Prior Authorization Requirements

Effective: 12/01/2015

Updated 11/2015

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

5HT3 ANTI-NAUSEA AGENT BVD DETERMINATION

DRUG NAME

GRANISETRON HCL | ONDANSETRON HCL | ONDANSETRON ODT

COVERED USES

THIS DRUG MAY BE COVERED UNDER MEDICARE 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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

ABATACEPT IV

DRUG NAME

ORENCIA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.

COVERAGE DURATION

INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

INITIAL: FOR RHEUMATOID ARTHRITIS: TRIAL OF OR CONTRAINDICATION TO HUMIRA AND ENBREL. FOR JUVENILE IDIOPATHIC ARTHRITIS: TRIAL OF OR CONTRAINDICATION TO HUMIRA AND ENBREL.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

ABATACEPT SQ

DRUG NAME

ORENCIA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

18 YEARS OR OLDER.

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.

COVERAGE DURATION

INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

INITIAL: RHEUMATOID ARTHRITIS: TRIAL OF OR CONTRAINDICATION TO HUMIRA AND ENBREL.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

ABIRATERONE

DRUG NAME

ZYTIGA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

ADALIMUMAB

DRUG NAME

HUMIRA | HUMIRA PEN CROHN'S-UC-HS

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, GASTROENTEROLOGIST.

COVERAGE DURATION

INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS. UC/CD: 12 MONTHS.

Brand New Day (HMO SNP)

Prior Authorization Requirements

OTHER CRITERIA

INITIAL: RHEUMATOID ARTHRITIS/JUVENILE IDIOPATHIC ARTHRITIS: TRIAL/FAILURE OF A DMARD (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE). PSORIATIC ARTHRITIS: TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE). PLAQUE PSORIASIS: TRIAL/FAILURE OF ONE OR MORE FORMS OF PREFERRED THERAPY (PUVA, UVB, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE). CROHN'S DISEASE: TRIAL/FAILURE OF ONE OR MORE CONVENTIONAL THERAPIES SUCH AS CORTICOSTEROIDS (BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. ULCERATIVE COLITIS: TRIAL/FAILURE OF AT LEAST ONE OF THE FOLLOWING SULFASALAZINE, CORTICOSTEROIDS, METHOTREXATE, AZATHIOPRINE, OLSALAZINE, MESALAMINE, CYCLOSPORINE, OR MERCAPTOPURINE. RENEWAL: RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS/ ANKYLOSING SPONDYLITIS: FOR HUMIRA 40 MG EVERY WEEK: TRY/FAIL AT LEAST A 3 MONTH TRIAL OF HUMIRA 40MG EVERY OTHER WEEK AND CURRENTLY TAKING OR HAS CONTRAINDICATION TO METHOTREXATE.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

AFATINIB DIMALEATE

DRUG NAME

GILOTRIF

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

ALIROCUMAB

DRUG NAME

PRALUENT PEN | PRALUENT SYRINGE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST

COVERAGE DURATION

INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

MUST HAVE AN LDL CHOLESTEROL LEVEL GREATER THAN 100MG/DL ON MAXIMAL DRUG TREATMENT FOR AT LEAST 2 MONTHS AND ONE OF THE FOLLOWING DIAGNOSES: (1) HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH) DETERMINED BY SIMON BROOME DIAGNOSTIC CRITERIA FOR HEFH OR A SCORE OF 6 OR GREATER ON THE DUTCH LIPID NETWORK CRITERIA FOR HEFH OR (2) HISTORY OF ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD) AS SUBSTANTIATED BY HOSPITAL ADMISSION, IMAGING STUDY, OR SURGICAL PROCEDURE. PATIENT MUST NOT HAVE HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA DIAGNOSIS. PATIENT MUST HAVE TRIED A PREFERRED FORMULARY PCSK9 INHIBITOR. PATIENT MUST NOT HAVE CONCURRENT USE OF REPATHA OR OTHER PCSK9 AGENT. INITIAL THERAPY: FOR STATIN TOLERANT PATIENTS: MUST BE TAKING A MAXIMALLY

Brand New Day (HMO SNP)

Prior Authorization Requirements

TOLERATED DOSE OF ANY STATIN FOR AT LEAST 2 MONTHS. FOR STATIN INTOLERANT PATIENTS: MUST BE ON MAXIMAL LIPID-LOWERING THERAPY FOR AT LEAST 2 MONTHS. PATIENTS WITH CONTRAINDICATIONS TO STATINS INCLUDING ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT OR HYPERSENSITIVITY REACTIONS WILL BE APPROVED FOR PRALUENT THERAPY WITHOUT REQUIREMENT OF DOCUMENTATION OF STATIN INTOLERANCE. DOCUMENTATION OF STATIN INTOLERANCE INCLUDES ALL OF THE FOLLOWING: (1) SEVERE AND INTOLERABLE ADVERSE EFFECTS WITH PREVIOUS STATINS WITH OTHER POTENTIAL CAUSES RULED OUT SUCH AS LOW VITAMIN D LEVELS, INCREASE IN OR PROLONGED PHYSICAL ACTIVITY, DRUG INTERACTIONS, OR OTHER METABOLIC OR INFLAMMATORY CAUSES, (2) TRIAL OF ALTERNATE DOSING STRATEGIES SUCH AS EVERY-OTHER-DAY OR TWICE WEEKLY DOSING, (3) DOCUMENTATION OF AT LEAST ONE OF THE FOLLOWING INCIDENTS: HOSPITALIZATION DUE TO ADVERSE EVENTS SUCH AS RHABDOMYOLYSIS, SEVERE MUSCLE WEAKNESS LEADING TO TEMPORARY DISABILITY, FALL, OR INABILITY TO USE A MAJOR MUSCLE GROUP DURING STATIN THERAPY. RENEWAL CRITERIA: RECEIVING PRIOR PRALUENT THERAPY FOR AT LEAST 12 WEEKS AND NO CLAIMS FOR REPATHA, JUXTAPID, OR KYNAMRO SINCE PRALUENT APPROVAL.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

ANAKINRA

DRUG NAME

KINERET

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

RA: 18 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.

COVERAGE DURATION

RA: INITIAL: 3 MONTHS RENEWAL: 12 MONTHS. NOMID: 12 MONTHS.

OTHER CRITERIA

INITIAL: RHEUMATOID ARTHRITIS: TRIAL OF OR CONTRAINDICATION TO HUMIRA AND ENBREL.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

APREMILAST

DRUG NAME

OTEZLA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.

COVERAGE DURATION

STARTER PACK: 14 DAYS. TABLETS (NON-STARTER PACK): 12 MONTHS

OTHER CRITERIA

TRIAL OF OR CONTRAINDICATION TO HUMIRA (ADALIMUMAB) AND ENBREL (ETANERCEPT).

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

APREPITANT BVD DETERMINATION

DRUG NAME

EMEND

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

ASPARAGINASE

DRUG NAME

ONCASPAR

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

AXITINIB

DRUG NAME

INLYTA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

BACILLUS OF CALMETTE AND GUERIN VACCINE BVD DETERMINATION

DRUG NAME

BCG (TICE STRAIN)

COVERED USES

THIS DRUG MAY BE COVERED UNDER MEDICARE 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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

BEDAQUILINE FUMARATE

DRUG NAME

SIRTURO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

24 WEEKS

OTHER CRITERIA

SIRTURO USED IN COMBINATION WITH AT LEAST 3 OTHER ANTIBIOTICS FOR IN THE TREATMENT OF PULMONARY MULTI-DRUG RESISTANT TUBERCULOSIS.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

BELIMUMAB

DRUG NAME

BENLYSTA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AUTOANTIBODY POSITIVE LUPUS TEST.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

BELINOSTAT

DRUG NAME

BELEODAQ

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

BEVACIZUMAB

DRUG NAME

AVASTIN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

BEXAROTENE

DRUG NAME

BEXAROTENE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

BORTEZOMIB

DRUG NAME

VELCADE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

BOSUTINIB

DRUG NAME

BOSULIF

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CML: BCR-ABL MUTATIONAL ANALYSIS CONFIRMING THAT BOTH T315I AND V299L MUTATIONS ARE NOT PRESENT.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

BOTULINUM NEUROTOXIN

DRUG NAME

BOTOX

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

COSMETIC DIAGNOSIS: WRINKLES.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

MIGRAINE HEADACHE: TRIAL OF TWO OF THE FOLLOWING: BETA BLOCKERS, TRICYCLIC ANTIDEPRESSANTS, OR VALPROIC ACID. OVERACTIVE BLADDER: TRIAL OR CONTRAINDICATION TO THE USE OF ONE ANTICHOLENERGIC MEDICATION ORAL OXYBUTYNIN, ORAL OXYBUTYNIN ER, TOLTERODINE, TOLTERODINE ER, TOVIAZ, TROSPIUM, OR TROPSIUM ER.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

CABOZANTINIB

DRUG NAME

COMETRIQ

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

CALCINEURIN INHIBITORS

DRUG NAME

ELIDEL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

ELIDEL 1% AND PROTOPIC 0.03%: 2 YEARS OR OLDER. PROTOPIC 0.1%: 16 YEARS OR OLDER.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIED/FAILED OR INTOLERABLE ADVERSE EFFECTS TO TOPICAL CORTICOSTEROIDS.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

CANAKINUMAB

DRUG NAME

ILARIS

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

PRESCRIBED OR SUPERVISED BY RHEUMATOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

CERITINIB

DRUG NAME

ZYKADIA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

POSITIVE FOR ANAPLASTIC LYMPHOMA KINASE (ALK) FUSION ONCOGENE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

CERTOLIZUMAB PEGOL

DRUG NAME

CIMZIA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, GASTROENTEROLOGIST.

COVERAGE DURATION

INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

FOR MODERATE TO SEVERE CROHN'S DISEASE: TRIAL/FAILURE OF ONE OR MORE CONVENTIONAL THERAPIES FOR CROHN'S DISEASE SUCH AS CORTICOSTEROIDS, AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE AND TRIAL OF OR CONTRAINDICATION TO HUMIRA. FOR MODERATE TO SEVERE RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS/ANKYLOSING SPONDYLITIS: TRIAL OF OR CONTRAINDICATION TO HUMIRA AND ENBREL.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

CLOBAZAM

DRUG NAME

ONFI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

CORTICOSTEROID BVD DETERMINATION

DRUG NAME

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

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

CRIZOTINIB

DRUG NAME

XALKORI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

CYCLOPHOSPHAMIDE BVD DETERMINATION

DRUG NAME

CYCLOPHOSPHAMIDE

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

DABRAFENIB MESYLATE

DRUG NAME

TAFINLAR

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

DACLATASVIR

DRUG NAME

DAKLINZA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

12 WEEKS OR 24 WEEKS (BASED ON FDA APPROVED INDICATIONS AND AASLD TREATMENT GUIDELINES)

OTHER CRITERIA

GUIDELINE CRITERIA ARE BASED ON AMERICAN ASSOCIATION FOR THE STUDY OF LIVER DISEASES AND INFECTIOUS DISEASE SOCIETY OF AMERICA (AASLD/IDSA) TREATMENT GUIDELINES AND BEST AVAILABLE EVIDENCE. NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). APPROVAL REQUIRES PATIENT HAS EVIDENCE OF HEPATITIS C INFECTION (AT LEAST 2 DETECTABLE HCV RNA LEVELS OVER THE PAST 6 MONTHS) OR PATIENT HAS AT LEAST ONE

Brand New Day (HMO SNP)

Prior Authorization Requirements

DETECTABLE HCV RNA LEVEL OVER THE PAST 6 MONTHS AND HAS PREVIOUS EVIDENCE OF INFECTION (E.G., PREVIOUS PRESCRIPTION FOR TREATMENT OF HEPATITIS C). MUST BE USED IN COMBINATION WITH SOVALDI. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER) MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, OR RIFAMPIN. TREATMENT NAIVE PATIENTS WITH GENOTYPE 1 OR 3 WITHOUT CIRRHOSIS: APPROVE 12 WEEKS. TREATMENT NAIVE PATIENTS WITH GENOTYPE 2 WHO CANNOT TOLERATE RIBAVIRIN: APPROVE 12 WEEKS. TREATMENT NAIVE PATIENTS WITH GENOTYPE 1 OR 3 WITH CIRRHOSIS: 24 WEEKS. TREATMENT EXPERIENCED PATIENTS WITH GENOTYPE 1 WITHOUT CIRRHOSIS WITH PREVIOUS FAILURE OF HCV NS3 PROTEASE INHIBITOR TRIPLE THERAPY (WITH PEGIFN/RBV), PREVIOUS PEGIFN/RBV FAILURE, OR PREVIOUS OLYSIO/SOVALDI FAILURE: 12 WEEKS. TREATMENT EXPERIENCED PATIENTS WITH GENOTYPE 1 AND CIRRHOSIS WITH PREVIOUS FAILURE OF HCV NS3 PROTEASE INHIBITOR TRIPLE THERAPY (WITH PEGIFN/RBV), PREVIOUS PEGIFN/RBV FAILURE, OR PREVIOUS OLYSIO/SOVALDI FAILURE: 24 WEEKS. GENOTYPE 2, INTERFERON INELIGIBLE PATIENTS WITH PREVIOUS FAILURE OF SOVALDI/RBV: APPROVE 24 WEEKS. PATIENTS WITH GENOTYPE 3 (WITHOUT CIRRHOSIS) WITH PREVIOUS FAILURE OF PEGIFN/RBV: 12 WEEKS. INTERFERON INELIGIBLE PATIENTS WITH GENOTYPE 3 WITH CIRRHOSIS AND PREVIOUS FAILURE OF PEGIFN/RBV: 24 WEEKS. INTERFERON INELIGIBLE PATIENTS WITH GENOTYPE 3 WITH PREVIOUS FAILURE OF SOVALDI/RBV: 24 WEEKS. INTERFERON INELIGIBILITY INCLUDES CONCURRENT DIAGNOSIS OF AUTOIMMUNE HEPATITIS OR KNOWN HYPERSENSITIVITY REACTION SUCH AS URTICARIA, ANGIOEDEMA, BRONCHOSPASM AND ANAPHYLAXIS TO ALPHA INTERFERONS OR ANY COMPONENT OF THE PRODUCT, DOCUMENTATION OF DEPRESSION, DECOMPENSATED HEPATIC DISEASE, A BASELINE NEUTROPHIL COUNT BELOW 1500 PER MICROLITER, A BASELINE PLATELET COUNT BELOW 90,000, OR A BASELINE HEMOGLOBIN BELOW 10G/DL THAT HAS NOT RESPONDED TO TREATMENT.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

DALFAMPRIDINE

DRUG NAME

AMPYRA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

NEUROLOGIST

COVERAGE DURATION

INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA

RENEWAL: PATIENT HAS EXPERIENCED OR MAINTAINED AT LEAST 15% IMPROVEMENT IN WALKING ABILITY.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

DASATINIB

DRUG NAME

SPRYCEL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

DENOSUMAB-XGEVA

DRUG NAME

XGEVA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

DIAGNOSIS OF MULTIPLE MYELOMA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

DICLOFENAC EPOLAMINE

DRUG NAME

FLECTOR

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

DIMETHYL FUMARATE

DRUG NAME

TECFIDERA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

18 YEARS AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

120 MG: 1 MONTH. 120-240 MG: 1 MONTH. 240 MG: 12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

DROXIDOPA

DRUG NAME

NORTHERA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

ELIGLUSTAT TARTRATE

DRUG NAME

CERDELGA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

ELTROMBOPAG

DRUG NAME

PROMACTA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

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

OTHER CRITERIA

CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIA PURPURA (ITP): INITIAL: TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY. ITP: RENEWAL: PATIENT HAS A CLINICAL RESPONSE AS DEFINED BY AN INCREASE IN PLATELET COUNT OF GREATER THAN OR EQUAL TO 50 X10^9/L (GREATER THAN OR EQUAL TO 50,0000 PER UL) AT THE MAX DOSE OF 75MG PER DAY FOR 4 WEEKS. HEPATITIS C: CONCURRENT INTERFERON THERAPY.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

ENDOTHELIN RECEPTOR ANTAGONISTS

DRUG NAME

LETAIRIS | OPSUMIT | TRACLEER

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

CARDIOLOGIST OR PULMONOLOGIST.

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

ENZALUTAMIDE

DRUG NAME

XTANDI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF ZYTIGA (ABIRATERONE ACETATE) IS ALSO REQUIRED IN PATIENTS WHO DO NOT HAVE A CONTRAINDICATION OR INTOLERANCE TO PREDNISONE.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

ERIBULIN

DRUG NAME

HALAVEN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

ERLOTINIB

DRUG NAME

TARCEVA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

ERYTHROPOIESIS STIMULATING AGENTS - EPOETIN ALFA

DRUG NAME

EPOGEN | PROCRIT

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

CHRONIC RENAL FAILURE HEMAGLOBIN LEVELS LESS THAN 10 G/DL IF NOT ON DIALYSIS AND LESS THAN 11 G/DL IF ON DIALYSIS OR HEMOGLOBIN HAS REACHED 11 G/DL IF ON DIALYSIS AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS OR HEMOGLOBIN HAS REACHED 10 G/DL IF NOT ON DIALYSIS AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CANCER CHEMOTHERAPY: HEMOGLOBIN LEVELS BETWEEN 10 AND 12 G/DL OR HEMOGLOBIN LEVEL LESS THAN 11 G/DL OR HEMOGLOBIN LEVEL DECREASED AT LEAST 2 G/DL BELOW THEIR BASELINE. ZIDOVUDINE THERAPY: HEMOGLOBIN LEVEL BETWEEN 10 AND 12 G/DL OR HEMOGLOBIN LESS THAN 10 G/DL. ELECTIVE, NONCARDIAC, NONVASCULAR SURGERY: HEMOGLOBIN LESS THAN 13 G/DL. CONCURRENT HEPATITIS C TREATMENT: HEMOGLOBIN LESS BETWEEN 10 AND 12 G/DL FOR PATIENTS CURRENTLY TAKING REQUESTED MEDICATION OR CONTRAINDICATION TO RIBAVIRIN DOSE REDUCTION AND HEMOGLOBIN LESS THAN 10 G/DL FOR NEW STARTS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

Brand New Day (HMO SNP)

Prior Authorization Requirements

COVERAGE DURATION

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

OTHER CRITERIA

ALL INDICATIONS: TRIAL OF PROCRIT. PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

ERYTHROPOIESIS STIMULATING AGENTS - MIRCERA

DRUG NAME

MIRCERA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

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

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

ESRD BVD DETERMINATION

DRUG NAME

CALCITRIOL | DOXERCALCIFEROL | HEPARIN SODIUM | IBANDRONATE SODIUM | LEVOCARNITINE | LIDOCAINE | LIDOCAINE HCL | LIDOCAINE-PRILOCAINE | MIACALCIN | PARICALCITOL | 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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

ETANERCEPT

DRUG NAME

ENBREL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST.

COVERAGE DURATION

INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

Brand New Day (HMO SNP)

Prior Authorization Requirements

OTHER CRITERIA

INITIAL: FOR RHEUMATOID ARTHRITIS/JUVENILE IDOPATHIC ARTHRITIS/PSORIATIC ARTHRITIS: TRIAL/FAILURE OF AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE). FOR MODERATE TO SEVERE PLAQUE PSORIASIS: TRIAL OR FAILURE OF ONE OR MORE FORMS OF PREFERRED THERAPY (PUVA, UVB, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE).

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

EVEROLIMUS

DRUG NAME

AFINITOR | AFINITOR DISPERZ

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

ADVANCED RENAL CELL CARCINOMA (RCC): TRIAL OF OR CONTRAINDICATION TO SUTENT OR NEXAVAR.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

FENTANYL NASAL SPRAY

DRUG NAME

LAZANDA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

FENTANYL TRANSDERMAL PATCH

DRUG NAME

FENTANYL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE SUSTAINED-RELEASE MORPHINE PRODUCT. EVERY 48 HOUR DOSING CONSIDERED FOR PATIENTS WHO FAIL EVERY 72 HOUR DOSING. NO APPROVAL WHEN PRESCRIBED FOR AS NEEDED DOSAGE FREQUENCY.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

FENTANYL TRANSMUCOSAL AGENTS - FENTANYL CITRATE

DRUG NAME

FENTANYL CITRATE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

FINGOLIMOD

DRUG NAME

GILENYA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

RECENT (WITHIN THE PAST 6 MONTHS) OCCURRENCE OF MYOCARDIAL INFARCTION, UNSTABLE ANGINA, STROKE, TRANSIENT ISCHEMIC ATTACK, DECOMPENSATED HEART FAILURE REQUIRING HOSPITALIZATION, OR CLASS III/IV HEART FAILURE. HISTORY OR PRESENCE OF MOBITZ TYPE II 2ND DEGREE OR 3RD DEGREE AV BLOCK OR SICK SINUS SYNDROME, UNLESS PATIENT HAS A PACEMAKER. BASELINE QTC INTERVAL OF 500MS OR ABOVE. TREATMENT WTIH CLASS 1A (QUINIDINE, PROCAINAMIDE, OR DISOPYRAMIDE) OR CLASS III ANTI-ARRHYTHMIC DRUGS (AMIODARONE, DOFETILIDE, DRONEDARONE, IBUTILIDE, OR SOTALOL).

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF OR CONTRAINDICATION TO AN AGENT INDICATED FOR THE TREATMENT OF MULTIPLE SCLEROSIS (COPAXONE, REBIF, TECFIDERA).

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

GLP-1 ANALOGS

DRUG NAME

VICTOZA 3-PAK

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF OR CONTRAINDICATION TO A FORMULARY GLP-1 AGONIST (BYETTA, BYDUREON) AND ONE OF THE FOLLOWING: METFORMIN, METFORMIN ER, A SULFONYLUREA, A METFORMIN-SULFONYLUREA COMBINATION, PIOGLITAZONE, A PIOGLITAZONE-METFORMIN COMBINATION OR A PIOGLITAZONE-GLIMEPIRIDE COMBINATION.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

GOLIMUMAB IV

DRUG NAME

SIMPONI ARIA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.

COVERAGE DURATION

INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

RHEUMATOID ARTHRITIS: INITIAL: TRIAL OF OR CONTRAINDICATION TO HUMIRA AND ENBREL.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

GOLIMUMAB SQ

DRUG NAME

SIMPONI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

18 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTANTION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR GASTROENTEROLOGIST.

COVERAGE DURATION

RA/PA/AS INITIAL: 3 MONTHS RENEWAL: 12 MONTHS. UC: 12 MONTHS.

OTHER CRITERIA

ACTIVE RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS/ANKYLOSING SPONDYLITIS INITIAL: TRIAL OF OR CONTRAINDICATION TO HUMIRA AND ENBREL. ULCERATIVE COLITIS: TRIAL OF OR CONTRAINDICATION TO SULFASALAZINE, CORTICOSTEROIDS, METHOTREXATE, AZATHIOPRINE, OLSALAZINE, MESALAMINE, CYCLOSPORINE, OR MERCAPTOPURINE AND TRIAL OF OR CONTRAINDICATION TO HUMIRA.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

HEPATITIS B VACCINE BVD DETERMINATION

DRUG NAME

ENGERIX-B ADULT | ENGERIX-B PEDIATRIC-ADOLESCENT | RECOMBIVAX HB

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - ANTI-INFECTIVE

DRUG NAME

NITROFURANTOIN | NITROFURANTOIN MONO-MACRO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

MEMBERS 65 YEARS OR OLDER WILL BE EVALUATED FOR LIMITED PRESCRIPTION USE TO NO MORE THAN 90 DAYS (TOTAL) OF CUMULATIVE USE. REQUESTS FOR GREATER THAN 90 DAYS OF CUMULATIVE USE WILL REQUIRE TRIAL OF OR CONTRAINDICATION TO SULFAMETHOXAZOLE/TRIMETHOPRIM (TMP-SMX) OR TRIMETHOPRIM.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS

DRUG NAME

CLEMASTINE FUMARATE | CYPROHEPTADINE HCL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: TRIAL OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE. ANXIETY: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - BUSPIRONE, PAROXETINE, DULOXETINE, OR VENLAFAXINE. MOTION SICKNESS: TRIAL OR CONTRAINDICATION TO MECLIZINE. INSOMNIA: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - BENZTROPINE_TRIHEXYPHENIDYL

DRUG NAME

BENZTROPINE MESYLATE | TRIHEXYPHENIDYL HCL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - HYDROXYZINE

DRUG NAME

HYDROXYZINE HCL | HYDROXYZINE PAMOATE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - PROMETHAZINE

DRUG NAME

PROMETHAZINE HCL | PROMETHEGAN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: TRIAL OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE. ANXIETY: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - BUSPIRONE, PAROXETINE, DULOXETINE, OR VENLAFAXINE. MOTION SICKNESS: TRIAL OR CONTRAINDICATION TO MECLIZINE.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - BARBITURATE COMBINATIONS

DRUG NAME

ASCOMP WITH CODEINE | BUTALB-ACETAMINOPH-CAFF-CODEIN | BUTALB-CAFF-ACETAMINOPH-CODEIN | BUTALBITAL-ACETAMINOPHEN | BUTALBITAL-ACETAMINOPHEN-CAFFE | BUTALBITAL-ASPIRIN-CAFFEINE | TENCON

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - BENZODIAZEPINE SEDIATIVE HYPNOTICS

DRUG NAME

ESTAZOLAM | FLURAZEPAM HCL | TEMAZEPAM | TRIAZOLAM

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

MEMBERS 65 YEARS OR OLDER WILL BE EVALUATED FOR LIMITED PRESCRIPTION USE TO NO MORE THAN 90 DAYS (TOTAL) OF CUMULATIVE USE WITHIN THE CURRENT PLAN YEAR. REQUESTS GREATER THAN 90 DAYS OF CUMULATIVE USE REQUIRES PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - CARDIOVASCULAR

DRUG NAME

GUANFACINE HCL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

HYPERTENSION: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - BENAZEPRIL, BENAZEPRIL/HYDROCHLOROTHIAZIDE, CAPTOPRIL, CAPTOPRIL/HYDROCHLOROTHIAZIDE, ENALAPRIL, ENALAPRIL/HYDROCHLOROTHIAZIDE, FOSINOPRIL, FOSINOPRIL/HYDROCHLOROTHIAZIDE, LISINOPRIL, LISINOPRIL/HYDROCHLOROTHIAZIDE, QUINAPRIL, QUINALPRIL/HYDROCHLOROTHIAZIDE, RAMIPRIL, MOEXIPRIL, MOEXIPRIL/HYDROCHLOROTHIAZIDE, PERINDOPRIL ERBUMINE, QUNINAPRIL, QUINAPRIL/HYDROCHLOROTHIAZIDE, TRANDOLAPRIL, TRANDOLAPRIL/VERAPAMIL, LOSARTAN, LOSARTAN/HYDROCHLOROTHIAZIDE, IRBESARTAN, IRBESARTAN/HYDROCHLOROTHIAZIDE, OLMESARTAN, OLMESARTAN/HYDROCHLOROTHIAZIDE,

Brand New Day (HMO SNP)

Prior Authorization Requirements

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - CENTRAL NERVOUS SYSTEM - THIORIDAZINE

DRUG NAME

THIORIDAZINE HCL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - DIGOXIN

DRUG NAME

DIGITEK | DIGOX | DIGOXIN | LANOXIN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIGOXIN LEVEL

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

APPROVAL FOR MEMBERS STABLE ON 250 MCG WITH DOCUMENTED THERAPEUTIC DIGOXIN LEVEL TAKEN WITHIN THE PAST YEAR.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - ESTROGEN

DRUG NAME

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

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

VULVAR/VAGINAL ATROPHY: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - ESTRACE VAGINAL CREAM, PREMARIN VAGINAL CREAM, OR VAGIFEM. OSTEOPOROSIS: TRIAL OR CONTRAINDICATION TO ONE OF THE FOLLOWING - ALENDRONATE, IBANDRONATE, OR RALOXIFENE. VASOMOTOR SYMPTOMS OF MENOPAUSE: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER. ALL OTHER FDA APPROVED INDICATIONS, SUCH AS PALLIATION TREATMENT, NOT PREVIOUSLY MENTIONED IN THIS SECTION, ARE TO BE APPROVED WITHOUT A TRIAL OF FORMULARY ALTERNATIVES.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - GLYBURIDE

DRUG NAME

GLYBURIDE | GLYBURIDE MICRONIZED | GLYBURIDE-METFORMIN HCL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - INDOMETHACIN

DRUG NAME

INDOMETHACIN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF OR CONTRAINDICATION TO CELECOXIB OR A TOPICAL NON-STEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) SUCH AS VOLTAREN GEL OR FLECTOR. PRESCRIPTIONS WRITTEN BY A RHEUMATOLOGIST DO NOT REQUIRE TRIAL OF FORMULARY ALTERNATIVES.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - NON-BENZODIAZEPINE

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

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

MEMBERS 65 YEARS OR OLDER WILL BE EVALUATED FOR LIMITED PRESCRIPTION USE TO NO MORE THAN 90 DAYS (TOTAL) OF CUMULATIVE USE WITHIN THE CURRENT PLAN YEAR. REQUESTS GREATER THAN 90 DAYS OF CUMULATIVE USE REQUIRES PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - SKELETAL MUSCLE RELAXANTS

DRUG NAME

CARISOPRODOL | CHLORZOXAZONE | CYCLOBENZAPRINE HCL | METAXALONE | METHOCARBAMOL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

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

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

HIGH RISK DRUGS IN THE ELDERLY - TCA

DRUG NAME

AMITRIPTYLINE HCL | CLOMIPRAMINE HCL | DOXEPIN HCL | IMIPRAMINE HCL | IMIPRAMINE PAMOATE | PERPHENAZINE-AMITRIPTYLINE | SURMONTIL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

IBRUTINIB

DRUG NAME

IMBRUVICA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

IDELALISIB

DRUG NAME

ZYDELIG

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

IMATINIB MESYLATE

DRUG NAME

GLEEVEC

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

ALL DIAGNOSIS: 12 MONTHS. GIST (TWICE DAILY DOSE): 36 MONTHS.

OTHER CRITERIA

GASTROINTESTINAL STROMAL TUMOR (GIST) KIT (CD117) POSITIVE USE FOR GLEEVEC 400MG TWICE DAILY: TRIAL OF GLEEVEC 400MG ONCE DAILY OR GIST TUMOR EXPRESSING A KIT EXON 9 MUTATION. PREVIOUSLY TREATED CML REQUIRES MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS FOLLOWING BCR-ABL MUTATIONAL ANALYSIS - T315I, V299L, F317L/V/I/C, Y253H, E255K/V, F359V/C/I.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

IMIQUIMOD - ALDARA

DRUG NAME

IMIQUIMOD

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

EXTERNAL GENITAL OR PERIANAL WARTS: GREATER THAN OR EQUAL TO 12 YEARS OF AGE. ACTINIC KERATOSIS: GREATER THAN OR EQUAL TO 18 YEARS OF AGE.

PRESCRIBER RESTRICTIONS

ACTINIC KERATOSIS: DERMATOLOGIST ONLY. SUPERFICIAL BASAL CELL CARCINOMA/LETIGO MALIGNA: DERMATOLOGIST OR ONCOLOGIST ONLY.

COVERAGE DURATION

4 MONTHS

OTHER CRITERIA

CRITERIA APPLIES TO NEW STARTS ONLY. EXTERNAL GENITAL WARTS: TRAIL OF OR CONTRAINDICATION TO PODOFILOX (CONDYLOX). ACTINIC KERATOSIS: TRIAL OF TOPICAL 5-FLUOROURACIL. ACTINIC KERATOSIS BRAND DRUG REQUEST: TRIAL/FAILURE OF GENERIC IMIQUIMOD 5%. SUPERFICIAL BASAL CELL CARCINOMA: LESS THAN 2CM IN SIZE AND NOT ON THE FACE. MOLLUSCUM CONTAGISOUM LIMITED TO THE FACE.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

IMMUNE GLOBULIN BVD DETERMINATION

DRUG NAME

CARIMUNE NF NANOFILTERED | FLEBOGAMMA DIF | GAMASTAN S-D | GAMMAGARD LIQUID | GAMMAPLEX | GAMUNEX-C | OCTAGAM | PRIVIGEN

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

IMMUNOSUPPRESSANT BVD DETERMINATION

DRUG NAME

ASTAGRAF XL | AZATHIOPRINE | CELLCEPT | CYCLOSPORINE | CYCLOSPORINE MODIFIED | GENGRAF | MYCOPHENOLATE MOFETIL | MYCOPHENOLIC ACID | NULOJIX | PROGRAF | RAPAMUNE | SIROLIMUS | TACROLIMUS | ZORTRESS

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

INFLIXIMAB

DRUG NAME

REMICADE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, RHEUMATOLOGIST OR DERMATOLOGIST.

COVERAGE DURATION

UC: 12 MO. OTHER INDICATIONS INITIAL: 4 MO RENEWAL: 12 MO

Brand New Day (HMO SNP)

Prior Authorization Requirements

OTHER CRITERIA

INITIAL: MODERATE TO SEVERE CROHN'S DISEASE/ULCERATIVE COLITIS/ACUTE ENTEROCUTANEOUS FISTULA: TRIAL/FAILURE OF ONE OR MORE OF THE FOLLOWING PREFERRED THERAPY AGENTS SUCH AS SULFASALAZINE, CORTICOSTEROIDS, AZATHIOPRINE, METHOTREXATE, OLSALAZINE, MESALAMINE, CYCLOSPORINE, OR MERCAPTOPURINE AND TRIAL OF HUMIRA FOR CROHNS DISEASE AND ULCERATIVE COLITIS. FOR MODERATE TO SEVERE RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS AND ANKYLOSING SPONDYLITIS: TRIAL OF HUMIRA AND ENBREL. FOR SEVERE PLAQUE PSORIASIS COVERING 5% BSA: TRIAL/FAILURE OF HUMIRA AND ENBREL. RENEWAL: FOR RHEUMATOID ARTHRITIS: CONCOMITANT METHOTREXATE USE.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

INFUSIBLE DRUG BVD DETERMINATION

DRUG NAME

ABELCET | ACYCLOVIR SODIUM | ADRUCIL | AMBISOME | AMPHOTERICIN B | BLEOMYCIN SULFATE | CYTARABINE | FLUOROURACIL | GANCICLOVIR SODIUM | IFOSFAMIDE | METHOTREXATE | MITOMYCIN | REMODULIN | TORISEL | VINBLASTINE SULFATE | VINCASAR PFS | 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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

INTERFERON ALFA-2B

DRUG NAME

INTRON A

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

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

OTHER CRITERIA

CRITERIA APPLIES TO NEW STARTS ONLY. DURATION LIMITATION OF 1 YEAR OF THERAPY. FOR HEPATITIS C INDICATION REQUIRES A TRIAL OF PEGINTERFERON ALFA 2A OR PEGINTERFERON ALFA 2B. HEP C: DRUG MUST BE USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED. TRIAL OF OR CONTRAINDICATION TO PEGINTERFERON ALFA-2A OR PEGINTERFERON ALFA-2B. GENOTYPE 1, 2, 3, 4, 5, OR 6.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

IVACAFTOR

DRUG NAME

KALYDECO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

F508DEL MUTATION IN CFTR GENE.

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

6 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

IVACAFTOR GRANULE PACKETS

DRUG NAME

KALYDECO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

F508DEL MUTATION IN CFTR GENE.

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

2 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

LEDIPASVIR-SOFOSBUVIR

DRUG NAME

HARVONI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

HCV RNA LEVEL.

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

DURATION BASED ON FDA APPROVED DOSING SEE OTHER CRITERIA FIELD FOR MORE INFORMATION.

OTHER CRITERIA

GUIDELINE CRITERIA ARE BASED ON AMERICAN ASSOCIATION FOR THE STUDY OF LIVER DISEASES AND INFECTIOUS DISEASE SOCIETY OF AMERICA (AASLD/IDSA) TREATMENT GUIDELINES AND BEST AVAILABLE EVIDENCE. NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). APPROVAL REQUIRES PATIENT HAS EVIDENCE OF HEPATITIS C INFECTION (AT LEAST 2 DETECTABLE

Brand New Day (HMO SNP)

Prior Authorization Requirements

HCV RNA LEVELS) OVER THE PAST 6 MONTHS OR PATIENT HAS AT LEAST ONE DETECTABLE HCV RNA LEVEL OVER THE PAST 6 MONTHS AND HAS PREVIOUS EVIDENCE OF INFECTION (E.G., PREVIOUS PRESCRIPTION FOR TREATMENT OF HEPATITIS C). PATIENT IS TREATMENT NAIVE (WITH OR WITHOUT CIRRHOSIS): WILL BE APPROVED FULL 12 WEEKS OF TREATMENT PER PRODUCT LABELING WITHOUT INTERRUPTION (NO RENEWAL). PATIENT WITHOUT CIRRHOSIS WHO HAVE RECEIVED PRIOR TREATMENT (TREATMENT EXPERIENCED PATIENT) SUCH AS PEGINTERFERON AND RIBAVIRIN OR TRIPLE THERAPY WITH HCV PROTEASE INHIBITOR, PEGINTERFERON AND RIBAVIRIN FOR HEPATITIS C: APPROVE 12 WEEKS PER PRODUCT LABELING WITHOUT INTERRUPTION (NO RENEWAL). PATIENT WITH CIRRHOSIS WHO HAS RECEIVED PRIOR TREATMENT (TREATMENT EXPERIENCED PATIENT) SUCH AS PEGINTERFERON AND RIBAVIRIN OR TRIPLE THERAPY WITH HCV PROTEASE INHIBITOR, PEGINTERFERON AND RIBAVIRIN FOR HEPATITIS C: APPROVE 24 WEEKS PER PRODUCT LABELING WITHOUT INTERRUPTION (NO RENEWAL). PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, SIMEPREVIR, SOFOSBUVIR (AS A SINGLE AGENT), STRIBILD (ELVITAGRAVIR/COBICISTAT/EMTRICITABINE /TENOFOVIR), OR TIPRANAVIR/RITONAVIR.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

LENALIDOMIDE

DRUG NAME

REVLIMID

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

LENVATINIB MESYLATE

DRUG NAME

LENVIMA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

LIDOCAINE

DRUG NAME

LIDOCAINE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL COVERAGE CONSIDERATION FOR DIABETIC NEUROPATHY, BURN, CANCER PAIN, TOPICAL LOCAL ANAESTHESIA.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

LUMACAFTOR-IVACAFTOR

DRUG NAME

ORKAMBI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

CONCURRENT KALYDECO THERAPY

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A PLUMONOLOGIST

COVERAGE DURATION

INITIAL: 4 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

INITIAL: BASELINE FEV1 OF AT LEAST 40%. RENEWAL: MAINTAINED OR IMPROVEMENT IN FEV1 OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS OR IMPROVEMENT IN BODY MASS INDEX (BMI).

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

METHOTREXATE BVD DETERMINATION

DRUG NAME

METHOTREXATE | TREXALL

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

METHYLNALTREXONE

DRUG NAME

RELISTOR

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

CONSTIPATION DUE TO OPIOIDS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

UP TO 6 MONTHS

OTHER CRITERIA

PATIENT IS RECEIVING PALLIATIVE CARE.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

MIFEPRISTONE

DRUG NAME

KORLYM

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

MODAFINIL AND ARMODAFINIL - NUVIGIL

DRUG NAME

NUVIGIL

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

NARCOLEPSY: TRIAL OF OR CONTRAINDICATION TO AMPHETAMINE, DEXTROAMPHETAMINE, OR METHYLPHENDATE.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

NATALIZUMAB

DRUG NAME

TYSABRI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

MULTIPLE SCLEROSIS:12 MONTHS. CROHN'S DISEASE: 6 MONTHS. RENEWAL: CROHN'S: 12 MONTHS.

OTHER CRITERIA

MULTIPLE SCLEROSIS: TRIAL OF AN INTERFERON OR COPAXONE. CROHN'S DISEASE: TRIAL OF A PREFERRED TNF-ALPHA INHIBITOR (HUMIRA). RENEWAL: CROHN'S: PATIENT IS NOT ON CONCOMITANT CORTICOSTEROID TREATMENT AFTER 6 MONTHS ON NATALIZUMAB, OR HAS NOT RECEIVED MORE THAN 3 MONTHS OF A CORTICOSTEROID WITHIN THE PAST 12 MONTHS.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

NEBULIZER BVD DETERMINATION

DRUG NAME

ACETYLCYSTEINE | ALBUTEROL SULFATE | BETHKIS | CROMOLYN SODIUM | NEBUPENT | PULMOZYME | TOBRAMYCIN | TYVASO | VENTAVIS | VIRAZOLE

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

NILOTINIB

DRUG NAME

TASIGNA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

NINTEDANIB ESYLATE

DRUG NAME

OFEV

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

NIVOLUMAB

DRUG NAME

OPDIVO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

OFATUMUMAB

DRUG NAME

ARZERRA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

PREVIOUSLY UNTREATED CLL:12 MONTHS TREATMENT REFRACTOR CLL: 6 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

OLAPARIB

DRUG NAME

LYNPARZA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

OMACETAXINE

DRUG NAME

SYNRIBO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

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

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

OMALIZUMAB

DRUG NAME

XOLAIR

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PATIENT 12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

SPECIALIST IN ALLERGY OR PULMONARY MEDICINE ONLY

COVERAGE DURATION

ASTHMA: 12 MONTHS. CIU: 6 MONTHS.

OTHER CRITERIA

FOR CIU:TRIAL OF A HIGH DOSE H1 ANTI-HISTAMINE (SUCH AS CLARINEX OR XYZAL) FOR AT LEAST 2 WEEKS AND STILL EXPERIENCES HIVES ON MOST DAYS OF THE WEEK.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

OMBITASVIR-PARITAPREVIR-RITONAVIR

DRUG NAME

TECHNIVIE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

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

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

12 WEEKS

OTHER CRITERIA

GUIDELINE CRITERIA ARE BASED ON AMERICAN ASSOCIATION FOR THE STUDY OF LIVER DISEASES AND INFECTIOUS DISEASE SOCIETY OF AMERICA (AASLD/IDSA) TREATMENT GUIDELINES AND BEST AVAILABLE EVIDENCE. NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). APPROVAL REQUIRES PATIENT HAS EVIDENCE OF HEPATITIS C INFECTION (AT LEAST 2 DETECTABLE HCV RNA LEVELS) OVER THE PAST 6 MONTHS OR PATIENT HAS AT LEAST ONE

Brand New Day (HMO SNP)

Prior Authorization Requirements

DETECTABLE HCV RNA LEVEL OVER THE PAST 6 MONTHS AND HAS PREVIOUS EVIDENCE OF INFECTION (E.G., PREVIOUS PRESCRIPTION FOR TREATMENT OF HEPATITIS C). PATIENT IS NOT ON HEMODIALYSIS. MUST BE USED CONCURRENTLY WITH RIBAVIRIN UNLESS PATIENT IS TREATMENT NAIVE AND HAS CONTRAINDICATION TO RIBAVIRIN. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER): ALFUZOSIN, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, RIFAMPIN, ERGOTAMINE DIHYDROERGOTAMINE, ERGONOVINE, METHYLERGONOVINE, ETHINYL ESTRADIOL CONTAINING MEDICATIONS (SUCH AS COMBINED ORAL CONTRACEPTIVES, NUVARING, ORTHO EVRA OR XULANE TRANSDERMAL PATCH SYSTEM), LOVASTATIN, SIMVASTATIN, PIMOZIDE, EFAVIRENZ (ATRIPLA, SUSTIVA), REVATIO (SILDENAFIL DOSE OF 20MG AND/OR DOSED TID FOR PAH), TRIAZOLAM, ORAL MIDAZOLAM, LOPINAVIR/RITONAVIR, RILVIRAPINE, SALMETEROL.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

OMBITASVIR-PARITAPREVIR-RITONAVIR-DASABUVIR

DRUG NAME

VIEKIRA PAK

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

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

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

DURATION BASED ON FDA APPROVED DOSING SEE OTHER CRITERIA FIELD FOR MORE INFORMATION.

OTHER CRITERIA

GUIDELINE CRITERIA ARE BASED ON AMERICAN ASSOCIATION FOR THE STUDY OF LIVER DISEASES AND INFECTIOUS DISEASE SOCIETY OF AMERICA (AASLD/IDSA) TREATMENT GUIDELINES AND BEST AVAILABLE EVIDENCE. NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). APPROVAL REQUIRES PATIENT HAS EVIDENCE OF HEPATITIS C INFECTION (AT LEAST 2 DETECTABLE

Brand New Day (HMO SNP)

Prior Authorization Requirements

HCV RNA LEVELS) OVER THE PAST 6 MONTHS OR PATIENT HAS AT LEAST ONE DETECTABLE HCV RNA LEVEL OVER THE PAST 6 MONTHS AND HAS PREVIOUS EVIDENCE OF INFECTION (E.G., PREVIOUS PRESCRIPTION FOR TREATMENT OF HEPATITIS C). APPROVAL REQUIRES PATIENT HAS INABILITY TO TOLERATE HARVONI-RIBAVIRIN COMBINATION THERAPY REQUIRED FOR GENOTYPE 1A WITHOUT CIRRHOSIS, GENOTYPE 1A WITH CIRRHOSIS, GENOTYPE 1B WITH CIRRHOSIS, AND FOR USE IN LIVER TRANSPLANT PATIENTS. GENOTYPE 1B WITHOUT CIRRHOSIS DOES NOT REQUIRE THE USE OF RIBAVIRIN. PATIENTS WITH GENOTYPE 1B WITH OR WITHOUT CIRRHOSIS (TREATMENT NAIVE AND TREATMENT EXPERIENCED): APPROVAL FOR FULL 12 WEEKS. PATIENTS WITH GENOTYPE 1A WHO DO NOT HAVE CIRRHOSIS (TREATMENT NAIVE AND TREATMENT EXPERIENCED): APPROVAL FOR FULL 12 WEEKS. PATIENTS WITHGENOTYPE 1A WITH CIRRHOSIS (TREATMENT NAIVE AND TREATMENT EXPERIENCED): APPROVAL FOR FULL 24 WEEKS. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: ALFUZOSIN, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, GEMFIBROZIL, RIFAMPIN, ERGOTAMINE DIHYDROERGOTAMINE, ERGONOVINE, METHYLERGONOVINE, ETHINYL ESTRADIOL CONTAINING MEDICATIONS (SUCH AS COMBINED ORAL CONTRACEPTIVES, NUVARING, ORTHO EVRA OR XULANE TRANSDERMAL PATCH SYSTEM), ST. JOHNS WORT, LOVASTATIN, SIMVASTATIN, PIMOZIDE, EFAVIRENZ, REVATIO, TRIAZOLAM, ORAL MIDAZOLAM, DARUNAVIR/RITONAVIR, LOPINAVIR/RITONAVIR, RILVIRIPINE, SALMETEROL.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

OPIOID DEPENDENCY AGENTS

DRUG NAME

BUPRENORPHINE HCL | BUPRENORPHINE-NALOXONE | ZUBSOLV

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

PATIENT CURRENTLY TAKING OPIOID ANALGESICS.

REQUIRED MEDICAL INFORMATION

PSYCHOSOCIAL COUNSELING

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

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

OTHER CRITERIA

CONTINUATION OF THERAPY WITH BUPRENORPHINE: CONTRAINDICATION OR UNABLE TO TOLERATE NALOXONE IN COMBINATION WITH BUPRENORPHINE.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

PALBOCICLIB

DRUG NAME

IBRANCE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

PANOBINOSTAT

DRUG NAME

FARYDAK

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL AND RENEWAL: 24 WEEKS EACH (48 WEEKS TOTAL)

OTHER CRITERIA

RENEWAL: PATIENT HAS TOLERATED THE FIRST 8 CYCLES OF THERAPY WITHOUT UNRESOLVED SEVERE OR MEDICALLY SIGNIFICANT TOXICITY.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

PARATHYROID HORMONE

DRUG NAME

NATPARA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

PAZOPANIB

DRUG NAME

VOTRIENT

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

DRUG NAME

ADCIRCA | SILDENAFIL | SILDENAFIL CITRATE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

CARDIOLOGIST OR PULMONOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

REQUEST FOR ADCIRCA REQUIRE TRIAL OR CONTRAINDICATION TO REVATIO.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

PEG-INTERFERON ALFA-2A

DRUG NAME

PEGASYS | PEGASYS PROCLICK

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

INITIAL: HEP C: PRETREATMENT HCV RNA LEVEL GREATER THAN OR EQUAL TO 50 IU/ML. HEP C WITH HIV: CD4 COUNT GREATER THAN 100 CELLS/MM3, HCV RNA LEVELS/VIRAL LOAD GREATER THAN OR EQUAL TO 50 IU/ML. RENEWAL: HCV RNA LEVELS TO DETERMINE LENGTH OF TREATMENT.

AGE RESTRICTIONS

5 YEARS OR OLDER.

PRESCRIBER RESTRICTIONS

GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST).

COVERAGE DURATION

HEP B: 6 MOS. HEP C: DURATION BY GENOTYPE DIAGNOSIS. SEE OTHER CRITERIA FIELD FOR MORE INFORMATION.

OTHER CRITERIA

HEP C: TRIAL OR CONTRAINDICATION TO PEGINTRON. DRUG MUST BE USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED. GENOTYPE 1 WITH SOVALDI (SOFOSBUVIR): APPROVE 3 MONTHS. GENOTYPE1 TRIPLE THERAPY WITH OYSIO: APPROVE 6 MONTHS. GENOTYPE 1 PEGINTERFERON ALONE, OR AS DOUBLE THEARPY WITH RIBAVIRIN, OR WITH TRIPLE THERAPY INCLUDING BOCEPREVIR: 4 MONTHS. GENOTYPE 3: APPROVE 6 MONTHS. GENOTYPE 2: 3 MONTHS. GENOTYPE 4

Brand New Day (HMO SNP)

Prior Authorization Requirements

WITH SOLVADI: 3 MONTHS. GENOTYPE 5 OR 6 WITH SOLVADI: 3 MONTHS. GENOTYPE 5 OR 6 WITH RIBAVIRIN AND OLYSIO: 6 MONTHS. GENOTYPE 5 OR 6 ON PEGINTERFERON ALONE, PEGINTERFERON WITH RIBAVIRIN, OR AS PART OF TRIPLE THERAPY WITH VICTRELIS (BOCEPREVIR): APPROVE 4 MONTHS. RENEWAL: HEP C: USED IN COMBINATION OR CONTRAINDICATION WITH RIBAVIRIN. GENOTYPE 1: USE WITH TRIPLE THERAPY REGIMEN WITH INCIVEK AND COMPLETED 12 WEEKS OF INCIVEK BUT DOES HAVE DETECTABLE HCV RNA LEVELS AT 24 WEEKS: APPROVE TO COMPLETE PEGINTERFERON THERAPY. USE IN A TRIPLE THERAPY WITH OLYISO AND IS A NON-RESPONDER: APPROVE 24 WEEKS. USE IN A TRIPLE THERAPY WITH OLYSIO AND IS NOT A NON-RESPONDER, TREATMENT NAIVE OR PRIOR RELAPER: APPROVE 24 WEEKS. GENOTYPE 2, 3, 4, 5, OR 6: TRIPLE THERAPY WITH SOLVADI: APPROVE 12 WEEKS.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

PEG-INTERFERON ALFA-2B

DRUG NAME

PEGINTRON | PEGINTRON REDIPEN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

INITIAL: HEP C: PRETREATMENT HCV RNA LEVEL GREATER THAN OR EQUAL TO 50 IU/ML. RENEWAL: HCV RNA LEVELS TO DETERMINE LENGTH OF TREATMENT.

AGE RESTRICTIONS

3 YEARS OR OLDER.

PRESCRIBER RESTRICTIONS

GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST).

COVERAGE DURATION

HEP C: DURATION BY GENOTYPE DIAGNOSIS. SEE OTHER CRITERIA FIELD FOR MORE INFORMATION.

OTHER CRITERIA

HEP C: DRUG MUST BE USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED. GENOTYPE 1 WITH SOVALDI (SOFOSBUVIR): APPROVE 3 MONTHS. GENOTYPE1 TRIPLE THERAPY WITH OYSIO: APPROVE 6 MONTHS. GENOTYPE 1 PEGINTERFERON ALONE, OR AS DOUBLE THEARPY WITH RIBAVIRIN, OR WITH TRIPLE THERAPY INCLUDING BOCEPREVIR: 4 MONTHS. GENOTYPE 3: APPROVE 6 MONTHS. GENOTYPE 2: 3 MONTHS. GENOTYPE 4 WITH SOLVADI: 3 MONTHS. GENOTYPE 5 OR 6 WITH SOLVADI: 3 MONTHS. GENOTYPE 5 OR 6 WITH RIBAVIRIN AND OLYSIO: 6 MONTHS. GENOTYPE 5 OR 6 ON PEGINTERFERON ALONE,

Brand New Day (HMO SNP)

Prior Authorization Requirements

PEGINTERFERON WITH RIBAVIRIN, OR AS PART OF TRIPLE THERAPY WITH VICTRELIS (BOCEPREVIR): APPROVE 4 MONTHS. RENEWAL: HEP C: USED IN COMBINATION OR CONTRAINDICATION WITH RIBAVIRIN. GENOTYPE 1: USE WITH TRIPLE THERAPY REGIMEN WITH INCIVEK AND COMPLETED 12 WEEKS OF INCIVEK BUT DOES HAVE DETECTABLE HCV RNA LEVELS AT 24 WEEKS: APPROVE TO COMPLETE PEGINTERFERON THERAPY. USE IN A TRIPLE THERAPY WITH OLYISO AND IS A NON-RESPONDER: APPROVE 24 WEEKS. USE IN A TRIPLE THERAPY WITH OLYSIO AND IS NOT A NON-RESPONDER, TREATMENT NAIVE OR PRIOR RELAPER: APPROVE 24 WEEKS. GENOTYPE 2, 3, 4, 5, OR 6: TRIPLE THERAPY WITH SOLVADI: APPROVE 12 WEEKS.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

PEG-INTERFERON ALFA-2B-SYLATRON

DRUG NAME

SYLATRON

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CRITERIA APPLIES TO NEW STARTS ONLY. DURATION LIMITATION OF 5 YEARS OF THERAPY.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

PEMBROLIZUMAB

DRUG NAME

KEYTRUDA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

PERTUZUMAB

DRUG NAME

PERJETA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

PIRFENIDONE

DRUG NAME

ESBRIET

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

POMALIDOMIDE

DRUG NAME

POMALYST

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

PONATINIB

DRUG NAME

ICLUSIG

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

PRAMLINTIDE

DRUG NAME

SYMLINPEN 120 | SYMLINPEN 60

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

QUININE SULFATE

DRUG NAME

QUININE SULFATE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

RABIES VACCINE BVD DETERMINATION

DRUG NAME

IMOVAX RABIES VACCINE | RABAVERT

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

RAMUCIRUMAB

DRUG NAME

CYRAMZA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

REGORAFENIB

DRUG NAME

STIVARGA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

RIFAXIMIN

DRUG NAME

XIFAXAN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

TRAVELERS' DIARRHEA: 12 YEARS OR OLDER. HEPATIC ENCEPHALOPATHY: 18 YEARS OR OLDER.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

TRAVELERS' DIARRHEA: 1 FILL IN 1 MONTH. HEPATIC ENCEPHALOPATHY: 12 MONTHS.

OTHER CRITERIA

TRAVELERS' DIARRHEA: TRIAL OF CIPROFLOXACIN OR AZITHROMYCIN. HEPATIC ENCEPHALOPATHY: TRIAL OF LACTULOSE MONOTHERAPY.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

RIOCIGUAT

DRUG NAME

ADEMPAS

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF OR CONTRAINDICATION TO A PHOSPHODIESTERASE-5 (PDE-5) INHIBITOR SUCH AS REVATIO OR ADCIRCA.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

RITUXIMAB

DRUG NAME

RITUXAN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR SUPERVISED BY: FOR RHEUMATOID ARTHRITIS A RHEUMATOLOGIST. FOR NHL OR CLL AN ONCOLOGIST.

COVERAGE DURATION

RA: INITIAL AND RENEWAL 4 MO. HNL: 1 YEAR. CLL: 6 MO. WG, MPA: 1 MO.

OTHER CRITERIA

INITIAL: RHEUMATOID ARTHRITIS: TRIAL OF OR CONTRAINDICATION TO HUMIRA AND ENBREL. NON HODGKIN'S LYMPHOMA/CHRONIC LYMPHOCYTIC LEUKEMIA: USED IN COMBINATION WITH CHEMOTHERAPY. WEGNER'S GRANULOMATOSIS/MICROSCOPIC POLYANGIITIS: CONCURRENT GLUCOCORTICOID USE.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

ROMIDEPSIN

DRUG NAME

ISTODAX

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF OR CONTRAINDICATION TO VORINOSTAT (ZOLINZA) AND NOT ABLE TO TOLERATE ORAL MEDICATIONS, OR IS ABLE TO TOLERATE ORAL MEDICATIONS AND HAS TRIED AT LEAST ONE SYSTEMIC THERAPY (RETINOID, INTERFERON, EXTRACORPOREAL PHOTOPHERESIS, DENILEUKIN DIFTITOX, METHOTREXATE, LIPOSOMAL DOXORUBICIN, GEMCITABINE, CHLORAMBUCIL, PENTOSTATIN, ETOPOSIDE, CYCLOPHOSPHAMIDE, TEMOZOLOMIDE, BORTEZOMIB).

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

RUXOLITINIB

DRUG NAME

JAKAFI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

SACUBITRIL-VALSARTAN

DRUG NAME

ENTRESTO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

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

REQUIRED MEDICAL INFORMATION

LEFT VENTRICULAR EJECTION FRACTION (LVEF)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

SECUKINUMAB

DRUG NAME

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

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

NA

REQUIRED MEDICAL INFORMATION

INITIAL: PLAQUE PSORIASISI: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT OF BODY SURFACE AREA (BSA) OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA

AGE RESTRICTIONS

18 YEARS AND OLDER

PRESCRIBER RESTRICTIONS

THERAPY PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST

COVERAGE DURATION

INITIAL: 4 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

FOR MODERATE TO SEVERE PLAQUE PSORIASIS: TRIAL WITH HUMIRA AND ENBREL. RENEWAL REQUIRES THAT THE PATIENT HAS ACHIEVED CLEAR OR MINIMAL DISEASE OR A DECREASE IN PASI (PSORIASIS AREA AND SEVERITY INDEX) OF AT LEAST 50% OR MORE.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

SILTUXIMAB

DRUG NAME

SYLVANT

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

SIMEPREVIR

DRUG NAME

OLYSIO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

12 WEEKS. SEE OTHER CRITERIA FIELD FOR MORE INFORMATION.

OTHER CRITERIA

GENOTYPE 1A NOT POSITIVE FOR NS3 Q80K POLYMORPHISM OR 1B WITH USE IN COMBINATION WITH RIBAVIRIN AND PEG-INTERFERON ALFA: MAXIMUM DURATION OF 12 WEEKS. INTERFERON INELIGIBLE (SUCH AS CONCURRENT DIAGNOSIS OF AUTOIMMUNE HEPATITIS OR HAS KNOWN HYPERSENSITIVITY REACTION SUCH AS URTICARIA, ANGIOEDEMA, BRONCHOSPASM AND ANAPHYLAXIS TO ALPHA INTERFERONS OR ANY COMPONENT OF THE PRODUCT, DOCUMENTATION OF DEPRESSION, DECOMPENSATED HEPATIC DISEASE, A

Brand New Day (HMO SNP)

Prior Authorization Requirements

BASELINE NEUTROPHIL COUNT BELOW 1500 PER MICROLITER, A BASELINE PLATELET COUNT BELOW 90,000, OR A BASELINE HEMOGLOBIN BELOW 10G/DL THAT HAS NOT RESPONDED TO TREATMENT): COMBINATION REGIMEN SOVALDI AND OLYSIO FOR 12 WEEKS AS LONG AS PATIENT HAS NOT FAILED A PRIOR COURSE OF THERAPY WITH ANY HCV PROTEASE INHIBITOR (SUCH AS INCIVEK OLYSIO, OR VICTRELIS) (I.E., HAS NOT ACHIEVED A SUSTAINED VIROLOGIC RESPONSE).

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

SOFOSBUVIR

DRUG NAME

SOVALDI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

PATIENT WITH END STAGE RENAL DISEASE OR REQUIRES DIALYSIS.

REQUIRED MEDICAL INFORMATION

FOR ALL GENOTYPE 1, INTERFERON INELIGIBLE PATIENTS USING OLYSIO AND SOVALDI AND HAVE GENOTYPE 1A: NS3 80K POLYMORPHISM LAB TEST AT BASELINE.

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

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

COVERAGE DURATION

DURATION PER GENOTYPE DIAGNOSIS. SEE OTHER CRITERIA FIELD FOR MORE INFORMATION.

OTHER CRITERIA

HEPATITIS C: USE WITH RIBAVIRIN: GENOTYPE 1, 2, 3, 4, 5 OR 6 WITH HEPATOCELLULAR CARCINOMA (THAT MEETS MILAN CRITERIA) AND IS AWAITING LIVER TRANSPLANT: MAXIMUM DURATION OF TREATMENT UP TO 48 WEEKS. GENOTYPE 1 WITHOUT USE OF RIBAVIRIN AND WITH CONTRAINDICATION

Brand New Day (HMO SNP)

Prior Authorization Requirements

TO INTERFERON (SUCH AS CONCURRENT DIAGNOSIS OF AUTOIMMUNE HEPATITIS OR HAS KNOWN HYPERSENSITIVITY REACTION SUCH AS URTICARIA, ANGIOEDEMA, BRONCHOSPASM AND ANAPHYLAXIS TO ALPHA INTERFERONS OR ANY COMPONENT OF THE PRODUCT, DOCUMENTATION OF DEPRESSION, DECOMPENSATED HEPATIC DISEASE, A BASELINE NEUTROPHIL COUNT BELOW 1500 PER MICROLITER, A BASELINE PLATELET COUNT BELOW 90,000, OR A BASELINE HEMOGLOBIN BELOW 10G/DL THAT HAS NOT RESPONDED TO TREATMENT): COMBINATION REGIMEN SOVALDI AND OLYSIO FOR 12 WEEKS AS LONG AS PATIENT HAS NOT FAILED A PRIOR COURSE OF THERAPY WITH ANY HCV PROTEASE INHIBITOR (SUCH AS INCIVEK, OLYSIO, OR VICTRELIS) UP TO 12 WEEKS. GENOTYPE 1, 4, 5, OR 6 WITH USE OF PEGINTERFERON AND RIBAVIRIN: MAXIMUM UP TO 12 WEEKS WITHOUT USE OF CONCURRENT PRESCRIPTION FOR ANY HCV PROTEASE INHIBITOR (SUCH AS INCIVEK, OLYSIO, OR VICTRELIS). GENOTYPE 2 WITH RIBAVIRIN: MAXIMUM DURATION UP TO 12 WEEKS. GENOTYPE 3 WITH PEGINTERFERON AND RIBAVIRIN: MAXIMUM DURATION UP TO 12 WEEKS. GENOTYPE 3 WITH RIBAVIRIN (CONTRAINDICATION TO INTERFERON): MAXIMUM DURATION UP TO 24 WEEKS. GENOTYPE 1 OR 1A WITH CONTRAINDICATION TO INTERFERON, WHEN USED WITH RIBAVIRIN (TREATMENT NAIVE OR WITH N3 Q80K POLYMORPHISM OR WITH PREVIOUS FAILURE OF A HCV PROTEASE INHIBITOR): MAXIMUM DURATION UP TO 24 WEEKS.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

SOMATROPIN - GROWTH HORMONE

DRUG NAME

GENOTROPIN | HUMATROPE | NORDITROPIN FLEXPRO | NUTROPIN AQ NUSPIN | OMNITROPE | SAIZEN | ZOMACTON

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

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

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

ENDOCRINOLOGIST.

COVERAGE DURATION

12 MONTHS.

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

SOMATROPIN - SEROSTIM

DRUG NAME

SEROSTIM

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES

REQUIRED MEDICAL INFORMATION

HIV/WASTING: MEETS CRITERA OF WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, OR 7.5% OVER 6 MONTHS, OR 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN), 23% (WOMEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BMI LESS THAN 20 KG PER METER SQUARED.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

HIV/AIDS: 3 MONTHS.

OTHER CRITERIA

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

SORAFENIB TOSYLATE

DRUG NAME

NEXAVAR

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

SUNITINIB MALATE

DRUG NAME

SUTENT

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

GASTROINTESTIONAL STROMAL TUMORS (GIST): TRIAL OF OR CONTRAINDICATION TO GLEEVEC.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

TERIFLUNOMIDE

DRUG NAME

AUBAGIO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF OR CONTRAINDICATION TO AN AGENT INDICATED FOR THE TREATMENT OF MULTIPLE SCLEROSIS (COPAXONE, REBIF, TECFIDERA).

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

TERIPARATIDE

DRUG NAME

FORTEO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

GREATER THAN 24 MONTHS OF THERAPY.

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

TESTOSTERONE

DRUG NAME

ANDRODERM | ANDROGEL | TESTOSTERONE | TESTOSTERONE CYPIONATE | TESTOSTERONE ENANTHATE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

LIFETIME OF MEMBERSHIP IN PLAN

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

TETRABENAZINE

DRUG NAME

TETRABENAZINE | XENAZINE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

NEUROLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

THALIDOMIDE

DRUG NAME

THALOMID

COVERED USES

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

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

TOCILIZUMAB IV

DRUG NAME

ACTEMRA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

ACTIVE RHEUMATOID ARTHRITIS, SJIA, OR PJIA RENEWAL: AT LEAST 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT.

AGE RESTRICTIONS

JIA, SJI: 2 YEARS AND OLDER

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.

COVERAGE DURATION

RA INITIAL: 6 MONTHS. RENEWAL: 6 MONTHS. PJIA/SJI: 12 MONTHS.

OTHER CRITERIA

FOR RHEUMATOID ARTHRITIS AND PJIA: TRIAL OF OR CONTRAINDICATION TO ENBREL AND HUMIRA.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

TOCILIZUMAB SQ

DRUG NAME

ACTEMRA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.

COVERAGE DURATION

INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA

TRIAL OF OR CONTRAINDICATION TO HUMIRA AND ENBREL.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

TOFACITINIB

DRUG NAME

XELJANZ

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.

COVERAGE DURATION

RA: INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.

OTHER CRITERIA

RHEUMATOID ARTHRITIS INITIAL: TRIAL OF OR CONTRAINDICATION TO HUMIRA AND ENBREL.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

TOPICAL TRETINOIN

DRUG NAME

TRETINOIN | TRETINOIN MICROSPHERE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

WRINKLES, PHOTOAGING, MELASMA.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

BRAND TRETINON WILL REQUIRE TRIAL OF GENERIC TOPICAL TRETINOIN.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

TOTAL PARENTARAL NUTRITION AGENT BVD DETERMINATION

DRUG NAME

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

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

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

TRAMETINIB DIMETHYL SULFOXIDE

DRUG NAME

MEKINIST

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

TRASTUZUMAB

DRUG NAME

HERCEPTIN

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

BREAST CANCER, METASTATIC BREAST CANCER, GASTRIC CANCER: HER2 POSITIVE

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

B VS D COVERAGE CONSIDERATION. BREAST CANCER: USED IN COMBINATION WITH CHEMOTHERAPY (EXAMPLES INCLUDE: DOXORUBICIN AND CYCLOPHOSPHAMIDE FOLLOWED BY PACLITAXEL OR DOCETAXEL AND CARBOPLATIN OR DOCETAXEL FOLLOWED BY FLUOROURICIL/EPIRUBICIN/CYCLOPHOSPHAMIDE OR DOXORUBICIN/CYCLOPHOSPHAMIDE FOLLOWED BY DOCETAXEL OR PACLITAXEL. GASTRIC CANCER: USED IN COMBINATION WITH CHEMOTHERAPY (EXAMPLES INCLUDE: CISPLATIN AND FLUOROPYRIMIDINE.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

TREPROSTINIL DIOLAMINE

DRUG NAME

ORENITRAM ER

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED OR IN CONSULTATION WITH A CARDIOLOGIST OR A PULMONOLOGIST.

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

USTEKINUMAB

DRUG NAME

STELARA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PASI SCORE GREATER THAN OR EQUAL TO 12. PATIENT'S WEIGHT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.

COVERAGE DURATION

INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA

FOR SEVERE PLAQUE PSORIASIS COVERING 5% BSA: TRIAL OF OR CONTRINDICATION TO HUMRIA AND ENBREL RENEWAL: PHYSICIAN'S GLOBAL ASSESMENT EQUAL TO ZERO OR ONE OR A DECREASE OF PASI OF AT LEAST 50% OR GREATER. FOR PSORIATIC ARTHRITIS: TRIAL OF OR CONTRAINDICATION TO HUMIRA AND ENBREL. RENEWAL: EXPERIENCED OR MAINTAINED A 20 PERCENT OR GREATER IMPROVEMENT IN TENDER JOINT AND SWOLLEN JOINT COUNT.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

VANDETANIB

DRUG NAME

CAPRELSA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

CRITERIA APPLIES TO NEW STARTS ONLY.

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

VEMURAFENIB

DRUG NAME

ZELBORAF

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

BRAFV600E MUTATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

VISMODEGIB

DRUG NAME

ERIVEDGE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Brand New Day (HMO SNP)

Prior Authorization Requirements

Effective Date: 12/01/2015

PRIOR AUTHORIZATION GROUP DESCRIPTION

ZIV-AFLIBERCEPT

DRUG NAME

ZALTRAP

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA