}$  (10 TO THE 9TH POWER) / L**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**FETZIMA**

**DRUG NAME**

**FETZIMA**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER**

**AGE RESTRICTIONS**

**MUST BE 18 YEARS OF AGE OR OLDER**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

**FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO AT LEAST TWO  
ANTIDEPRESSANT CLASSES.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**FIRAZYR**

**DRUG NAME**

**FIRAZYR**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**MUST BE AT LEAST 18 YEARS OF AGE**

**PRESCRIBER RESTRICTIONS**

**ALLERGIST, IMMUNOLOGIST, HEMATOLOGIST, OR DERMATOLOGIST**

**COVERAGE DURATION**

**6 MONTHS INITIAL AND 1 YEAR CONTINUATION**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**FYCOMPA**

**DRUG NAME**

**FYCOMPA**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DIAGNOSIS OF PARTIAL ONSET SEIZURES**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

**FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ALTERNATIVES AND DOCUMENTATION THAT FYCOMPA IS BEING USED CONCOMITANTLY WITH AT LEAST ONE OTHER FORMULARY ANTICONVULSANT AGENT**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**GATTEX**

**DRUG NAME**

**GATTEX**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DIAGNOSIS OF SHORT BOWEL SYNDROME**

**AGE RESTRICTIONS**

**MUST BE AT LEAST 18 YEARS OF AGE**

**PRESCRIBER RESTRICTIONS**

**GASTROENTEROLOGIST**

**COVERAGE DURATION**

**6 MONTHS INITIAL AND 1 YEAR CONTINUATION**

**OTHER CRITERIA**

**DOCUMENTATION THAT THE MEMBER HAS BEEN DEPENDENT ON PARENTERAL NUTRITION/INTRAVENOUS SUPPORT FOR A MINIMUM OF 12 CONSECUTIVE MONTHS CONTINUOUSLY AND THAT THE MEMBER REQUIRES PARENTERAL NUTRITION AT LEAST 3 TIMES PER WEEK.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**GILOTRIF**

**DRUG NAME**

**GILOTRIF**

**COVERED USES**

**ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**ONCOLOGIST OR HEMATOLOGIST**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**GRANIX**

**DRUG NAME**

**GRANIX**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**6 MONTHS**

**OTHER CRITERIA**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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 SEVERE RA AND TRIAL OF MTX OR OTHER DMARD IF MTX NOT TOLERATED OR CONTRAINDICATED. JIA - DIAGNOSIS OF MODERATE TO SEVERE JIA AND A TRIAL OF ONE NSAID AND MTX THERAPY OR OTHER DMARD IF MTX IS CONTRAINDICATED. PSORIATIC ARTHRITIS - DIAGNOSIS OF MODERATE TO SEVERE PSA WITH ACTIVE PSORIATIC LESIONS OR HISTORY OF PSORIASIS AND INTOLERANCE OR FAILURE ON MTX OR SULFASALAZINE - IF THESE ARE CONTRAINDICATED THERAPY WITH AN ALTERNATED 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 CROHN'S 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**

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**Geisinger Health Plan - 14326  
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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

Effective Date: 09/01/2014

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**IMBRUVICA**

**DRUG NAME**

**IMBRUVICA**

**COVERED USES**

**ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DIAGNOSIS OF MANTLE CELL LYMPHOMA (MCL)**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**HEMATOLOGIST OR ONCOLOGIST**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

**FAILURE ON, 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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**INCIVEK**

**DRUG NAME**

**INCIVEK**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DIAGNOSIS OF GENOTYPE 1 CHRONIC HEPATITIS C**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**12 WEEK COURSE OF THERAPY PER LIFETIME**

**OTHER CRITERIA**

**MUST BE USED CONCURRENTLY WITH PEGINTERFERON ALFA AND RIBAVIRIN**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**INLYTA**

**DRUG NAME**

**INLYTA**

**COVERED USES**

**ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM  
PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DX OF ADVANCED RENAL CELL CARCINOMA**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**ONCOLOGIST**

**COVERAGE DURATION**

**6 MONTHS**

**OTHER CRITERIA**

**FAILURE ON ONE PRIOR SYSTEMIC THERAPY**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**INVOKANA**

**DRUG NAME**

**INVOKANA**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DIAGNOSIS OF TYPE II DIABETES MELLITUS**

**AGE RESTRICTIONS**

**MUST BE AT LEAST 18 YEARS OF AGE**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

**DOCUMENTATION OF ESTIMATED GLOMERULAR FILTRATION RATE (EGFR)  
GREATER THAN OR EQUAL TO 45 ML/MIN. FAILURE ON, INTOLERANCE TO, OR  
CONTRAINDICATION TO 2 OTHER FORMULARY ANTIDIABETIC MEDICATIONS, ONE  
OF WHICH MUST BE METFORMIN.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**ISTODAX**

**DRUG NAME**

**ISTODAX**

**COVERED USES**

**ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DX OF CUTANEOUS OR PERIPHERAL T-CELL LYMPHOMA**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**HEMATOLOGIST OR ONCOLOGIST**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

Effective Date: 09/01/2014

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**IVIG**

**DRUG NAME**

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

**COVERED USES**

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

**EXCLUSION CRITERIA**

**USE OF IVIG FOR THE FOLLOWING INDICATIONS IS CONSIDERED INVESTIGATIONAL AND WILL NOT BE COVERED: ALZHEIMER'S DISEASE, AMYOTROPHIC LATERAL SCLEROSIS, ATOPIC DERMATITIS, AUTISM, CHRONIC FATIGUE SYNDROME, CHRONIC MUCOCUTANEOUS CANDIDIASIS, COMPLEX REGIONAL PAIN SYNDROME, EPILEPSY, INCLUSION BODY MYOSITIS, LYME DISEASE, NEUROMYELITIS OPTICA (DEVIC'S DISEASE), OPTIC NEURITIS, PARAPROTEINEMIC 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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**Geisinger Health Plan - 14326**  
**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 APPROPRIATE ABX PROPHYLAXIS, CIDP: DEFINITIVE DIAGNOSIS 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) & IMMUNOSUPPRESSANTS (AT LEAST TWO OF THE FOLLOWING CYCLOSPORINE, AZATHIOPRINE, METHOTREXATE, CYCLOPHOSPHAMIDE). AHA: WARM-TYPE AUTOIMMUNE HEMOLYTIC ANEMIA WITH FAILURE OF, INTOLERANCE TO, OR CONTRAINDICATIONS TO CORTICOSTEROIDS OR SPLENECTOMY. MS: FAILURE ON AT LEAST 2 STANDARD APPROACHES (INTERFERONS, COPAXONE) AFTER A MINIMUM TRIAL OF 3 MONTHS OR, 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 SEGMENTS 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 MEASURABLE RESPONSE OR IMPROVMENT IN SIGNS AND SYMPTOMS.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

Effective Date: 09/01/2014

**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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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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 WITHOUT NEUROENDOCRINE FEATURES AND DOCUMENTATION OF NEUTROPHIL COUNT GREATER THAN 1500 CELLS/MM(3) AND FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO A DOCETAXEL-BASED REGIMEN.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**KALYDECO**

**DRUG NAME**

**KALYDECO**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**MUST BE 6 YEARS OF AGE OR OLDER**

**PRESCRIBER RESTRICTIONS**

**PULMONOLOGIST**

**COVERAGE DURATION**

**2 MONTHS INITIAL AND 1 YEAR CONTINUATION**

**OTHER CRITERIA**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**KETEK**

**DRUG NAME**

**KETEK**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DX OF COMMUNITY ACQUIRED PNEUMONIA**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**KORLYM**

**DRUG NAME**

**KORLYM**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**PREGNANCY**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**ENDOCRINOLOGIST**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**KYNAMRO**

**DRUG NAME**

**KYNAMRO**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DIAGNOSIS OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA THAT IS CAUSED BY MUTATIONS OF THE LDL RECEPTOR GENE**

**AGE RESTRICTIONS**

**MUST BE AT LEAST 18 YEARS OF AGE**

**PRESCRIBER RESTRICTIONS**

**HEPATOLOGIST, LIDIPOLOGIST OR CARDIOLOGIST REGISTERED WITH THE KYNAMRO REMS PROGRAM**

**COVERAGE DURATION**

**6 MONTHS INITIAL AND 1 YEAR CONTINUATION**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**LETAIRIS**

**DRUG NAME**

**LETAIRIS**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DIAGNOSIS OF FUNCTIONAL CLASS 2 OR 3 PULMONARY ARTERIAL HYPERTENSION**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**PULMONOLOGIST OR CARDIOLOGIST**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**COVERAGE DURATION**

**6 MONTHS**

**OTHER CRITERIA**



**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**LIDODERM**

**DRUG NAME**

**LIDOCAINE | LIDODERM**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DX OF POST-HERPETIC NEURALGIA**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

**FAILURE ON, CONTRAINDICATION TO, OR INTOLERANCE TO GABAPENTIN**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**LUZU**

**DRUG NAME**

**LUZU**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DIAGNOSIS OF TINEA PEDIS, TINEA CRURIS, OR TINEA CORPORIS**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**2 WEEKS**

**OTHER CRITERIA**

**FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO GENERIC FORMULARY ALTERNATIVES (CLOTRIMAZOLE, ECONAZOLE, AND/OR KETOCONAZOLE)**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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 DIGOXIN, PRIOR AUTHORIZATION WILL NOT BE  
REQUIRED.**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**1 MONTH**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

Effective Date: 09/01/2014

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**MEKINIST**

**DRUG NAME**

**MEKINIST**

**COVERED USES**

**ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**ONCOLOGIST OR DERMATOLOGIST**

**COVERAGE DURATION**

**6 MONTHS**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**MUSCLE RELAXANTS**

**DRUG NAME**

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

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**AGE RESTRICTIONS**

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

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**NAGLAZYME**

**DRUG NAME**

**NAGLAZYME**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DX OF MUCOPOLYSACCHARIDOSIS VI (MAROTEAUX-LAMY DISEASE)**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**METABOLIC SPECIALIST**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**NEULASTA**

**DRUG NAME**

**NEULASTA**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

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

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**COVERAGE DURATION**

**6 MONTHS**

**OTHER CRITERIA**



**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**COVERAGE DURATION**

**6 MONTHS**

**OTHER CRITERIA**



**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**NEXAVAR**

**DRUG NAME**

**NEXAVAR**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**ONCOLOGIST**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**NOXAFIL**

**DRUG NAME**

**NOXAFIL**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**OPSUMIT**

**DRUG NAME**

**OPSUMIT**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**CARDIOLOGIST OR PULMONOLOGIST**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

**DOCUMENTATION THAT OPSUMIT WILL BE USED IN COMBINATION WITH OR  
THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO  
SILDENAFIL AND THERAPEUTIC FAILURE ON, INTOLERANCE TO, OR  
CONTRAINDICATION TO TRACLEER**

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**Geisinger Health Plan - 14326  
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**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**ORENCIA**

**DRUG NAME**

**ORENCIA**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

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

**PRESCRIBER RESTRICTIONS**

**RHEUMATOLOGIST**

**COVERAGE DURATION**

**6 MONTHS INITIAL AND 1 YEAR CONTINUATION**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**ORENITRAM**

**DRUG NAME**

**ORENITRAM ER**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DOCUMENTATION OF WHO GROUP 1 PULMONARY ARTERIAL HYPERTENSION  
WITH WHO FUNCTIONAL CLASS II OR III SYMPTOMS**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**CARDIOLOGIST OR PULMONOLOGIST**

**COVERAGE DURATION**

**6 MONTHS**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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).**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**PROMETHAZINE HRM**

**DRUG NAME**

**PHENADOZ | PROMETHAZINE HCL | PROMETHAZINE VC | PROMETHEGAN**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**AGE RESTRICTIONS**

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

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**PROVIGIL**

**DRUG NAME**

**MODAFINIL**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**RELISTOR**

**DRUG NAME**

**RELISTOR**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
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-  
MERCAPTOPYRINE AND AZATHIOPRINE).**



**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**REVATIO**

**DRUG NAME**

**REVATIO | SILDENAFIL**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**CONCOMITANT USE OF ORGANIC NITRATES**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**PULMONOLOGIST OR CARDIOLOGIST**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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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**Geisinger Health Plan - 14326  
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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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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 ACCORDANCE WITH THE AMERICAN COLLEGE OF RHEUMATOLOGY CRITERIA FOR THE CLASSIFICATION AND DIAGNOSIS OF RA & DOCUMENTATION OF THE NUMBER OF SWOLLEN OR TENDER JOINTS PRIOR TO INITIATING THERAPY WITH A MINIMUM DOCUMENTED JOINT COUNT OF GREATER THAN FOUR SWOLLEN OR TENDER JOINTS BASED ON A 28 JOINT COUNT. DX OF CHRONIC LYMPHOID LEUKEMIA USED IN COMBO WITH FLUDARABINE & CYCLOPHOSPHAMIDE. DX OF MICROSCOPIC POLYARTERITIS NODOSA USED IN COMBO WITH GLUCOCORTICOID. 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 GLUCOCORTICOID.**

**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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**Geisinger Health Plan - 14326  
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**

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**Geisinger Health Plan - 14326  
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**Effective Date: 09/01/2014**

**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  $100 \times 1000000000$  (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  $50 \times 10^9$  / 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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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**



**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**SIMPONI**

**DRUG NAME**

**SIMPONI**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**6 MONTHS INITIAL AND 1 YEAR CONTINUATION**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**SIMPONI ARIA**

**DRUG NAME**

**SIMPONI ARIA**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**FOR DX OF RHEUMATOID ARTHRITIS BEING USED IN CONJUNCTION WITH  
METHOTREXATE**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**6 MONTHS INITIAL AND 1 YEAR CONTINUATION**

**OTHER CRITERIA**

**FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO ENBREL AND HUMIRA.  
FOR CONTINUED THERAPY. MEDICAL RECORD DOCUMENTATION SHOWING  
MAINTENANCE OR IMPROVEMENT OF CONDITION.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**SIMVASTATIN 40MG AND 80MG**

**DRUG NAME**

**SIMVASTATIN**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**STELARA**

**DRUG NAME**

**STELARA**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**DERMATOLOGIST**

**COVERAGE DURATION**

**6 MONTHS INITIAL AND 1 YEAR CONTINUATION**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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, UNRESECTABLE OR METASTATIC GASTROINTESTINAL STROMAL TUMOR (GIST).**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**HEMATOLOGIST OR ONCOLOGIST**

**COVERAGE DURATION**

**6 MONTHS**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**STRATTERA**

**DRUG NAME**

**STRATTERA**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DX OF ADD/ADHD**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**SULFONYLUREAS HRM**

**DRUG NAME**

**CHLORPROPAMIDE | GLYBURIDE | GLYBURIDE MICRONIZED | GLYBURIDE-METFORMIN HCL**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**AGE RESTRICTIONS**

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

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**



**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**SYNRIBO**

**DRUG NAME**

**SYNRIBO**

**COVERED USES**

**ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**HEMATOLOGIST OR ONCOLOGIST**

**COVERAGE DURATION**

**3 MONTHS**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**TASIGNA**

**DRUG NAME**

**TASIGNA**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**HEMATOLOGIST OR ONCOLOGIST**

**COVERAGE DURATION**

**3 MONTHS**

**OTHER CRITERIA**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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 NOTRIPTYLINE AND DESIPRAMINE**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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)**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**TOBI**

**DRUG NAME**

**TOBI PODHALER**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DIAGNOSIS OF CYSTIC FIBROSIS**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**PULMONOLOGIST**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**TORISEL**

**DRUG NAME**

**TORISEL**

**COVERED USES**

**ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM  
PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DX OF ADVANCED RENAL CELL CARCINOMA**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**ONCOLOGIST**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**TRACLEER**

**DRUG NAME**

**TRACLEER**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**PULMONOLOGIST OR CARDIOLOGIST**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**TROKENDI XR**

**DRUG NAME**

**QUDEXY XR | TROKENDI XR**

**COVERED USES**

**ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

**DOCUMENTATION OF FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO TWO FORMULARY ALTERNATIVES, ONE OF WHICH MUST BE TOPIRAMATE.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**TYKERB**

**DRUG NAME**

**TYKERB**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DOCUMENTATION OF A DIAGNOSIS OF HER2 ADVANCED OR METASTATIC BREAST  
CANCER**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**ONCOLOGIST**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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-MERCAPTOPYRINE, AZATHIOPRINE, CYCLOSPORINE, METHOTREXATE) OR INHIBITORS OF TNF-A**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

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

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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**Geisinger Health Plan - 14326  
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**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**TYVASO**

**DRUG NAME**

**TYVASO**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DIAGNOSIS OF FUNCTIONAL CLASS 3 PULMONARY ARTERY HYPERTENSION**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**PULMONOLOGIST OR CARDIOLOGIST**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

Effective Date: 09/01/2014

**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, LOCALLY ADVANCED, OR METASTATIC DISEASE.**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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**Geisinger Health Plan - 14326  
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**Effective Date: 09/01/2014**

**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)**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**VENTAVIS**

**DRUG NAME**

**VENTAVIS**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**PULMONOLOGIST OR CARDIOLOGIST**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**



**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

Effective Date: 09/01/2014

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**VOTRIENT**

**DRUG NAME**

**VOTRIENT**

**COVERED USES**

**ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**ONCOLOGIST**

**COVERAGE DURATION**

**6 MONTHS**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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 ELEYSO IF PATIENT IS 18 YEARS OF AGE OR OLDER.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**XELJANZ**

**DRUG NAME**

**XELJANZ**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**MUST BE 18 YEARS OF AGE OR OLDER**

**PRESCRIBER RESTRICTIONS**

**RHEUMATOLOGIST**

**COVERAGE DURATION**

**6 MONTHS INITIAL AND 1 YEAR CONTINUATION**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**XERESE**

**DRUG NAME**

**XERESE**

**COVERED USES**

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DIAGNOSIS OF COLD SORES (HERPES SIMPLEX 1 OR HERPES LABIALIS)**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

**FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO VALACYCLOVIR AND  
FAMCICLOVIR**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**XTANDI**

**DRUG NAME**

**XTANDI**

**COVERED USES**

**ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

**DOCUMENTATION OF METASTATIC CASTRATION-RESISTANT PROSTATE CANCER**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**HEMATOLOGIST OR ONCOLOGIST OR UROLOGIST**

**COVERAGE DURATION**

**6 MONTHS**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**ZALTRAP**

**DRUG NAME**

**ZALTRAP**

**COVERED USES**

**ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**HEMATOLOGIST OR ONCOLOGIST**

**COVERAGE DURATION**

**6 MONTHS**

**OTHER CRITERIA**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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).**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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.**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**ZYKADIA**

**DRUG NAME**

**ZYKADIA**

**COVERED USES**

**ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**ONCOLOGIST**

**COVERAGE DURATION**

**6 MONTHS**

**OTHER CRITERIA**

**FAILURE ON, INTOLERANCE TO, OR CONTRAINDICATION TO XALKORI**

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**PRIOR AUTHORIZATION GROUP DESCRIPTION**

**ZYTIGA**

**DRUG NAME**

**ZYTIGA**

**COVERED USES**

**ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D**

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**

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

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**ONCOLOGIST OR UROLOGIST**

**COVERAGE DURATION**

**6 MONTHS**

**OTHER CRITERIA**

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

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**Geisinger Health Plan - 14326  
Prior Authorization Requirements**

**Effective Date: 09/01/2014**

**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 STAPHYLOCOCCUS AUREUS (METHICILLIN SUSCEPTIBLE ONLY). DX OF COMMUNITY-ACQUIRED PNEUMONIA CAUSED BY STREPTOCOCCUS PNEUMONIA (PENICILLIN SUSCEPTIBLE STRAINS ONLY) OR STAPHYLOCOCCUS AUREUS (METHICILLIN-SUSCEPTIBLE STRAINS ONLY).**

**AGE RESTRICTIONS**

**PRESCRIBER RESTRICTIONS**

**INFECTIOUS DISEASE SPECIALIST**

**COVERAGE DURATION**

**REMAINDER OF CONTRACT YEAR**

**OTHER CRITERIA**

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