Prior Authorization
Medical Coverage Drug List

Actemra®
Coverage is provided for the treatment of rheumatoid arthritis (RA), polyarticular juvenile idiopathic arthritis, or systemic juvenile idiopathic arthritis when prescribed by a rheumatologist.

For a diagnosis of RA: Treatment with one disease-modifying antirheumatic drug (DMARD) (must be methotrexate) and a trial and failure of one of the following agents: Simponi Aria® or Remicade®.

For a diagnosis of polyarticular juvenile idiopathic arthritis or systemic juvenile idiopathic arthritis, treatment with one disease-modifying antirheumatic drug (DMARD) and a trial and failure of one of the following agents: Humira® or Remicade®.

Medical record notes must be provided to support all requests for Actemra®.

Acthar® Gel (H.P. Acthar® Gel)
Coverage is provided for the treatment of infantile spasms in children younger than 2 years old.

Medical record notes must be provided to support all requests for Acthar®.

Alpha-1 Proteinase Inhibitors (Aralast™, Glassia™, Prolastin®-C, Zemaira®)
Coverage is provided for the treatment of alpha-1 antitrypsin deficiency (AATD).

Diagnosis of AATD must be confirmed by an alpha-1 antitrypsin level of less than 80mg/dl, which is consistent with AATD. Patient must have symptoms of emphysema and worsening lung function. Patient must be a non-smoker.

Medical record notes must be provided to support all requests for Alpha-1 Proteinase Inhibitors.

Benlysta®
Coverage is provided for the treatment of systemic lupus erythematosus (SLE) in patients who have tested positive for serum antibodies.

Patients must have active disease as indicated by a score of at least 6 on the Safety of Estrogens in Lupus Erythematosus National Assessment modification on the SLE Disease Activity Index (SELENA-SLEDAI).

Patient must not have severe lupus nephritis, active nephritis or central nervous system lupus.

Patient must be currently receiving, and will continue to receive, a stable standard of care regimen including antimalarials, corticosteroids or nonbiologic immunosuppressives.

Medical record notes must be provided to support all requests for Benlysta®.

Berinert®, Firazyr®, Kalbitor®, Ruconest®
Coverage is provided for the treatment of type 1 or type 2 hereditary angioedema (HAE) when prescribed by an immunologist, allergist, or hematologist. The requested medication must be used for the treatment of acute HAE attacks.

Diagnosis of HAE must be confirmed by genetic testing or with all the following laboratory findings:

1. Normal C1q levels
2. C4 levels below the limits of the laboratory’s normal reference range
3. C1-INH levels (antigenic or functional) below the limits of the laboratory’s normal reference range

Medical record notes must be provided to support all requests for Berinert®, Firazyr®, Kalbitor® and Ruconest®.

Botox® (also Dysport® and Xeomin®)
Coverage is provided for the treatment of spasticity or dystonia associated with the following conditions when unresponsive to other treatments and when causing functional impairment:

- Cervical dystonia
- Spasmodic torticollis
- Blepharospasm
- Strabismus
- Cerebral palsy
- Spastic paraplegia
- Facial nerve VII disorders
- Laryngeal spasm
• Upper limb spasticity
• Lower limb spasticity

Coverage is provided for chronic migraines when documentation supports the patient has recurring debilitating headaches 15 or more days per month with the migraine headache lasting for four hours a day or longer. The patient must have been evaluated by a neurologist, with rebound headache being ruled out. Any other conditions or aggravating factors that are contributing to the development of chronic migraine headaches must be treated.

The patient must also have tried at least two preventative medication classes for at least 2 months (such as beta-blockers, tricyclic antidepressants, calcium channel blockers, anticonvulsants, ACE (angiotensin-converting enzyme) inhibitor/angiotensin II receptor blockers, or venlafaxine).

Coverage is provided for primary axillary hyperhidrosis which results in functional impairment or medical complications, when a prior therapy was tried and failed, and when other medical conditions and drugs have been eliminated as a cause of hyperhidrosis.

Coverage is provided for urinary incontinence associated with a neurologic condition or overactive bladder when an anticholinergic medication was tried and failed.

Coverage is provided for excessive saliva (sialorrhea) associated with Parkinson’s disease.

Medical record notes must be provided to support all requests for Botox®, Dysport® and Xeomin®.

**CIMZIA®**

Coverage is provided for the treatment of Crohn’s disease, rheumatoid arthritis, psoriatic arthritis, or ankylosing spondylitis when prescribed by a specialist.

For a diagnosis of Crohn’s disease: One of the following criteria must be met:

• Treatment with an adequate course of systemic corticosteroids must have been ineffective or contraindicated,
• The patient has been unable to reduce the dose of systemic corticosteroids without experiencing worsening of disease, or

• The patient is experiencing breakthrough disease (for example, active disease flares) while stabilized for at least 2 months on immunomodulatory medication (such as azathioprine, mercaptopurine, cyclosporine, or methotrexate), unless contraindicated

For a diagnosis of rheumatoid arthritis: Treatment with methotrexate has been ineffective or contraindicated.

For a diagnosis of psoriatic arthritis: Treatment with one DMARD (disease-modifying antirheumatic drug, such as methotrexate, sulfasalazine, azathioprine, hydroxychloroquine/chloroquine, cyclosporine, gold, or penicillamine) has been ineffective or contraindicated.

Medical record notes must be provided to support all requests for Cimzia®.

**CINQAIR®**

Coverage is provided for add-on maintenance treatment of patients with severe asthma aged 18 years and older, and with an eosinophilic phenotype.

Diagnosis of eosinophilic asthma must be confirmed by appropriate lab tests.

Documentation of a consultation with an allergist, immunologist, or pulmonologist prior to initiation of therapy must be provided.

Patient must have tried and failed chronic administration of systemic corticosteroids or high dose inhaled corticosteroids, in combination with a long acting inhaled beta2 agonist or leukotriene receptor antagonist, for at least 3 months.

Cinqair® cannot be used in combination with other biologics for asthma such as Nucala® and/or Xolair®.

**CINRYZE®**

Coverage is provided for the treatment of type 1 or type 2 hereditary angioedema (HAE) when prescribed by an immunologist, allergist, or hematologist.

Diagnosis of HAE must be confirmed by genetic testing or with all the following laboratory findings:

1. Normal C1q levels
2. C4 levels below the limits of the laboratory’s normal reference range
3. C1-INH levels (antigenic or functional) below the limits of the laboratory’s normal reference range

The requested medication must be used for the treatment of one of the following:

- Short-term prophylaxis for patients scheduled to undergo dental work, invasive medical procedures, or surgical procedures. **OR**

- Long-term prophylaxis: Patient must have a history of at least 2 HAE attacks per month or a history of attacks that are considered severe with swelling of the face, throat or gastrointestinal tract.

Patient must have had an inadequate response, a contraindication, or an intolerance to attenuated androgens (such as danazol, stanozolol, or oxandrolone)

Medical record notes must be provided to support all requests for Cinryze®.

**Dysport®**
See Botox®.

**Entyvio™**
Coverage is provided for the diagnosis of moderately to severely active ulcerative colitis (UC) or Crohn’s disease (CD).

For a diagnosis of UC or CD, the medication must be prescribed by, or in consultation with, a gastroenterologist. Conventional therapy (such as corticosteroids or an immunomodulator) must be tried and ineffective or contraindicated/not tolerated based on clinical documentation. The patient must also have had an inadequate response to Humira® and Remicade®.

Medical record notes must be provided to support all requests for Entyvio™.

**Enzyme Replacement Therapy**


Coverage is provided for Cerezyme®, Elelyso™, and VPRIV® for Type 1 Gaucher disease when diagnosis has been confirmed by a geneticist or metabolic specialist and laboratory testing. Symptoms such as enlarged spleen or low hemoglobin must be present.

Coverage is provided for Aldurazyme®, Elaprase®, Naglazyme®, and Vimizim™ when diagnosis of the correct form of mucopolysaccharidosis has been made by a geneticist or metabolic specialist and confirmed with laboratory testing.

Coverage is provided for Fabrazyme® when the diagnosis of Fabry disease has been made by a geneticist or metabolic specialist and confirmed by laboratory testing. All other diseases must be ruled out, patient must show symptoms of active disease, and goals of therapy must be provided.

Coverage is provided for Lumizyme® when the diagnosis of either infantile or late onset Pompe disease has been made by a geneticist or metabolic specialist and confirmed by laboratory testing. All other diseases must be ruled out.

Coverage is provided for Adagen® when the diagnosis of adenosine deaminase deficiency has been made by an immune specialist and confirmed by laboratory testing. Patient must have tried and failed, or not be a candidate for, bone marrow transplantation. Patient must not have extremely low platelet counts.

Coverage is provided for Kanuma™ when the diagnosis of lysosomal acid lipase deficiency has been made by a geneticist or metabolic specialist and confirmed by laboratory testing. Patient must show symptoms such as elevated liver enzymes or coronary artery disease.

Medical record notes must be provided to support all requests for Enzyme Replacement Therapy.

**Exondys 51™**

Coverage of Exondys 51™ is considered investigational/experimental for all indications and will not be provided.

**Ilaris®**

Coverage is provided for the treatment of cryopyrin-associated periodic syndromes (CAPS), tumor necrosis factor receptor associated periodic syndrome (TRAPS), hyperimmunoglobulin D syndrome (HIDS)/mevalonate kinase deficiency (MKD), Familial Mediterranean Fever
Prior Authorization
Medical Coverage Drug List

(FMF), or systemic juvenile idiopathic arthritis (SJIA) when prescribed by a rheumatologist.

Diagnosis of CAPS must be confirmed by either genetic testing or through physical assessment of symptoms. Patient must have significant functional impairment which limits activities of daily living. Patient must be experiencing one or more of the following classic syndromes of CAPS: familial cold auto-inflammatory syndrome (FCAS), Muckle-Wells syndrome (MWS), and/or neonatal-onset multisystem inflammatory disease (NOMID)/chronic infantile neurologic cutaneous articular syndrome (CINCA).

For diagnosis of SJIA: patient must have tried and failed at least one oral drug from a class called DMARD (Disease-Modifying Antirheumatic Drug, for example, methotrexate). Patient must have also tried and failed Enbrel, Remicade, and Actemra.

Medical record notes must be provided to support all requests for Ilaris®.

Immune Globulin Replacement Therapy

Drug names: Bivigam™, Carimune® NF, Cuvitru™, Flebogamma® DIF, Gammagard® Liquid or S/D, Gammaked®, Gammaplex®, Gamunex®, Hizentra®, HyQvia®, Octagam®, Privigen®

Coverage is provided for multiple diseases including common variable immunodeficiency, immune thrombocytopenia purpura, and hypogammaglobulinemia.

Diagnosis of disease must be confirmed by standard testing. Patient must try and fail common therapies such as systemic steroids or immunosuppressants. Patient must have significant functional impairment which limits activities of daily living.

Medical record notes must be provided to support all requests for Immune Globulin Replacement Therapy.

Inflectra™

Coverage is provided following trial and failure of Remicade® in patients with the following diagnoses:

• Active Crohn’s disease diagnosed by a gastroenterologist when treatment with a systemic corticosteroid was ineffective, or the patient was not able to decrease the dose of steroids without experiencing worsening of disease, or the patient is experiencing active flares while stabilized on immunomodulatory medication (such as azathioprine, cyclosporine, or methotrexate).
  • Fistulizing Crohn’s disease diagnosed by a gastroenterologist
  • Pediatric Crohn’s disease diagnosed by a gastroenterologist when the patient has a poor response to conventional therapy
  • Ulcerative colitis diagnosed by a gastroenterologist when treatment with a systemic corticosteroid was ineffective, or the patient was not able to decrease the dose of steroids without experiencing worsening of disease, or the patient is experiencing active flares while stabilized on immunomodulatory medication (such as azathioprine, cyclosporine, or methotrexate)
  • Pediatric ulcerative colitis diagnosed by a gastroenterologist when the patient has a poor response to conventional therapy
  • Rheumatoid arthritis diagnosed by a rheumatologist when clinical documentation shows that oral disease-modifying antirheumatic drugs (DMARD) were not effective after an adequate trial and Inflectra™ is prescribed with methotrexate
  • Psoriatic arthritis diagnosed by a dermatologist or rheumatologist
  • Plaque psoriasis diagnosed by a dermatologist or rheumatologist with documentation that psoriasis is affecting at least 10% of the patient’s body surface area or causing significant functional disability. Treatment with phototherapy or photochemotherapy must have been ineffective. At least one oral systemic agent must have been ineffective. Examples of systemic agents include, but are not limited to, cyclosporine, methotrexate, and acitretin
  • Ankylosing spondylitis diagnosed by a rheumatologist

Medical record notes must be provided to support all requests for Inflectra™.
**Prior Authorization**

**Medical Coverage Drug List**

**KRISTEXXA®**
Coverage is provided for the treatment of chronic gout. Patient must be experiencing two or more of the following: three or more gouty flares in an 18 month period, presence of one or more tophi, and/or chronic gouty arthritis. Patient must not have a known G6PD deficiency.

Treatment with maximum appropriate doses of standard therapy (allopurinol and Uloric [feboxustat]) must have been ineffective, not tolerated or contraindicated. Patient must have a serum uric acid level of at least 8mg/dL.

Medical record notes must be provided to support all requests for Krystexxa®.

**LEMTTRA®D**
Coverage is provided for the treatment of relapsing forms of multiple sclerosis for patients 18 years of age or older, when diagnosis is confirmed by, or made in consultation with, a neurologist.

Patient must have evidence of disease activity demonstrated by either clinical documentation from the previous 12 months or new lesions on MRI from the previous 6 months.

Patient must have tried all of the following, unless all products are contraindicated based on clinical documentation:

- One injectable agent (such as Avonex®, Betaseron®, Copaxone®, Extavia®, or Rebif®),
- One oral agent (such as Gilenya® or Tecfidera®), and
- Failed treatment with Ocrevus™

Before starting treatment with Lemtrada, patients without a history of chickenpox or who have not been vaccinated against varicella zoster virus (VZV) should be tested for the presence of antibodies to VZV. For patients without VZV antibodies, vaccination should be considered prior to the start of treatment with Lemtrada.

Preventative therapy for herpes viral infections must be started on the first day of treatment with Lemtrada™ and continued for a minimum of two months following treatment, or until the patient’s CD4+ lymphocyte count is greater than 200 cells/mcL, whichever occurs later.

Patient must undergo complete blood count (CBC) with differential, serum creatinine levels, and urinalysis prior to treatment initiation. CBC must be obtained monthly during treatment.

Patient must complete thyroid function test prior to treatment initiation and quarterly during treatment.

Medical record notes must be provided to support all requests for Lemtrada™.

**MAKENA™**
Coverage is provided for patients who are pregnant with one baby, who had a previous spontaneous preterm delivery (less than 37 weeks gestation), who will start treatment between 16 weeks 0 days and 20 weeks 6 days, and have no known fetal abnormality and no known risk factors for preterm delivery.

Medical record notes must be provided to support all requests for Makena™.

**MYOBLOC®**
Coverage is provided for cervical dystonia, spasmodic torticollis, sialorrhea with Parkinson’s disease, amyotrophic lateral sclerosis or cerebral palsy.

Medical record notes must be provided to support all requests for Myobloc®.

**NPLATE®**
Coverage is provided for the treatment of chronic immune thrombocytopenia purpura (ITP), when diagnosis is confirmed by, or made in consultation with, a hematologist.

Patient must have a persistent platelet count below 100,000 mCL for more than 3 months. Patient must also have either a current platelet count below 20,000 mCL, or a current platelet count below 30,000 mCL with symptoms of active bleeding.

Patient must have had an inadequate response to, or not be a candidate for, therapy with Promacta®. Patient must have had an inadequate response to therapy with corticosteroids, immunoglobulins, or splenectomy.

Medical record notes must be provided to support all requests for Nplate®.
**Prior Authorization**  
**Medical Coverage Drug List**

**NUCALA®**
Coverage is provided as an add-on maintenance treatment for patients 12 years of age or older with a diagnosis of severe uncontrolled eosinophilic asthma.
Diagnosis of eosinophilic asthma must be confirmed by appropriate lab tests.
Documentation of a consultation with an allergist, immunologist, or pulmonologist prior to initiation of therapy must be provided.
Patient must have tried and failed chronic administration of systemic corticosteroids or high dose inhaled corticosteroids, in combination with a long acting inhaled beta2 agonist or leukotriene receptor antagonist, for at least 3 months.
Nucala® cannot be used in combination with other biologics for asthma such as Cinqair® and/or Xolair®.
Medical record notes must be provided to support all requests for Nucala®.

**ORENCIA®**
Coverage is provided for the treatment of rheumatoid arthritis (RA) or juvenile idiopathic arthritis (JIA) when prescribed by a rheumatologist.
For a diagnosis of RA: Treatment with one disease-modifying antirheumatic drug (DMARD) (must be methotrexate, unless contraindicated) and a trial and failure of one of the following agents: Simponi Aria® or Remicade®.
For a diagnosis of JIA: Treatment with one disease-modifying antirheumatic drug (DMARD) (e.g. methotrexate or leflunomide, unless contraindicated) and a trial and failure of Humira® or Remicade®.
Medical record notes must be provided to support all requests for Orencia®.

**OCREVUS™**
Coverage is provided for patients 18 years of age or older when prescribed by a neurologist for the treatment of:

- Primary progressive multiple sclerosis (PPMS) with documented evidence of disease progression for at least one year AND at least one of the following:
  One brain lesion, positive CSF, or two spinal lesions.
  OR
- A relapsing form of multiple sclerosis with documented evidence of the presence of new and/or newly enlarged MRI lesions in the previous year and clinical relapse or progression despite patient adherence to treatment. Patient must have tried and failed at least one injectable agent (examples: Avonex®, Betaseron®, Copaxone®, Extavia®, or Rebif®) and at least one oral agent (examples: Gilenya® or Tecfidera®).
Medical record notes must be provided to support all requests for Ocrevus™.

**PROBUPHINE®**
Coverage is provided for the treatment of opioid dependence when prescribed by a physician participating in the Probuphine® REMS Program and who meets criteria to prescribe Probuphine®.
Patient must be diagnosed with opioid dependence, and diagnosis must be made using authorized screening tools. Patient must be stabilized on low to moderate doses of sublingual buprenorphine for at least 3 months before switching to Probuphine®. Probuphine® must be used together with a complete treatment program that includes counseling and psychosocial support. Patient must agree to be compliant to entire treatment program and have signed an informed consent.
Medical record notes must be provided to support all requests for Probuphine®.

**PROLIA®**
Coverage is provided for the treatment of osteoporosis when both of the following criteria are met:

- Bone mineral density score at or below -2.5 at the lumbar spine or total hip
Prior Authorization

Medical Coverage Drug List

- Treatment with at least one drug from a group called bisphosphonates (such as alendronate) for 24 months is not effective (if intolerance to oral administration due to gastrointestinal issues, intravenous administration for 24 months will be required)
- Patient must supplement with 1,000 mg calcium daily and at least 400 IU vitamin D daily

OR

Coverage is provided to increase bone mass in men at high risk for fracture due to receiving androgen deprivation therapy for nonmetastatic prostate cancer or for women at high risk for fracture due to receiving adjuvant aromatase inhibitor therapy for nonmetastatic breast cancer, when all of the following criteria are met:
- The 10-year probability of hip fracture is at least 3 percent or the 10-year probability of a major osteoporosis-related fracture is at least 20 percent.
- Treatment with at least one drug from a group called bisphosphonates (such as alendronate) for 24 months is not effective (if intolerance to oral administration due to gastrointestinal issues, intravenous administration for 24 months will be required).
- Patient must supplement with 1,000 mg calcium daily and at least 400 IU vitamin D daily.

Medical record notes must be provided to support all requests for Prolia®.

Radicava™

Coverage is provided for patients who have a diagnosis of amyotrophic lateral sclerosis (ALS) and are being treated in consultation with a neurologist. Patients will be eligible for start of treatment within 2 years of diagnosis OR after 2 years of diagnosis, with a percent predicted forced vital capacity (FVC) value of greater than or equal to 80%. A pretreatment measurement from the ALSFRS-R (Revised ALS Functional Rating Scale) should be submitted. Patients must also be receiving treatment with riluzole.

Medical record notes must be provided to support all requests for Radicava™.

Remicade®

Coverage is provided for the following:
- Active Crohn's disease diagnosed by a gastroenterologist when treatment with a systemic corticosteroid was ineffective, or the patient was not able to decrease the dose of steroids without experiencing worsening of disease, or the patient is experiencing active flares while stabilized on immunomodulatory medication (such as azathioprine, cyclosporine, or methotrexate).
- Fistulizing Crohn’s disease diagnosed by a gastroenterologist
- Pediatric Crohn’s disease diagnosed by a gastroenterologist
- Coverage is provided to increase bone mass in men at high risk for fracture due to receiving androgen deprivation therapy for nonmetastatic prostate cancer or for women at high risk for fracture due to receiving adjuvant aromatase inhibitor therapy for nonmetastatic breast cancer, when all of the following criteria are met:
- The 10-year probability of hip fracture is at least 3 percent or the 10-year probability of a major osteoporosis-related fracture is at least 20 percent.
- Treatment with at least one drug from a group called bisphosphonates (such as alendronate) for 24 months is not effective (if intolerance to oral administration due to gastrointestinal issues, intravenous administration for 24 months will be required).
- Patient must supplement with 1,000 mg calcium daily and at least 400 IU vitamin D daily.

Medical record notes must be provided to support all requests for Prolia®.

Rheumatoid arthritis diagnosed by a rheumatologist when clinical documentation shows that oral disease-modifying antirheumatic drugs (DMARD) were not effective after an adequate trial and Remicade® is prescribed with methotrexate
- Psoriatic arthritis diagnosed by a dermatologist or rheumatologist
- Plaque psoriasis diagnosed by a dermatologist or rheumatologist with documentation psoriasis is affecting at least 10% of a patient's body surface area or causing significant functional disability. Treatment with phototherapy or photochemotherapy must have been ineffective. At least one oral systemic agent must have been ineffective. Examples of systemic agents include, but are not limited to, cyclosporine, methotrexate, and acitretin.
• Ankylosing spondylitis diagnosed by a rheumatologist

Medical record notes must be provided to support all requests for Remicade®.

**RENFLExIS™**

Coverage is provided following trial and failure of Remicade® in patients with the following diagnoses:

• Active Crohn’s disease diagnosed by a gastroenterologist when treatment with a systemic corticosteroid was ineffective, or the patient was not able to decrease the dose of steroids without experiencing worsening of disease, or the patient is experiencing active flares while stabilized on immunomodulatory medication (such as azathioprine, cyclosporine, or methotrexate)

• Fistulizing Crohn’s disease diagnosed by a gastroenterologist

• Pediatric Crohn’s disease diagnosed by a gastroenterologist when the patient has a poor response to conventional therapy

• Ulcerative colitis diagnosed by a gastroenterologist when treatment with a systemic corticosteroid was ineffective, or the patient was not able to decrease the dose of steroids without experiencing worsening of disease, or the patient is experiencing active flares while stabilized on immunomodulatory medication (such as azathioprine, cyclosporine, or methotrexate)

• Pediatric ulcerative colitis diagnosed by a gastroenterologist when the patient has a poor response to conventional therapy

• Rheumatoid arthritis diagnosed by a rheumatologist when clinical documentation shows that oral disease-modifying antirheumatic drugs (DMARD) were not effective after an adequate trial and Renflexis™ is prescribed with methotrexate

• Psoriatic arthritis diagnosed by a dermatologist or rheumatologist

• Plaque psoriasis diagnosed by a dermatologist or rheumatologist with documentation that psoriasis is affecting at least 10% of the patient’s body surface area or causing significant functional disability. Treatment with phototherapy or photochemotherapy must have been ineffective. At least one oral systemic agent must have been ineffective. Examples of systemic agents include, but are not limited to, cyclosporine, methotrexate, and acitretin

• Ankylosing spondylitis diagnosed by a rheumatologist

**SIGNIFOR® LAR**

Coverage is provided for patients diagnosed with acromegaly who have had a poor response to surgery and/or for whom surgery is not an option. Patient must have a higher than normal Insulin-like Growth Factor (IGF-1) level. The prescribing physician must be an endocrinologist.

Patient must have tried and failed at least one of the following: Somatuline Depot®, Sandostatin®, Sandostatin LAR®, or Somavert®.

Medical record notes must be provided to support all requests for Signifor® LAR.

**SIMPONI ARIA®**

Coverage is provided for patients who have a diagnosis of advanced rheumatoid arthritis, when prescribed by, or in conjunction with, a rheumatologist.

Patient must have tried and failed at least one oral drug from a class called DMARD (disease-modifying antirheumatic drug; must be methotrexate).

Medical record notes must be provided to support all requests for Simponi Aria®.

**SOLIRIS®**

Coverage is provided for patients who have a diagnosis of atypical hemolytic uremic syndrome or paroxysmal nocturnal hemoglobinuria.

Patient must be immunized with a meningococcal vaccine at least 2 weeks prior to administering the first dose of Soliris.

Patient must have had one transfusion in the 24 months preceding Soliris, or documented history of major adverse events from obstruction of a blood vessel.
**Prior Authorization**
**Medical Coverage Drug List**

**Spinraza®**
Coverage is provided for patients age 14 years and younger with type 1, 2, or 3 spinal muscular atrophy confirmed by genetic testing and who are being treated by a neurologist specializing in pediatric neuromuscular disorders. Patient must not be fully ventilator dependent and submission of baseline (before treatment), age appropriate exam to establish baseline motor function and ability must be included (examples: Hammersmith Infant Neurological Exam (HINE), Hammersmith Functional Motor Scale Expanded (HFMSE), Upper Limb Module (ULM) Test, Six-Minute Walk Test (6MWT) or Children’s Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)).

Renewal request for Spinraza® requires record of response to therapy which is defined as a significant improvement in a repeat assessment of motor function and ability.

Medical record notes must be provided to support all requests for Spinraza®.

**Stelara®**
Coverage is provided for patients who have a diagnosis of chronic plaque psoriasis involving at least 10 percent of the body surface area or who experience significant functional disability, when prescribed by a dermatologist. Treatment with phototherapy or photochemotherapy must have been ineffective.

At least one oral systemic agent must have been ineffective. Examples of systemic agents include, but are not limited to, cyclosporine, methotrexate, and acitretin.

Coverage is provided for patients who have a diagnosis of psoriatic arthritis when prescribed by a dermatologist or rheumatologist. At least one disease-modifying antirheumatic drug (DMARD) must have been ineffective. Examples of DMARDs include, but are not limited to, cyclosporine, methotrexate, and sulfasalazine.

Coverage is provided for patients who have a diagnosis of Crohn’s disease when prescribed by a gastroenterologist. Treatment with conventional oral therapies (such as corticosteroids or immunomodulators) must not have been effective or were not tolerated.

Treatment with subcutaneous Stelara® will only be approved following documentation of a one-time weight based intravenous dose.

Medical record notes must be provided to support all requests for Stelara®.

**Synagis®**
Coverage is provided for the prevention of respiratory syncytial virus (RSV) infections when one or more of the following criteria are met:

When gestational age is a consideration:
- Patient was born at 28 weeks gestation or less and is less than 12 months of age at the start of RSV season.
- Patient was born at less than 32 weeks gestation and has chronic lung disease (CLD). Patient must have had a requirement of greater than 21% oxygen for at least the first 28 days after birth. Patient must also be less than 1 year of age. **Exceptions may be made for children less than 2 years old who fulfill the definition of CLD of prematurity and continue to require medical support during the 6-month period before the start of the second RSV season.**

When gestational age is not a consideration:
- Patient is younger than 12 months of age with a diagnosis of hemodynamically significant cyanotic or acyanotic coronary heart disease (CHD) (such as congestive heart failure (CHF), moderate to severe pulmonary hypertension, or cyanotic heart disease) which requires treatment.
- Patient is younger than 12 months of age with significant congenital abnormalities of the airway or neuromuscular disease, either of which compromises the handling of respiratory tract secretions.
- Patient younger than 12 months of age with cystic fibrosis with clinical evidence of CLD and/ or nutritional compromise may be considered for prophylaxis.
**Prior Authorization**

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- Patient is younger than 24 months of age and is immunocompromised with severe combined immunodeficiency or advanced AIDS (acquired immune deficiency syndrome).

Coverage will not be provided for an infant or child who is currently receiving monthly Synagis as prophylaxis treatment and experiences a breakthrough RSV hospitalization/infection.

Medical record notes must be provided to support all requests for Synagis®.

**Testosterone Therapies (Aveed®, TestoPel®)**

Coverage is provided for the following:

- Male patients with androgen deficiency syndrome documented by two below-normal morning testosterone levels within the past year. Patient’s signs and symptoms must be suggestive of androgen deficiency (for example, height loss or incomplete or delayed sexual development).

- Patients with breast cancer who are in need of adjunctive palliative treatment.

Medical record notes must be provided to support all requests for Testosterone Therapy.

**Tysabri®**

Coverage is provided for the treatment of relapsing forms of multiple sclerosis (MS) or Crohn’s disease (CD) for patients 18 years of age or older with anti-JCV antibody testing that includes the index value and documentation that the patient has been counseled on progressive multifocal leukoencephalopathy.

For MS, the diagnosis must be confirmed by, or made in consultation with, a neurologist. Patient must have tried at least one injectable agent (such as Avonex®, Betaseron®, Copaxone®, Extavia®, or Rebi®, at least one oral agent (such as Gilenya® or Tecfidera®) and tried and failed therapy with Ocrevus™.

For CD, the diagnosis must be confirmed by, or made in consultation with, a gastroenterologist. Patient must have tried and failed both Humira® and Remicade® and at least one systemic agent (such as corticosteroids, mesalamine, or sulfasalazine).

Medical record notes must be provided to support all requests for Tysabri®.

**Xeomin®**

See Botox®.

**Xgeva®**

Coverage is provided for:

- Adults and skeletally mature adolescents with giant cell tumor of the bone documented by computed tomography (CT) scan or magnetic resonance imaging (MRI) when surgery is ruled out as an option.

- The prevention of skeletal related events in patients with bone metastases from breast cancer, prostate cancer, or solid tumors with documentation supporting that at least one intravenous (IV) bisphosphonate (examples: pamidronate or zoledronic acid) has been ineffective or is contraindicated.

- Treatment of hypercalcemia of malignancy (HCM) with a corrected serum calcium (CSC) level greater or equal to 12mg/dL with documentation supporting that at least one IV bisphosphonate (examples: pamidronate or zoledronic acid) has been ineffective or is contraindicated.

Medical record notes must be provided to support all requests for Xgeva®.

**Xiaflex®**

Coverage is provided for the treatment of Dupuytren’s contracture in patients 18 or older. Documentation must support a finger flexion contracture with a palpable cord of at least one finger (other than the thumb) involving the metacarpophalangeal joint or the proximal interphalangeal joint. Administering physician must be a surgeon who has experience and training in hand surgeries.

Coverage is provided for the treatment of Peyronie’s disease in patients 18 or older. Documentation must support a palpable plaque and curvature deformity of 30 degrees or more at start of therapy. The patient must also have tried intralesional verapamil and at least
one of the following: pentoxifylline or verapamil gel. Administering physician must be a urologist.

The physician must have completed the Xiaflex® training, and the facility must be enrolled to receive Xiaflex® through Xiaflex® REMS.

Medical record notes must be provided to support all requests for Xiaflex®.

**Xolair®**

Coverage is provided for patients who have a diagnosis of moderate to severe allergic asthma, confirmed with either a positive skin test or reaction to yearly or seasonal allergens.

For a diagnosis of moderate to severe allergic asthma: patient must have tried and failed chronic administration of systemic corticosteroids or a high dose inhaled corticosteroid, in combination with a long acting inhaled beta 2 agonist or leukotriene receptor antagonist for at least 3 months.

Patient must have IgE levels between 30 and 700 IU/ml.

Coverage is provided for patients who have a diagnosis of chronic idiopathic urticaria.

For a diagnosis of chronic idiopathic urticaria: patient must have tried and failed antihistamine and leukotriene receptor antagonist therapy.

Xolair must be prescribed by an allergist/immunologist or pulmonologist and cannot be used in combination with other biologics such as Nucala® and Cinqair®.

Medical record notes must be provided to support all requests for Xolair®.

**Zinplava™**

Coverage is provided for patients who are greater than 18 years of age and who have a diagnosis of Clostridium difficile infection (CDI) and a positive stool test. Patients also must be at high risk for CDI recurrence (e.g. patients aged 65 years or older, history of CDI in the past 6 months, immunocompromised state, severe CDI at presentation or Clostridium difficile ribotype 027).

Zinplava™ must be prescribed by or in consultation with a gastroenterologist or infectious disease specialist and must be used with standard of care antibacterial agents (i.e. metronidazole or vancomycin).