

Mercy Care Advantage 2009 PA Guidelines

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ACTIQ

Affected Drugs

ACTIQ®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

1. Acute and/or postoperative pain 2. Pre-anesthesia preoperative
anxiolysis and sedation and/or supplement to anesthesia.

Required Medical Information

Pain management treatment plan

Age Restrictions

16 years and older

Prescriber Restrictions

N/A

Coverage Duration

3 months

Other Criteria

N/A

ALDURAZYME

Affected Drugs

ALDURAZYME®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Plan year

Other Criteria

N/A

AMEVIVE

Affected Drugs

AMEVIVE®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

1. Psoriatic arthritis in patients without plaque psoriasis 2. Rheumatoid arthritis

Required Medical Information

N/A

Age Restrictions

16 years and older

Prescriber Restrictions

N/A

Coverage Duration

3 months per authorization

Other Criteria

Patient has chronic greater than or equal to 1 year plaque psoriasis and is prescribed by a dermatologist and patient has minimum body surface area involvement with plaque psoriasis of greater than or equal to 15%, patients with plaque psoriasis of the palms, soles, head and neck, or genitalia are not required to have a minimum body surface area involvement and patient has tried a systemic therapy

ANDROGEN DRUGS

Affected Drugs

ANADROL-50®

OXANDRIN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Per course of treatment

Other Criteria

N/A

ARANESP

Affected Drugs

ARANESP®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 months

Other Criteria

N/A

ARCALYST

Affected Drugs

ARCALYST®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Rheumatologist or Immunologist

Coverage Duration

Plan year

Other Criteria

N/A

AVASTIN

Affected Drugs

AVASTIN®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

Plan year

Other Criteria

N/A

AVONEX

Affected Drugs

AVONEX ADMINISTRATION PACK®
AVONEX®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Neurologist

Coverage Duration

Plan year

Other Criteria

N/A

B VS D - PART B VERSUS PART D COVERAGE PA

Affected Drugs

CELLCEPT®
CYCLOPHOSPHAMIDE
CYCLOSPORINE
EMEND®
GENGRAF
METHOTREXATE
MYFORTIC®
PROGRAF®
RAPAMUNE®

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.

BETASERON

Affected Drugs

BETASERON®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Neurologist

Coverage Duration

Plan year

Other Criteria

N/A

BOTOX

Affected Drugs

BOTOX®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Per course of treatment

Other Criteria

N/A

BYETTA

Affected Drugs

BYETTA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Plan year

Other Criteria

Formulary products have failed or are contraindicated

CEREZYME

Affected Drugs

CEREDASE®
CEREZYME®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Plan year

Other Criteria

N/A

COPAXONE

Affected Drugs

COPAXONE®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Neurologist

Coverage Duration

Plan year

Other Criteria

N/A

ENBREL

Affected Drugs

ENBREL®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Rheumatologist or Dermatologist

Coverage Duration

Plan year

Other Criteria

N/A

ERBITUX

Affected Drugs

ERBITUX®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

Plan year

Other Criteria

N/A

ERYTHROID STIMULANTS

Affected Drugs

PROCRIT®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 months

Other Criteria

Diagnosis of anemia associated with CRF, and who are on dialysis or are pre-dialysis, Anemia in cancer patients due chemotherapy or Patients with HIV who are receiving zidovudine therapy if Hb less than 11.0 g/dL. Anemic patients (Hb less than 13 g/dL) at high risk for perioperative transfusion.

FABRAZYME

Affected Drugs

FABRAZYME®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

12 years and older

Prescriber Restrictions

N/A

Coverage Duration

Plan year

Other Criteria

N/A

FORTEO

Affected Drugs

FORTEO®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

1. Prevention of osteoporosis women and men 2. Paget's disease 3. Prior skeletal radiation therapy 4. Patients with bone metastases, a history of skeletal malignancies, or metabolic bone diseases other than osteoporosis 5. Patients with hypercalcemia

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Plan year

Other Criteria

N/A

GROWTH HORMONES AND RELATED DRUGS

Affected Drugs

NORDITROPIN NORDIFLEX®
NORDITROPIN®
NUTROPIN AQ®
NUTROPIN®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Plan year

Other Criteria

N/A

HERCEPTIN

Affected Drugs

HERCEPTIN®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

Per course of treatment

Other Criteria

N/A

HUMIRA

Affected Drugs

HUMIRA®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Rheumatologist or Dermatologist or Gastroenterologist

Coverage Duration

Per course of treatment

Other Criteria

N/A

INCRELEX

Affected Drugs

INCRELEX®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Pediatric Endocrinologist

Coverage Duration

Plan year

Other Criteria

N/A

IRESSA

Affected Drugs

IRESSA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Oncologist

Coverage Duration

Plan year

Other Criteria

N/A

JANUVIA

Affected Drugs

JANUMET®

JANUVIA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

1. Hypersensitivity to sitagliptin
2. Type 1 diabetes patients
3. Diabetic ketoacidosis
4. Naïve type 2 diabetes patients
5. Pediatric use

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Plan year

Other Criteria

N/A

KETEK

Affected Drugs

KETEK®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Per course of treatment

Other Criteria

No formulary products for the treatment diagnosis are indicated. Formulary products have failed or are contraindicated

KINERET

Affected Drugs

KINERET®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Rheumatologist

Coverage Duration

Per course of treatment

Other Criteria

N/A

LEUPROLIDE

Affected Drugs

ELIGARD®
LEUPROLIDE ACETATE
LUPRON DEPOT®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 months

Other Criteria

N/A

LIDOCAINE 5% TOPICAL PATCH

Affected Drugs

LIDODERM®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

Rheumatoid arthritis RA and fibromyalgia

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 months

Other Criteria

N/A

MEPRON

Affected Drugs

MEPRON®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Per course of treatment

Other Criteria

N/A

NEULASTA

Affected Drugs

NEULASTA®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 months

Other Criteria

N/A

NEUPOGEN

Affected Drugs

NEUPOGEN®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 months

Other Criteria

N/A

ORENCIA

Affected Drugs

ORENCIA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Rheumatologist

Coverage Duration

Per course of treatment

Other Criteria

N/A

OTHER ANTICONVULSANTS

Affected Drugs

TOPAMAX®
ZONISAMIDE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Plan year

Other Criteria

N/A

OTHER ATYPICAL ANTIPSYCHOTICS

Affected Drugs

GEODON®
ZYPREXA ZYDIS®
ZYPREXA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Plan year

Other Criteria

NEW STARTS ONLY - After an adequate trial of a formulary agent has failed or formulary agents are contraindicated or an adverse reaction has occurred

OTHER RESPIRATORY DRUGS

Affected Drugs

ARALAST®
PROLASTIN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

1. Cystic fibrosis 2. Bronchiectasis or chronic obstructive pulmonary disease without alpha1-antitrypsin deficiency 3. Alpha1-antitrypsin deficiency 4. Panniculitis due to alpha1-antitrypsin deficiency

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Plan year

Other Criteria

N/A

OXYCONTIN

Affected Drugs

OXYCONTIN®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

PRN pain

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

6 month increments

Other Criteria

N/A

PEGYLATED INTERFERONS

Affected Drugs

PEGASYS®
PEGINTRON REDIPEN®
PEGINTRON®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

18 years or older

Prescriber Restrictions

N/A

Coverage Duration

3 months

Other Criteria

Initial auth 14 weeks, review HCV RNA for response per nationally recognized expert guidelines it is either discontinued, approved for a total of 24 or 48 weeks.

PROVIGIL

Affected Drugs

PROVIGIL®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

1. Alcoholic organic brain syndrome 2. Performance enhancement 3. Fibromyalgia

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Per course of treatment

Other Criteria

N/A

PULMOZYME

Affected Drugs

PULMOZYME®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Pulmonologist

Coverage Duration

Per course of treatment

Other Criteria

N/A

RAPTIVA

Affected Drugs

RAPTIVA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

1. Psoriatic arthritis without plaque psoriasis 2. Rheumatoid arthritis

Required Medical Information

N/A

Age Restrictions

18 years or older

Prescriber Restrictions

N/A

Coverage Duration

3 months

Other Criteria

N/A

REMICADE

Affected Drugs

REMICADE®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 months

Other Criteria

N/A

RESTASIS

Affected Drugs

RESTASIS®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Ophthalmologist

Coverage Duration

Plan year

Other Criteria

N/A

REVATIO

Affected Drugs

REVATIO®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Cardiologist or Pulmonologist

Coverage Duration

Per course of treatment

Other Criteria

N/A

RISPERDAL

Affected Drugs

RISPERDAL CONSTA®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

Treatment of acute agitation

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

By or in consultation with a psychiatrist

Coverage Duration

Plan year

Other Criteria

NEW STARTS ONLY

RITUXAN

Affected Drugs

RITUXAN®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Oncologist or Rheumatologist

Coverage Duration

Per course of treatment

Other Criteria

N/A

SENSIPAR

Affected Drugs

SENSIPAR®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 months

Other Criteria

All FDA approved indications and other uses with supportive evidence.

SOMAVERT

Affected Drugs

SOMAVERT®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Endocrinologist

Coverage Duration

Per course of treatment

Other Criteria

N/A

STRATTERA

Affected Drugs

STRATTERA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Plan year

Other Criteria

NEW STARTS ONLY - After an adequate trial of a formulary agent(methylphenidate or amphetamine salts products) have failed or formulary agents are contraindicated or an adverse reaction has occurred

SYMLIN

Affected Drugs

SYMLIN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Plan year

Other Criteria

Formulary products have failed or are contraindicated

SYNAGIS

Affected Drugs

SYNAGIS®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

RSV season per Department of Health

Other Criteria

N/A

TOBI

Affected Drugs

TOBI®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Pulmonologist

Coverage Duration

Per course of treatment

Other Criteria

N/A

TRACLEER

Affected Drugs

TRACLEER®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Patients taking concomitant cyclosporine A or glyburide

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Cardiologist or Pulmonologist

Coverage Duration

Per course of treatment

Other Criteria

N/A

TYSABRI

Affected Drugs

TYSABRI®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

1. Patients who have progressive multifocal leukoencephalopathy 2. Immunocompromised patients such as HIV or AIDS, leukemia or lymphoma, or an organ transplant, and others 3. Patients who are taking immunosuppressive agents

Required Medical Information

N/A

Age Restrictions

18 years or older

Prescriber Restrictions

Neurologist or Gastroenterologist

Coverage Duration

Plan year

Other Criteria

1. Failure of a compliant regimen of Avonex for 6 months 2. Failure of a compliant regimen to Copaxone for 6 months 3. Approve only when used as monotherapy

VFEND

Affected Drugs

VFEND®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

1. Onychomycosis candidiasis
2. Treatment or prevention of vaginal or vulvovaginal
3. superficial fungal infections

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Infectious Disease

Coverage Duration

Per course of treatment

Other Criteria

N/A

XOLAIR

Affected Drugs

XOLAIR®

Covered Uses

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

1. Treatment of peanut allergy 2. Treatment of latex allergy

Required Medical Information

N/A

Age Restrictions

12 years and older

Prescriber Restrictions

Allergist or Immunologist or Pulmonologist

Coverage Duration

3 months

Other Criteria

N/A

XYREM

Affected Drugs

XYREM®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

No documented diagnosis of narcolepsy

Required Medical Information

Documentation of narcolepsy

Age Restrictions

16 years and older

Prescriber Restrictions

N/A

Coverage Duration

Plan year

Other Criteria

Trial and failure of a formulary approved drug for narcolepsy

ZYVOX

Affected Drugs

ZYVOX®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. 2. Vancomycin (Vancocin®) resistant Enterococcus species, 3. Methicillin resistant Staphylococcus or to allow continuation of therapy

Exclusion Criteria

Pseudomembranous colitis

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

By or in consultation with infectious disease

Coverage Duration

28 days

Other Criteria

Cultures must be done for VRE MRSA. For safety reasons, if there is insufficient information available to make a determination regarding coverage and the prescribing physician or representative of the physician cannot be contacted, then approve.

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