

2012 CIGNA Medicare Select Plus Rx (HMO) Formulary Prior Authorization Criteria
(effective 01/01/2012)

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Actemra

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions: Authorization is limited to patients 2 years old and older.

Coverage Duration: Authorization is for one year.

Other Criteria: Treatment of rheumatoid arthritis (RA) when ANY of the following criteria are met: 1) history of positive clinical response to tocilizumab therapy OR 2) inadequate response, intolerance, or contraindication to at least one disease-modifying anti-rheumatic drug (DMARD) (i.e., Methotrexate (MTX) Azathioprine, gold, Hydroxychloroquine, Penicillamine, Sulfasalazine). For RA new starts that meet the above criteria, the patient must also have failure, contraindication or intolerance to Enbrel or Humira before authorization of Actemra.

Adcirca

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Alpha-1 Proteinase Inhibitor Therapy

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information: Intravenous alpha1-proteinase inhibitor (human) is authorized for the treatment of congenital alpha1-proteinase inhibitor deficiency-associated lung disease when all of the following criteria are met: 1) alpha1-antitrypsin (AAT) concentration less than 80mg/dl or less than 11 micromolar 2) obstructive lung disease as defined by a forced expiratory volume in one second (FEV1) of 30 to 65% of predicted or a rapid decline in lung function defined as a change in FEV1 of greater than 120ml per year.

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Amevive

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information: The total lymphocyte and CD4+ T cell counts must be within normal range in order for reauthorization.

Age Restrictions: Authorization is limited to patients 18 years old and older.

Coverage Duration: Initial authorization 12 weeks. If reauthorization criteria met, an additional 12 weeks may be authorized.

Other Criteria: Patient is a candidate for, or has previously received ONE of the following: 1) systemic therapy (e.g., methotrexate, cyclosporin, soriatane) OR 2) Phototherapy [narrow or broad band ultraviolet B (UVB), or psoralen plus ultraviolet A (PUVA)] AND must also have failure, contraindication or intolerance to Enbrel or Humira before Amevive is authorized. Coverage may be approved for re-treatment ONCE as long as a minimum of 12 weeks has passed since the last course of therapy.

Ampyra

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Initial authorization 3 months. Reauthorization is one year.

Other Criteria: Approval for continuation of therapy is contingent upon a demonstrated improvement in walking.

Anzemet Inj

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Aranesp

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information: Aranesp is authorized for the treatment of anemia [Hemoglobin (Hgb) less than 10 g/dl (Hgb less than 12 g/dl for chronic kidney disease patients)] in the presence of adequate iron stores (i.e., normal transferrin or serum ferritin level) associated with one of the following conditions: 1) chronic kidney disease, including patients who are predialysis or on dialysis, or 2) cancer chemotherapy regimens planned for at least two months in duration. Continued authorization is considered medically necessary when the following criteria are met: Hgb does not exceed 12 g/dl (13g/dl for chronic kidney disease).

Age Restrictions:

Coverage Duration: Anemia associated with chronic kidney disease - 6 months. Anemia due to chemotherapy - 8 weeks.

Other Criteria:

Arcalyst

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions: Authorization is limited to patients 12 years old and older.

Coverage Duration: Authorization is for one year.

Other Criteria:

Avonex

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Betaseron

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Botox

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information: treatment of strabismus disorders in adults, in situations when one of the following is present: horizontal strabismus up to 50 prism diopters, vertical strabismus, or persistent sixth nerve palsy of one month or longer duration AND when one of the following also present: diplopia, impaired depth perception, impaired peripheral vision, or impaired ability to maintain fusion.

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria: Treatment of cervical dystonia which is causing persistent pain or interfering with the ability to perform age-related activities of daily living. Treatment of hyperhidrosis, when ANY of the following indications are met: 1) primary axillary hyperhidrosis that is inadequately managed with a prescription topical agent or 2) palmar hyperhidrosis that is inadequately managed with a prescription topical agent AND when ONE of the following criteria is met: 1) The condition is significantly interfering with the patient's ability to perform age-appropriate activities of daily living OR 2) the condition is causing persistent or chronic cutaneous conditions such as skin maceration, dermatitis, fungal infections and secondary microbial conditions. Treatment of gustatory sweating (Frey's syndrome, diabetic gustatory sweating). For migraine prophylaxis, the patient must have failure, contraindication or intolerance to at least two different migraine prophylaxis medications (e.g. beta-blockers, calcium channel blockers, tricyclic antidepressants or anticonvulsants).

Copaxone

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Daliresp

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria: Patient must have failure, contraindication or intolerance to one formulary alternative such as Advair Diskus, Foradil, ipratropium/albuterol, Serevent, Spiriva or Symbicort before Daliresp is authorized.

Desoxyn

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria: Patient must have failure, contraindication or intolerance to one formulary alternative such as dextroamphetamine, amphetamine/dextroamphetamine, methylphenidate or dexmethylphenidate before Desoxyn is authorized.

Egrifta

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information: Males must have a waist circumference of at least 95cm (37.5in) and a waist-to-hip ratio of at least 0.94. Females must have a waist circumference of at least 94cm (37in) and a waist-to-hip ratio of at least 0.88. Patients must have a baseline CT documenting increased visceral adipose tissue (VAT). Reauthorization criteria requires improvement to be demonstrated by a decrease in CT Scan VAT thickness and a decrease in waist-to-hip ratio.

Age Restrictions:

Coverage Duration: Initial authorization 28 weeks. Reauthorization 1 year.

Other Criteria: Patient must be on a stable antiretroviral regimen for at least 8 weeks.

Eligard

Covered uses: All medically accepted indications not otherwise excluded from Part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria: Patient must have failure, contraindication or intolerance to Trelstar before Eligard is authorized.

Enbrel

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions: JRA - 2 to 17 years old. RA and plaque psoriasis 18 years of age and older.

Coverage Duration: Authorization is for one year.

Other Criteria: Treatment of rheumatoid arthritis (RA) OR Juvenile Rheumatoid Arthritis (JRA) and when ANY of the following criteria are met: 1) history of positive clinical response to etanercept therapy OR 2) inadequate response, intolerance, or contraindication to at least one disease-modifying anti-rheumatic drug (DMARD) (i.e., Methotrexate (MTX) Azathioprine, gold, Hydroxychloroquine, Penicillamine, Sulfasalazine). Treatment of chronic plaque psoriasis and 1) history of positive clinical response to etanercept therapy OR 2) patient is a candidate for, or has previously received ONE of the following: a) systemic therapy (e.g., methotrexate, cyclosporin, soriatane) OR b) phototherapy [narrow or broad band ultraviolet B (UVB), or psoralen plus ultraviolet A (PUVA)]. Treatment of ankylosing spondylitis and either of the following criteria are met: history of positive clinical response to etanercept therapy OR the patient had failure, contraindication, or intolerance to one non-steroidal anti-inflammatory drug (NSAIDs).

Epogen

Covered uses: All FDA-approved indications not otherwise excluded from part D and anemia of chronic disease including myelodysplastic syndrome, ribavirin use in individuals infected with hepatitis C, rheumatoid arthritis, rheumatic disease and prematurity.

Required Medical Information: Epogen is authorized for the treatment of anemia [Hemoglobin (Hgb) less than 10 g/dl (Hgb less than 12 g/dl for chronic kidney disease patients or females with HIV and 13 g/dl for surgery patients or males with HIV)] in the presence of adequate iron stores (i.e., normal transferrin or serum ferritin level) associated with ANY of the following conditions: 1) chronic kidney disease, including patients who are predialysis or on dialysis, 2) cancer chemotherapy regimens planned for at least two months in duration, 3) human immunodeficiency virus (HIV) infection in patients receiving zidovudine therapy, 4) surgical patients or 5) chronic disease including myelodysplastic syndrome, ribavirin use in individuals infected with hepatitis C, rheumatoid arthritis, rheumatic disease and prematurity. Continued authorization is considered medically necessary when the following criteria are met: Hgb does not exceed 12 g/dl (13g/dl for chronic kidney disease, males with HIV and surgery patients).

Age Restrictions:

Coverage Duration: Anemia associated with chronic kidney disease - 6 mos. Anemia for other covered uses - 8 wks.

Other Criteria: Patients must also have failure, contraindication or intolerance to Procrit or Aranesp before Epogen will be authorized.

Fentanyl Citrate Oral Transmucosal

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions: Authorized for patients 16 years of age and older.

Coverage Duration: Authorization is for 6 months.

Other Criteria:

Genotropin

Covered uses: All FDA-approved indications not otherwise excluded from part D. Growth Hormone Use in Children: (1) growth hormone deficiency in children (2) small for gestational age (SGA) (3) growth delay in children with chronic renal failure (4) Turner Syndrome (5) Prader-Willi Syndrome (6) Noonan Syndrome (7) SHOX Gene Deletion. Growth Hormone Use in Adults: (1) for growth hormone deficiency in adults (2) for the continuation of therapy from growth hormone deficiency in childhood.

Required Medical Information: For GHD in children: 1) growth failure demonstrated by growth velocity or height more than two standard deviations below average AND 2) diagnosis confirmed by at least two GH stimulation tests. Note: For children with documented panhypopituitarism, it may be assumed that growth hormone is absent and no stimulation testing is required. For SGA: 1) birth weight and/or length at least 2 standard deviations below the mean for gestational age AND 2) child fails to manifest catch-up growth by 2 y/o. For growth delay in children with chronic kidney disease: 1) renal function at stage 2 chronic kidney disease (or GFR from 60–89 ml/min/1.73m²) AND 2) patient's height is more than 2 SD below average. For Turner Syndrome, Prader-Willi Syndrome, SHOX gene deletion or Noonan Syndrome: 1) diagnosis confirmed by genetic testing AND 2) patient's height is more than 2 SD below average. Diagnosis of Noonan Syndrome may alternatively be determined by genetic consultation. For all covered uses in children, a yearly reassessment for reauthorization of coverage is required. Coverage for continuation of therapy requires meeting current initial use criteria and evaluation of response as shown by growth curve chart. Coverage for growth promotion ends when bony epiphyses have closed. For GHD in adults: 1) the etiology of GHD is a result of destructive hypothalamic or pituitary disease, radiation therapy, surgery or trauma OR is a result of documented GHD in childhood AND 2) diagnosis confirmed by at least one GH stimulation test. Note: No stimulation testing is required for a diagnosis of panhypopituitarism. A yearly reassessment for reauthorization of coverage is required. Coverage for continuation of therapy requires meeting current initial use criteria.

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria: For GHD in children or adults, Turner Syndrome, SGA, SHOX gene deletion or growth delay in children with chronic kidney disease, the patient must have failure, contraindication or intolerance to Humatrope or Saizen before coverage of Genotropin.

Gilenya

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria: Gilenya will be used as monotherapy for the treatment of multiple sclerosis.

Hizentra

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information: Hizentra is authorized for primary immunodeficiency when one of the following criteria are met: 1) Agammaglobulinemia 2) Hypogammaglobulinemia with impaired specific antibody production as manifested by ALL of the following: a) Hypogammaglobulinemia as evidenced by IgG less than 400mg/dl on at least 2 occasions or for CVID, IgG levels reduced to 2 standard deviations below the mean for age b) Impaired Antibody Response and c) history of recurrent bacterial sinopulmonary infections 3) Normogammaglobulinemia with impaired specific antibody production as manifested by ALL of the following: a) Immunglobulin Evaluation – one of the following i) for IgG sub-class deficiency, at least one IgG subclass deficiency as defined as 2 standard deviations below the age-adjusted mean ii) for selective IgA deficiency, Serum IgA less than 0.07 g/L with normal IgG, IgM in an individual older than 4 years iii) for Specific Antibody Deficiency (SAD) b) Impaired Antibody Response c) history of recurrent bacterial sinopulmonary infections 4) ANY of the following: a) transient hypogammaglobulinemia of infancy b) diagnosis of a combined immunodeficiency disorder with supporting documentation of a recognized genetic defect c) Hyperimmunoglobulemia E syndrome (HIES).

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Humatrope

Covered uses: All FDA-approved indications not otherwise excluded from part D. Growth Hormone Use in Children: (1) growth hormone deficiency in children (2) small for gestational age (SGA) (3) growth delay in children with chronic renal failure (4) Turner Syndrome (5) Prader-Willi Syndrome (6) Noonan Syndrome (7) SHOX Gene Deletion. Growth Hormone Use in Adults: (1) for growth hormone deficiency in adults (2) for the continuation of therapy from growth hormone deficiency in childhood.

Required Medical Information: For GHD in children: 1) growth failure demonstrated by growth velocity or height more than two standard deviations below average AND 2) diagnosis confirmed by at least two GH stimulation tests. Note: For children with documented panhypopituitarism, it may be assumed that growth hormone is absent and no stimulation testing is required. For SGA: 1) birth weight and/or length at least 2 standard deviations below the mean for gestational age AND 2) child fails to manifest catch-up growth by 2 y/o. For growth delay in children with chronic kidney disease: 1) renal function at stage 2 chronic kidney disease (or GFR from 60–89 ml/min/1.73m²) AND 2) patient's height is more than 2 SD below average. For Turner Syndrome, Prader-Willi Syndrome, SHOX gene deletion or Noonan Syndrome: 1) diagnosis confirmed by genetic testing AND 2) patient's height is more than 2 SD below average. Diagnosis of Noonan Syndrome may alternatively be determined by genetic consultation. For all covered uses in children, a yearly reassessment for reauthorization of coverage is required. Coverage for continuation of therapy requires meeting current initial use criteria and evaluation of response as shown by growth curve chart. Coverage for growth promotion ends when bony epiphyses have closed. For GHD in adults: 1) the etiology of GHD is a result of destructive hypothalamic or pituitary disease, radiation therapy, surgery or trauma OR is a result of documented GHD in childhood AND 2) diagnosis confirmed by at least one GH stimulation test. Note: No stimulation testing is required for a diagnosis of panhypopituitarism. A yearly reassessment for reauthorization of coverage is required. Coverage for continuation of therapy requires meeting current initial use criteria.

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Humira

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions: JIA - 4 to 17 years old. RA and plaque psoriasis 18 years of age and older.

Coverage Duration: Authorization is for one year.

Other Criteria: Treatment of rheumatoid arthritis (RA) OR polyarticular juvenile idiopathic arthritis (JIA) and when ANY of the following criteria are met: 1) history of positive clinical response to adalimumab therapy OR 2) inadequate response, intolerance, or contraindication to at least one disease-modifying anti-rheumatic drug (DMARD) (i.e., Methotrexate (MTX) Azathioprine, gold, Hydroxychloroquine, Penicillamine, Sulfasalazine). Treatment of ankylosing spondylitis and either of the following criteria are met: history of positive clinical response to adalimumab therapy OR the patient had failure, contraindication, or intolerance to one non-steroidal anti-inflammatory drug (NSAIDs). Treatment of active Crohn's disease AND when ANY of the following criteria are met: history of positive clinical response to adalimumab therapy OR failure, inadequate response, contraindication or intolerance to one of the following conventional therapies (aminosalicylate, corticosteroids, or immunomodulators) OR failure or intolerance to infliximab therapy. Treatment of chronic plaque psoriasis and patient is a candidate for, or has previously received ONE of the following: 1) systemic therapy (e.g., methotrexate, cyclosporin, soriatane) OR 2) phototherapy [narrow or broad band ultraviolet B (UVB), or psoralen plus ultraviolet A (PUVA)].

IGIM

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Increlex

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Infergen

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions: Authorization is limited to patients 18 years old and older.

Coverage Duration: Approval duration ranges between 16 to 48 weeks depending on diagnosis and clinical information.

Other Criteria: Infergen is authorized as monotherapy or in combination with ribavirin for the treatment of Hepatitis C (HCV) in adults age 18 years or older who have compensated liver disease with intolerance to peginterferon alfa therapy (i.e., injection-site reaction) OR are classified as a nonresponder/relapser after treatment with a peginterferon alfa therapy AND ANY of the following conditions: 1) Genotype 1 - approval of 16 weeks as initial authorization. Subsequent authorizations are contingent on clinical response of at least a 2 log (100 fold decrease in quantitative HCV RNA by week 16 as follows: a) If HCV RNA is undetectable (less than 50 IU/ml), an additional 32 weeks (total 48 weeks) will be authorized. OR b) If HCV RNA is detectable (greater than 50 IU/ml), an additional 8 weeks will be authorized and HCV RNA re-evaluated at 24 weeks. An additional 56 weeks (total 72 weeks) will be authorized if there is no detectable virus at 24 weeks (less than 50 IU/ml). 2) Genotype 2 and 3 treatment authorized for 24 weeks although genotype 3 with steatosis and initial high viral loads (HCV RNA greater than 600,000 IU/mL) treatment authorized for 48 weeks. 3) Genotype 4, 5, or 6 treatment authorized for 48 weeks. 4) Patients with bridging fibrosis or cirrhosis treatment authorized for 48 weeks regardless of HCV genotype and changes in HCV RNA levels at week 12. 5) Patients who have co-infection with human immunodeficiency virus (HIV) treatment authorized for 48 weeks. Note: When medical necessity criteria have been met, CIGNA HealthCare covers Infergen on a 3 times per week dosing schedule. Daily dosing may be indicated in select populations including liver transplantation candidates and non-responders to pegylated interferon treatment.

IVIG

Covered uses: All FDA-approved indications not otherwise excluded from part D and multiple myeloma, myasthenia gravis, chronic inflammatory demyelinating polyneuropathy (CIDP), relapsing-remitting multiple sclerosis (RRMS), dermatomyositis, polymyositis, autoimmune mucocutaneous blistering diseases such as Pemphigus, Pemphigoid, and Epidermolysis Bullosa Acquisita.

Required Medical Information: IVIG authorized for PID for: 1) Agammaglobulinemia OR 2) Hypogammaglobulinemia with impaired specific antibody production with a) IgG less than 400mg/dl on at least 2 occasions or for CVID, IgG levels 2 SD below the mean for age and b) Impaired Antibody Response OR 3) Normogammaglobulinemia with impaired specific antibody production with a) immunoglobulin evaluation - one of the following i) for IgG sub-class deficiency, at least one IgG subclass deficiency or ii) selective IgA deficiency, serum IgA less than 0.07 g/L with normal IgG, IgM or iii) SAD and b) impaired antibody response OR 4) transient hypogammaglobulinemia of infancy OR 5) combined immunodeficiency disorder with a recognized genetic defect OR 6) HIES. IVIG authorized for CIDP when ALL: 1) symptomatic polyradiculoneuropathy with BOTH: a) progressive or relapsing motor or sensory impairment of more than one limb and b) widespread hyporeflexia or areflexia 2) any 3 of 4 of the following a) partial conduction block of 1 or more motor nerve, b) reduced conduction velocity of 2 or more motor nerves, c) prolonged distal latency of 2 or more motor nerves, d) prolonged F-wave latencies of 2 or more motor nerves or absence of F waves 3) lumbar puncture with a) white blood cell count less than 10/mm³ and b) negative VDRL. For reauth, significant improvement in clinical

condition documented by Rankin, Modified Rankin, or MRC scales and, if applicable, a reduction in the level of sensory loss. IVIG authorized for 1) dermatomyositis or polymyositis on biopsy and failure of standard medical therapy as reflected by persistently elevated serum CK levels and/or lack of improvement on muscle strength improvement scales OR 2) multiple myeloma with a) disease is stable (more than 3 months since diagnosis) and b) serum IgG less than 600 mg/dL.

Age Restrictions:

Coverage Duration: Myasthenia gravis 5 days. Other uses: initial auth up to 3 months and re-auth up to 6 months.

Other Criteria: IVIG is authorized for any of the following: 1) chronic treatment of RRMS when there is failure, contraindication, or intolerance to standard conventional therapies (e.g. interferon beta, glatiramer) or 2) treatment of Myasthenia gravis during an acute crisis (e.g., significant dysphagia, respiratory failure, inability to perform physical activity) or 3) prevention of infection during the first 100 days following transplantation in BMT recipients age 20 years or older or 4) acute treatment of Kawasaki disease when given in conjunction with aspirin within ten days of onset of symptoms or 5) treatment of autoimmune mucocutaneous blistering diseases when either of the following: a) failure, contraindication or intolerance of at least one of the following conventional therapies (corticosteroids, azathioprine, cyclophosphamide, CellCept) or b) rapidly progressive disease in which a clinical response can not be affected quickly enough using conventional agents. In these situations, IVIG therapy should be given along with conventional treatment(s) and the IVIG used only until conventional therapy takes effect.

Ketorolac Tromethamine Inj

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for 5 days of therapy.

Other Criteria:

Leuprolide Acetate Inj

Covered uses: All medically accepted indications not otherwise excluded from Part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria: For central precocious puberty the onset of secondary sexual characteristics must be earlier than 8 years of age in females and 9 years of age in males. For the treatment of prostate cancer, the patient must have failure, contraindication or intolerance to Trelstar before Lupron is authorized.

Lotronex

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Neumega

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization duration is 1 to 12 months based on number of chemo cycles.

Other Criteria:

Norditropin

Covered uses: All FDA-approved indications not otherwise excluded from part D. Growth Hormone Use in Children: (1) growth hormone deficiency in children (2) small for gestational age (SGA) (3) growth delay in children with chronic renal failure (4) Turner Syndrome (5) Prader-Willi Syndrome (6) Noonan Syndrome (7) SHOX Gene Deletion. Growth Hormone Use in Adults: (1) for growth hormone deficiency in adults (2) for the continuation of therapy from growth hormone deficiency in childhood.

Required Medical Information: For GHD in children: 1) growth failure demonstrated by growth velocity or height more than two standard deviations below average AND 2) diagnosis confirmed by at least two GH stimulation tests. Note: For children with documented panhypopituitarism, it may be assumed that growth hormone is absent and no stimulation testing is required. For SGA: 1) birth weight and/or length at least 2 standard deviations below the mean for gestational age AND 2) child fails to manifest catch-up growth by 2 y/o. For growth delay in children with chronic kidney disease: 1) renal function at stage 2 chronic kidney disease (or GFR from 60–89 ml/min/1.73m²) AND 2) patient's height is more than 2 SD below average. For Turner Syndrome, Prader-Willi Syndrome, SHOX gene deletion or Noonan Syndrome: 1) diagnosis confirmed by genetic testing AND 2) patient's height is more than 2 SD below average. Diagnosis of Noonan Syndrome may alternatively be determined by genetic consultation. For all covered uses in children, a yearly reassessment for reauthorization of coverage is required. Coverage for continuation of therapy requires meeting current initial use criteria and evaluation of response as shown by growth curve chart. Coverage for growth promotion ends when bony epiphyses have closed. For GHD in adults: 1) the etiology of GHD is a result of destructive hypothalamic or

pituitary disease, radiation therapy, surgery or trauma OR is a result of documented GHD in childhood AND 2) diagnosis confirmed by at least one GH stimulation test. Note: No stimulation testing is required for a diagnosis of panhypopituitarism. A yearly reassessment for reauthorization of coverage is required. Coverage for continuation of therapy requires meeting current initial use criteria.

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria: For GHD in children or adults, Turner Syndrome, SGA, SHOX gene deletion or growth delay in children with chronic kidney disease, the patient must have failure, contraindication or intolerance to Humatrope or Saizen before coverage of Norditropin.

Nuedexta

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Nutropin

Covered uses: All FDA-approved indications not otherwise excluded from part D. Growth Hormone Use in Children: (1) growth hormone deficiency in children (2) small for gestational age (SGA) (3) growth delay in children with chronic renal failure (4) Turner Syndrome (5) Prader-Willi Syndrome (6) Noonan Syndrome (7) SHOX Gene Deletion. Growth Hormone Use in Adults: (1) for growth hormone deficiency in adults (2) for the continuation of therapy from growth hormone deficiency in childhood.

Required Medical Information: For GHD in children: 1) growth failure demonstrated by growth velocity or height more than two standard deviations below average AND 2) diagnosis confirmed by at least two GH stimulation tests. Note: For children with documented panhypopituitarism, it may be assumed that growth hormone is absent and no stimulation testing is required. For SGA: 1) birth weight and/or length at least 2 standard deviations below the mean for gestational age AND 2) child fails to manifest catch-up growth by 2 y/o. For growth delay in children with chronic kidney disease: 1) renal function at stage 2 chronic kidney disease (or GFR from 60–89 ml/min/1.73m²) AND 2) patient's height is more than 2 SD below average. For Turner Syndrome, Prader-Willi Syndrome, SHOX gene deletion or Noonan Syndrome: 1) diagnosis confirmed by genetic testing AND 2) patient's height is more than 2 SD below average. Diagnosis of Noonan Syndrome may alternatively be determined by genetic consultation. For all covered uses in children, a yearly reassessment for reauthorization of coverage is required. Coverage for continuation of therapy requires meeting current initial use criteria and evaluation of response as shown by growth curve chart. Coverage for growth promotion ends when bony epiphyses have closed. For GHD in adults: 1) the etiology of GHD is a result of destructive hypothalamic or

pituitary disease, radiation therapy, surgery or trauma OR is a result of documented GHD in childhood AND 2) diagnosis confirmed by at least one GH stimulation test. Note: No stimulation testing is required for a diagnosis of panhypopituitarism. A yearly reassessment for reauthorization of coverage is required. Coverage for continuation of therapy requires meeting current initial use criteria.

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria: For GHD in children or adults, Turner Syndrome, SGA or SHOX gene deletion, the patient must have failure, contraindication or intolerance to Humatrope or Saizen before coverage of Nutropin.

Omnitrope

Covered uses: All FDA-approved indications not otherwise excluded from part D. Growth Hormone Use in Children: (1) growth hormone deficiency in children (2) small for gestational age (SGA) (3) growth delay in children with chronic renal failure (4) Turner Syndrome (5) Prader-Willi Syndrome (6) Noonan Syndrome (7) SHOX Gene Deletion. Growth Hormone Use in Adults: (1) for growth hormone deficiency in adults (2) for the continuation of therapy from growth hormone deficiency in childhood.

Required Medical Information: For GHD in children: 1) growth failure demonstrated by growth velocity or height more than two standard deviations below average AND 2) diagnosis confirmed by at least two GH stimulation tests. Note: For children with documented panhypopituitarism, it may be assumed that growth hormone is absent and no stimulation testing is required. For SGA: 1) birth weight and/or length at least 2 standard deviations below the mean for gestational age AND 2) child fails to manifest catch-up growth by 2 y/o. For growth delay in children with chronic kidney disease: 1) renal function at stage 2 chronic kidney disease (or GFR from 60–89 ml/min/1.73m²) AND 2) patient's height is more than 2 SD below average. For Turner Syndrome, Prader-Willi Syndrome, SHOX gene deletion or Noonan Syndrome: 1) diagnosis confirmed by genetic testing AND 2) patient's height is more than 2 SD below average. Diagnosis of Noonan Syndrome may alternatively be determined by genetic consultation. For all covered uses in children, a yearly reassessment for reauthorization of coverage is required. Coverage for continuation of therapy requires meeting current initial use criteria and evaluation of response as shown by growth curve chart. Coverage for growth promotion ends when bony epiphyses have closed. For GHD in adults: 1) the etiology of GHD is a result of destructive hypothalamic or pituitary disease, radiation therapy, surgery or trauma OR is a result of documented GHD in childhood AND 2) diagnosis confirmed by at least one GH stimulation test. Note: No stimulation testing is required for a diagnosis of panhypopituitarism. A yearly reassessment for reauthorization of coverage is required. Coverage for continuation of therapy requires meeting current initial use criteria.

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria: For GHD in children or adults, Turner Syndrome, SGA, SHOX gene deletion or growth delay in children with chronic kidney disease, the patient must have failure, contraindication or intolerance to Humatrope or Saizen before coverage of Omnitrope.

Onsolis

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria: Patient must have failure, contraindication or intolerance to fentanyl citrate lozenge before Onsolis is authorized.

Orencia

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions: Authorization is limited to patients 6 years old and older.

Coverage Duration: Authorization is for one year.

Other Criteria: Treatment of rheumatoid arthritis (RA) OR polyarticular juvenile idiopathic arthritis (JIA) and when ANY of the following criteria are met: 1) history of positive clinical response to abatacept therapy OR 2) inadequate response, intolerance, or contraindication to at least one disease-modifying anti-rheumatic drug (DMARD) (i.e., Methotrexate (MTX) Azathioprine, gold, Hydroxychloroquine, Penicillamine, Sulfasalazine) AND when the following condition is met: the patient has had failure, contraindication, or intolerance to Enbrel or Humira.

Peg- Intron

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information: Peg-Intron is authorized as monotherapy or in combination with ribavirin for the treatment of Hepatitis C (HCV) in patients who have compensated liver disease AND ANY of the following conditions: 1) Genotype 1 - approval of 16 weeks as initial authorization. Subsequent authorizations are contingent on clinical response of at least a 2 log (100 fold decrease in quantitative HCV RNA by week 16 as follows: a) If HCV RNA is undetectable (less than 50 IU/ml), an additional 32 weeks (total 48 weeks) will be authorized. OR b) If HCV RNA is detectable (greater than 50 IU/ml), an additional 8 weeks will be authorized and HCV RNA re-evaluated at 24 weeks. An additional 56 weeks (total 72 weeks) will be authorized if there is no detectable virus at 24 weeks (less than 50 IU/ml). 2) Genotype 2 and 3 treatment authorized for 24 weeks although genotype 3 with steatosis and initial high viral loads (HCV RNA greater than 600,000 IU/mL) treatment authorized for 48 weeks. 3) Genotype 4, 5, or 6 treatment authorized for 48 weeks. 4) Patients with bridging fibrosis or cirrhosis treatment authorized for 48 weeks regardless of HCV genotype and changes in HCV RNA levels at week 12. 5) Patients who have co-infection with human immunodeficiency virus (HIV) treatment authorized for 48 weeks. 6) Patients who are classified as a nonresponder or relapser after treatment with a non-pegylated interferon. Duration of therapy should be based on the patient's genotype.

Age Restrictions: Authorization is limited to patients 3 years old and older.

Coverage Duration: Approval duration ranges between 16 to 48 weeks depending on diagnosis and clinical information.

Other Criteria:

Penlac

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information: If the patient is not diabetic or immunocompromised, then ALL of the following criteria need to be met: treatment of onychomycosis AND diagnosis has been confirmed by either a positive potassium hydroxide (KOH) stain, para-aminosalicylic acid (PAS) stain, positive dermatophyte testing medium (DTM) or positive fungal culture AND the patient has failure, contraindication or intolerance to oral terbinafine tablets.

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria: Treatment of onychomycosis if the patient is diabetic or immunocompromised due to disease or medical condition (i.e., cancer HIV/AIDS, organ or bone marrow transplant recipient) AND the patient has failure, contraindication or intolerance to oral terbinafine tablets.

Procrit

Covered uses: All FDA-approved indications not otherwise excluded from part D and anemia of chronic disease including myelodysplastic syndrome, ribavirin use in individuals infected with hepatitis C, rheumatoid arthritis, rheumatic disease and prematurity.

Required Medical Information: Procrit is authorized for the treatment of anemia [Hemoglobin (Hgb) less than 10 g/dl (Hgb less than 12 g/dl for chronic kidney disease patients or females with HIV and 13 g/dl for surgery patients or males with HIV)] in the presence of adequate iron stores (i.e., normal transferrin or serum ferritin level) associated with ANY of the following conditions: 1) chronic kidney disease, including patients who are predialysis or on dialysis, 2) cancer chemotherapy regimens planned for at least two months in duration, 3) human immunodeficiency virus (HIV) infection in patients receiving zidovudine therapy, 4) surgical patients or 5) chronic disease including myelodysplastic syndrome, ribavirin use in individuals infected with hepatitis C, rheumatoid arthritis, rheumatic disease and prematurity. Continued authorization is considered medically necessary when the following criteria are met: Hgb does not exceed 12 g/dl (13g/dl for chronic kidney disease, males with HIV and surgery patients).

Age Restrictions:

Coverage Duration: Anemia associated with chronic kidney disease - 6 months. Anemia for other covered uses - 8 weeks.

Other Criteria:

Protopic

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria: The patient must have failure, contraindication or intolerance to Elidel before Protopic is authorized.

Provigil

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information: Treatment of obstructive sleep apnea/hypopnea syndrome (OSAHS) AND patient has been evaluated through a sleep study AND patient has tried and failed 2 or more months of continuous positive airway pressure (CPAP) monotherapy AND will continue to use CPAP treatment in conjunction with Provigil.

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria: For the treatment of narcolepsy, the patient must have failure, contraindication, or intolerance to methylphenidate or dextroamphetamine sulfate before Provigil is authorized.

Qualaquin

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for 7 days.

Other Criteria:

Rebif

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Regranex

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for 20 weeks.

Other Criteria:

Remicade

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions: RA and plaque psoriasis 18 years of age and older.

Coverage Duration: Authorization is for one year.

Other Criteria: Treatment of rheumatoid arthritis (RA) and when ANY of the following criteria are met: 1) history of positive clinical response to infliximab therapy OR 2) inadequate response, intolerance, or contraindication to at least one disease-modifying anti-rheumatic drug (DMARD) (i.e., Methotrexate (MTX) Azathioprine, gold, Hydroxychloroquine, Penicillamine, Sulfasalazine). For treatment of chronic plaque psoriasis the patient is a candidate for, or has previously received ONE of the following: 1) systemic therapy (e.g., methotrexate, cyclosporin, soriatane) OR 2) phototherapy [narrow or broad band ultraviolet B (UVB), or psoralen plus ultraviolet A (PUVA)]. Treatment of active Crohn's disease AND when ANY of the following criteria are met: history of positive clinical response to infliximab therapy OR failure, inadequate response, contraindication or intolerance to one conventional therapy (aminosalicylate, corticosteroids, or immunomodulators) AND failure or intolerance to adalimumab therapy. Treatment of ulcerative colitis (UC) AND when either of the following criteria are met: history of positive clinical response to infliximab therapy OR failure, inadequate response, contraindication or intolerance to one conventional therapy: corticosteroids (e.g, prednisone, methylprednisolone), 5-aminosalicylic acid agents (e.g., sulfasalazine, mesalamine, balsalazide), immunosuppressants (e.g., azathioprine, cyclosporine, 6-mercaptopurine). For new starts for any covered indication where criteria is met, the patient must also have failure, contraindication or intolerance to Enbrel or Humira before coverage of Remicade.

Revatio

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria: Patient must have failure, contraindication or intolerance to Adcirca before authorization of Revatio.

Rituxan

Covered uses: All FDA-approved indications not otherwise excluded from part D and treatment of relapsed/refractory chronic lymphocytic leukemia, treatment of relapsed/refractory Waldenstrom's macroglobulinemia, and treatment of immune or idiopathic thrombocytopenic purpura

Required Medical Information:

Age Restrictions: For RA, authorization is limited to patients 18 years old and older.

Coverage Duration: Authorization is for one year.

Other Criteria: Treatment of rheumatoid arthritis (RA) and when ANY of the following criteria are met: 1) history of positive clinical response to rituximab therapy OR 2) inadequate response, intolerance, or contraindication to at least one disease-modifying anti-rheumatic drug (DMARD) (i.e., Methotrexate (MTX) Azathioprine, gold, Hydroxychloroquine, Penicillamine, Sulfasalazine) AND when the following condition is met: the patient has had failure, contraindication, or intolerance to Enbrel or Humira.

Saizen

Covered uses: All FDA-approved indications not otherwise excluded from part D. Growth Hormone Use in Children: (1) growth hormone deficiency in children (2) small for gestational age (SGA) (3) growth delay in children with chronic renal failure (4) Turner Syndrome (5) Prader-Willi Syndrome (6) Noonan Syndrome (7) SHOX Gene Deletion. Growth Hormone Use in Adults: (1) for growth hormone deficiency in adults (2) for the continuation of therapy from growth hormone deficiency in childhood.

Required Medical Information: For GHD in children: 1) growth failure demonstrated by growth velocity or height more than two standard deviations below average AND 2) diagnosis confirmed by at least two GH stimulation tests. Note: For children with documented panhypopituitarism, it may be assumed that growth hormone is absent and no stimulation testing is required. For SGA: 1) birth weight and/or length at least 2 standard deviations below the mean for gestational age AND 2) child fails to manifest catch-up growth by 2 y/o. For growth delay in children with chronic kidney disease: 1) renal function at stage 2 chronic kidney disease (or GFR from 60–89 ml/min/1.73m²) AND 2) patient's height is more than 2 SD below average. For Turner Syndrome, Prader-Willi Syndrome, SHOX gene deletion or Noonan Syndrome: 1) diagnosis confirmed by genetic testing AND 2) patient's height is more than 2 SD below average. Diagnosis of Noonan Syndrome may alternatively be determined by genetic consultation. For all covered uses in children, a yearly reassessment for reauthorization of coverage is required. Coverage for continuation of therapy requires meeting current initial use criteria and evaluation of response as shown by growth curve chart. Coverage for growth promotion ends when bony epiphyses have closed. For GHD in adults: 1) the etiology of GHD is a result of destructive hypothalamic or pituitary disease, radiation therapy, surgery or trauma OR is a result of documented GHD in childhood AND 2) diagnosis confirmed by at least one GH stimulation test. Note: No stimulation testing is required for a diagnosis of panhypopituitarism. A yearly reassessment for reauthorization of coverage is required. Coverage for continuation of therapy requires meeting current initial use criteria.

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Sancuso

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria: Patient must have failure, contraindication or intolerance to one oral formulary alternative such as ondansetron, granisetron or Granisol before authorization of Sancuso.

Serostim

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Initial authorization to be limited to 12 weeks.

Other Criteria: Treatment of AIDS Wasting when ALL of the following criteria are met: 1) there has been weight loss greater than 10% of pre-illness baseline body weight or body mass index (BMI) less than 20kg/m², 2) there has been documented failure, intolerance, or contraindication to one appetite stimulant and/or one anabolic agent and 3) there is continuous use antiviral therapy.

Stadol Inj

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for 6 months.

Other Criteria:

Synagis

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for 5 months with the first dose in November and last dose in March.

Other Criteria: When used for prophylaxis against lower respiratory tract infection with respiratory syncytial virus (RSV) with five monthly doses (administration of the first dose in November and the last dose in March) of palivizumab (Synagis®) administration to infants and children less than or equal to 24 months old in any of the following indications: 1) Chronic Lung Disease - For infants or children less than or equal to 24 months old, with Chronic Lung Disease (i.e. bronchopulmonary dysplasia) who have required medical care (supplemental oxygen, bronchodilator, diuretic, or corticosteroid therapy) for CLD within 6 months before the anticipated start of RSV season. 2) Prematurity - Infants less than or equal to 28 weeks gestational age at birth may benefit from prophylaxis up to 12 months of age at the start of RSV season. Infants born at 29-32 weeks of gestation may benefit from prophylaxis if they are less than six months of age at the start of the RSV season. Infants born between 32-35 weeks of gestation may benefit from prophylaxis if they are less than six months of age at the start of RSV season, provided they have AT LEAST TWO of the following Risk Factors: School age siblings living in the home, Child-care attendance, Exposure to environmental pollutants (NOT smoking in the home), Severe neuromuscular disease, Congenital abnormalities of the airways. 3) Congenital Heart Disease - Infants and children who are less than or equal to 24 months of age or younger with hemodynamically significant cyanotic and acyanotic congenital heart disease as further defined by any of the following: Receiving medication to control congestive heart failure, Moderate to severe pulmonary hypertension, Cyanotic congenital heart disease 4) Severe immunodeficiency - Infant or child with severe immunodeficiencies (e.g., severe combined immunodeficiency or severe acquired immunodeficiency syndrome) who are less than 24 months of age at the start of the RSV season. Note: For coverage of greater than 5 doses a season, CIGNA HealthCare requires that providers supply recommendations from the CDC, or local health department to support medical necessity for administration prior to November or after March.

Synarel

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions: For endometriosis authorization of Synarel is limited to women 18 years of age and older.

Coverage Duration: Central precocious puberty - authorization 1 year. Endometriosis - authorization 6 months.

Other Criteria: For central precocious puberty the onset of secondary sexual characteristics must be earlier than 8 years of age in females and 9 years of age in males.

Testosterone Inj

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Tev-tropin

Covered uses: All FDA-approved indications not otherwise excluded from part D. Growth Hormone Use in Children: (1) growth hormone deficiency in children (2) small for gestational age (SGA) (3) growth delay in children with chronic renal failure (4) Turner Syndrome (5) Prader-Willi Syndrome (6) Noonan Syndrome (7) SHOX Gene Deletion. Growth Hormone Use in Adults: (1) for growth hormone deficiency in adults (2) for the continuation of therapy from growth hormone deficiency in childhood.

Required Medical Information: For GHD in children: 1) growth failure demonstrated by growth velocity or height more than two standard deviations below average AND 2) diagnosis confirmed by at least two GH stimulation tests. Note: For children with documented panhypopituitarism, it may be assumed that growth hormone is absent and no stimulation testing is required. For SGA: 1) birth weight and/or length at least 2 standard deviations below the mean for gestational age AND 2) child fails to manifest catch-up growth by 2 y/o. For growth delay in children with chronic kidney disease: 1) renal function at stage 2 chronic kidney disease (or GFR from 60–89 ml/min/1.73m²) AND 2) patient's height is more than 2 SD below average. For Turner Syndrome, Prader-Willi Syndrome, SHOX gene deletion or Noonan Syndrome: 1) diagnosis confirmed by genetic testing AND 2) patient's height is more than 2 SD below average. Diagnosis of Noonan Syndrome may alternatively be determined by genetic consultation. For all covered uses in children, a yearly reassessment for reauthorization of coverage is required. Coverage for continuation of therapy requires meeting current initial use criteria and evaluation of response as shown by growth curve chart. Coverage for growth promotion ends when bony epiphyses have closed. For GHD in adults: 1) the etiology of GHD is a result of destructive hypothalamic or pituitary disease, radiation therapy, surgery or trauma OR is a result of documented GHD in childhood AND 2) diagnosis confirmed by at least one GH stimulation test. Note: No stimulation testing is required for a diagnosis of panhypopituitarism. A yearly reassessment for reauthorization of coverage is required. Coverage for continuation of therapy requires meeting current initial use criteria.

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria: Patient must have failure, contraindication or intolerance to Humatrope or Saizen before coverage of Tev-Tropin.

Trelstar

Covered uses: All medically accepted indications not otherwise excluded from Part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Tretinoin - Topical

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Tysabri

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Ventavis

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Victrelis

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Exclusion Criteria: 1) HCV genotype other than one. 2) Victrelis not being used in combination with pegylated interferon and ribavirin. 3) Previous failure with Victrelis or another HCV NS3/4A protease inhibitor. 4) HCV coinfection with HIV or HBV. 5) Patient has a history of a liver or another solid organ transplant. 6) Patient has decompensated liver disease such as ascites, hepatic encephalopathy or bleeding esophagogastric varices.

Required Medical Information: HCV RNA levels at 4 weeks, 8 weeks, 12 weeks and 24 weeks of triple therapy for hepatitis C.

Age Restrictions:

Coverage Duration: Initial authorization 12 weeks. Reauthorization up to 32 more weeks depending on clinical response.

Other Criteria:

Vivaglobin

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information: Vivaglobin is authorized for primary immunodeficiency when one of the following criteria are met: 1) Agammaglobulinemia 2) Hypogammaglobulinemia with impaired specific antibody production as manifested by ALL of the following: a) Hypogammaglobulinemia as evidenced by IgG less than 400mg/dl on at least 2 occasions or for CVID, IgG levels reduced to 2 standard deviations below the mean for age and b) Impaired Antibody Response 3) Normogammaglobulinemia with impaired specific antibody production as manifested by ALL of the following: a) Immunglobulin Evaluation – one of the following i) for IgG sub-class deficiency, at least one IgG subclass deficiency as defined as 2 standard deviations below the age-adjusted mean ii) for selective IgA deficiency, Serum IgA less than 0.07 g/L with normal IgG, IgM in an individual older than 4 years iii) for Specific Antibody Deficiency (SAD) and b) Impaired Antibody Response 4) ANY of the following: a) transient hypogammaglobulinemia of infancy b) diagnosis of a combined immunodeficiency disorder with supporting documentation of a recognized genetic defect c) Hyperimmunoglobulemia E syndrome (HIES).

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Vivitrol

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria: For the treatment of alcohol dependence, the patient must have failure, contraindication, or intolerance to oral naltrexone hcl before Vivitrol is authorized.

Xeomin

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Xgeva

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Xifaxan 200MG

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for 3 days.

Other Criteria: For the traveler's diarrhea, the patient must have failure, contraindication or intolerance to one formulary alternative: ciprofloxacin or trimethoprim/sulfamethoxazole.

Xifaxan 550MG

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Xolair

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions: Authorization for Xolair is limited to patients 12 years of age and older.

Coverage Duration: Authorization is for one year.

Other Criteria: In order for initial therapy with Xolair to be authorized, the patient must require regular use of an inhaled corticosteroid and another controller therapy such as a long acting beta agonist or leukotriene receptor antagonist.

Zometa

Covered uses: All medically accepted indications not otherwise excluded from Part D

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for one year.

Other Criteria:

Zorbtive

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization to consist of one four-week course of therapy.

Other Criteria:

Zyvox

Covered uses: All FDA-approved indications not otherwise excluded from part D.

Required Medical Information:

Age Restrictions:

Coverage Duration: Authorization is for 28 days.

Other Criteria:

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