

BCN AdvantageSM Step Therapy and Prior Authorization requirements

The goal of the BCN Pharmacy department is to ensure that all members receive high-quality, cost-effective pharmaceutical care. To meet this objective, BCN Advantage requires prior authorization for certain medications, and clinical criteria must be met before coverage is approved. Clinical criteria are based on current medical information and recommendations of BCBSM/BCN's Pharmacy and Therapeutics Committee. In addition, as required by the Centers for Medicare & Medicaid Services, drugs that can be processed under either Part B or Part D may require prior authorization in order to determine how to process the claim. Drugs that are covered under Part B, based on the member's circumstance, cannot be processed as a Part D claim.

To request an override of one of BCN's drug utilization management tools, health care providers should contact the BCN Pharmacy Help Desk at 800-910-1824. This number is available to providers 24

hours a day, seven days a week, including holidays. Responses to requests for coverage determinations are made within 72 hours. The provider should alert the Pharmacy Help Desk if the request is urgent. Urgent requests include requests for drugs without which the BCN Advantage member's life, health or ability to regain maximum function would be jeopardized or that, in the opinion of the prescriber with knowledge of the member's condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment requested. The provider should consider these criteria when providing documentation if the request is urgent. A response to these requests will be provided within 24 hours.

Updates to BCN's step therapy and prior authorization criteria are available online at MiBCN.com > I am a provider > BCN Formulary > BCN Advantage Formulary > Review the drugs included in the program and criteria for use.

Medication / Drug Class	Criteria
Administrative PA (Part D vs Part B processing)	Requires documentation that the drug is not covered under Part B.
Aldosterone inhibitors (Inspra [®])	Requires documentation that the member has experienced failure of or intolerance to generic Aldactone (spironolactone).
Angiotensin II receptor blockers (ARBs) Benicar [®] /HCT, Cozaar [®] / Hyzaar [®] , Atacand [®] , HCT; Avapro [®] /Avalide [®] , Diovan [®] /HCT, Micardis [®] /HCT, Teveten [®] / HCT	Requires documentation that the member has experienced failure of or intolerance to an ACE-Inhibitor such as Prinivil [®] /Zestril [®] (g), Monopril [®] (g), Lotensin [®] (g), Vasotec [®] (g), Accupril [®] (g), etc.
Antidepressants Lexapro [®] , Effexor XR [®] , Cymbalta [®] , Paxil CR [™] , Pexeva [™] , Prozac Weekly [®] , Sarafem [®] , Wellbutrin XL [™]	Requires documentation of FDA approved or supported diagnosis, and that member has experienced failure of or intolerance to at least one generic antidepressant, such as Celexa [®] (g), Paxil(g), Prozac(g) or Wellbutrin/SR(g) or Zoloff [®] (g).
Beta-blockers (Bystolic [®])	Requires documentation that the member has experienced failure of or intolerance to at least two generic cardioselective beta-blockers, such as Sectral [®] (g), Tenormin [®] (g), Kerlone [®] (g), Zebeta [®] (g), Lopressor [®] (g), or Toprol XL [®] (g).
Bisphosphonates Boniva [®] , Actonel [®] , Actonel [®] with calcium	Requires documentation of FDA approved or supported diagnosis, and that member has experienced failure of or intolerance to generic alendronate.
Intravenous bisphosphonates (Forteo [®] , Reclast [®] , Boniva [®])	Criteria for intravenous bisphosphonates: <ul style="list-style-type: none"> Covered for patients with osteoporosis who have demonstrated an intolerance, poor response, or contraindication for FDA approved oral bisphosphonates. Reclast is covered for Paget's disease. Requires documentation of intolerance to oral bisphosphonates, demonstrated by difficulty swallowing pills or inability to sit upright for 30 to 60 minutes after taking the oral form of bisphosphonates. Documentation of treatment failure, including fallen bone mineral density and/or failure to suppress bone turnover (for example, persisting high bone turnover marker measurements).

Medication / Drug Class	Criteria
Byetta® (exenatide)	Requires that all of the following criteria be met: <ul style="list-style-type: none"> • Member has a diagnosis of Type 2 diabetes • Must be prescribed concurrently with metformin and/or sulfonylurea • Covered only when insulin has failed; no concurrent insulin • Limited to one cartridge per month
Cardiovascular agents Azor®, Exforge®	Coverage of Azor requires documentation that the member has been on stable doses of generic amlodipine and olmesartan for at least 30 days. Coverage of Exforge requires documentation that the member has been on stable doses of generic amlodipine and an Angiotensin Receptor Blocker (ARB) for at least 30 days.
Cinryze™	<ul style="list-style-type: none"> • Covered for all FDA approved uses not otherwise excluded by Part D. Initial coverage is provided for Cinryze in patients who meet all of the following criteria: <ul style="list-style-type: none"> • Age 9 years or older • Diagnosis of hereditary angioedema established by an immunologist or hematologist • Laboratory confirmation of diagnosis including: <ul style="list-style-type: none"> • C4 level less than 14mg per liter • C1INH antigenic level less than 150 mg • C1 INH F functional level at 84 percent or below • History of at least two attacks of hereditary angioedema per month. • For short term prophylaxis, patient must meet criteria above and have history of attacks involving swelling of the face and airway or inadequate response or contraindication or intolerance to antifibrinolytic agents such as epsilon aminocaproic acid, (EACA), or attenuated androgens such as danazol or stanozolol or oxandrolone. • For long term prophylaxis, documentation of the above listed age, diagnostic information, and history of attacks is required and documentation of inadequate response or contraindication or intolerance to antifibrinolytic agents such as epsilon aminocaproic acid, EACA, or attenuated androgens such as danazol or stanozolol or oxandrolone is required. • Coverage for renewal of therapy requires documentation of response of at least 50 percent or greater reduction in attacks and or severity. Dosage is limited to 1,000 units or less every three to four days. • Cinryze is considered not medically necessary for all other clinical conditions including but not limited to acute angioedema, myocardial infarction, sepsis or vascular leak syndrome. All requests not meeting criteria listed above will be reviewed by a plan physician.
Diabetic agents (oral) Actos®, Avandia®, Avandamet®, Actoplus Met®, Avandaryl®, Duetact®, Januvia®, Janumet®	Requires documentation that the member has experienced failure with metformin or a sulfonylurea drug.
Endocrine agents Symlin® (pramlintide)	Requires documentation of failure of intensive treatment with insulin as monotherapy. Symlin is covered for concurrent use with an insulin product.

Medication / Drug Class	Criteria
Erythropoiesis stimulating agents (ESAs) Aranesp [®] , Epogen [®] , Procrit [®]	<p>Covered for the treatment of anemia associated with chronic renal failure to maintain the red blood cell level, as manifested by hemoglobin determinations, and to decrease transfusion need in these patients. Also covered for anemia secondary to active chemotherapy of solid tumors, anemia secondary to active zidovudine (AZT) therapy, anemia in myelodysplastic disorders, and prophylactic use during major surgeries.</p> <p>Aranesp requires the above plus requires documentation of failure with or intolerance to Procrit or Epogen.</p> <p>Documentation of diagnosis, laboratory values of hemoglobin and hematocrit, and medication history are required where applicable.</p> <p>ESAs are not covered for anemia due to folate, vitamin B12, iron deficiencies, hemolysis, bleeding, or bone marrow fibrosis. ESAs are not covered for anemia associated with treatment of acute and chronic myelogenous leukemias or erythroid cancers; or anemia due to cancer treatment in patients with uncontrolled hypertension. ESAs are not covered for anemia not associated with cancer treatment or renal disease under inclusions. ESAs are not covered for anemia associated only with radiotherapy. ESAs are also not covered for prophylactic use to prevent chemotherapy induced anemia, for prophylactic use to reduce tumor hypoxia, or for erythropoietin-type resistance due to neutralizing antibodies.</p>
Gastrointestinal agents Amitiza [®]	<p>Covered for women 18 years or older who are diagnosed with IBS with constipation. Covered for adults for the treatment of chronic idiopathic constipation, with documentation of failure within the previous 12 months of use of a fiber laxative and one of the following: a stimulant laxative or an osmotic laxative. Drug induced constipation must be ruled out.</p>
Growth hormone (all) Nutropin [®] , Saizen [®] , Genotropin [®] , Humatrope [®] , Norditropin [®] , Omnitrope [®] , Serostim [®] , Tev-tropin [®] , Zorbtive [®] , Increlex [®] , iPLEX [®] , Valtropin [®] , Somavert	<p>Covered for the replacement of endogenous growth hormone in adults with growth hormone deficiency of childhood onset or adult onset, covered if initial diagnosis based on two growth hormone stimulation tests and that the patient does not have edema, arthralgias, or carpal tunnel syndrome. Serostim is covered for aids wasting cachexia. Norditropin is covered for Noonan syndrome, Turner syndrome, and adult growth hormone deficiency. Nutropin is covered for Turner syndrome, and adult growth hormone deficiency. Omnitrope and Saizen are covered for adult growth hormone deficiency. Zorbtive is covered for the treatment of short-bowel syndrome in patients receiving specialized nutritional support. Somavert is covered for acromegaly. Initial approval for 1 year and renewal can be obtained if clinical response with therapy. Not covered for edema, arthralgias, or carpal tunnel syndrome.</p>
High risk medications in the elderly All members: Dicyclomine HCL oral Diphenhydramine HCL 50mg oral Fluoxetine HCL (daily) oral Indomethacin oral Meperidine oral Meprobamate oral Pentazocine/Acetaminophen Pentazocine HCL/Naloxone HCL Propoxyphene HCL oral Propoxyphene Napsylate Propoxyphene/Acetaminophen Members with enhanced benefit: Belladonna alkaloids Chlordiazepoxide Clindinium/Chlordiazepoxide Diazepam Flurazepam Hyoscyamine Trimethobenzamide	<p>For members age > 64 years: Covered for patients 65 years or older if intolerance, contraindications, or trial with failure has occurred with safer alternatives, or if documentation of short term use only.</p> <ul style="list-style-type: none"> Dicyclomine is covered for short term use or if patient has demonstrated intolerance to or failure of other agents for bowel/GI cramping. Propoxyphene and pentazocine are covered if patient is intolerant to or has failed other agents for moderate pain such as acetaminophen or aspirin with or without codeine or hydrocodone. <p>Chlorpropamide is covered if patient has failed or is intolerant to safer alternatives such as glyburide, glipizide, Precose[®], Prandin[®], or thiazolidinediones.</p> <ul style="list-style-type: none"> Meperidine or Pentazocine is covered if patient is intolerant to safer narcotic alternatives such as morphine or oxycodone. Meprobamate is covered if patient is intolerant to or has failed other anxiolytic agents such as buspirone. Indomethacin is approved if patient is intolerant to or has failed therapy with other safer nonsteroidal alternatives such as meloxicam or celecoxib. Diphenhydramine is approved if patient has failed or is intolerant to other safer alternative sedative or anxiolytic agents such as zolpidem. Fluoxetine is covered for patients who have a history of use. For those patients initiating therapy, fluoxetine is covered if patient has failure of or intolerance to safer alternative SSRI agents such as citalopram, escitalopram or paroxetine.

Medication / Drug Class	Criteria
Hypnotic agents Ambien CR [®] , Lunesta [®] , Rozerem [®]	Requires documentation of failure with or intolerance to generic Ambien (zolpidem).
Intranasal steroids Beconase AQ [®] , Nasacort AQ [®] , Nasonex [®] , Veramyst [®]	Requires documentation of failure with or intolerance to generic intranasal steroid, such as fluticasone or flunisolide.
Iron overload agents Exjade [®]	Requires documentation of failure with or intolerance to Desferal [®] (deferoxamine).
Kapidex [™]	Requires documentation of failure with or intolerance to at least two generic or formulary preferred PPI agents, such as Prilosec OTC, pantoprazole, or omeprazole.
Kuvan [®] (sapropterin)	Covered for patients with hyperphenylalaninemia (HPA) due to tetrahydrobiopterin (BH4) - responsive phenylketonuria (PKU). Documentation of dietary restrictions and diagnosis are required for approval. Excluded for non-FDA or unsupported use.
Lipid lowering agents Advicor [®] , Altoprev [®] , Caduet [®] , Crestor [®] , Lipitor [®] , Simcor [®] , Vytorin [®] , Zetia [®]	Requires documentation of failure with or intolerance to high dose (40mg or greater/day) of generic Mevacor [®] (lovastatin), generic Zocor [®] (simvastatin) or generic Pravachol [®] (pravastatin). Coverage of Simcor [®] requires documentation of stable therapy of simvastatin and extended release niacin, as demonstrated by trials of at least 90 days of the individual agents.
Mozobil [™]	Covered for all FDA approved uses not otherwise excluded by Part D. Covered for patients requiring autologous transplantation, when poor response is documented to apheresis with granulocyte colony stimulating factor alone, and covered for patients with Non-Hodgkin's lymphoma and multiple myeloma. Requires documentation of diagnosis and that granulocyte colony stimulating factor is administered concomitantly, and documentation of poor response to apheresis with granulocyte colony stimulating factor alone.
Narcotic analgesics Actiq [®] (Fentanyl oral transmucosal) Fentora [®] (Fentanyl buccal) Oxycontin [®] (oxycodone)	Actiq and Fentora are covered for cancer or cancer related diagnosis in patients already receiving long acting opioids. Oxycontin extended release tablets are covered for the management of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time.
Neuropathic pain treatment Lyrica [®] (pregabalin)	Covered for patients with seizures being treated concurrently with other anticonvulsants. Covered for patients with neuropathic pain associated with diabetic peripheral neuropathy or post-herpetic neuralgia if the member has treatment failure or intolerance to adequate trial including adequate doses of gabapentin. Covered for patients with fibromyalgia who have treatment failure or intolerance to adequate trials of gabapentin and any of the following agents including antidepressants such as SSRI agents or SNRI agents or tricyclic antidepressant agents, or cyclobenzaprine or tramadol. Requires documentation of diagnosis and medication history or intolerance(s).
Non-sedating antihistamines Allegra-D [®] , Allegra ODT [®] , Clarinet [®] , Clarinet-D [®] , Zyrtec, D [®] , Xyzal [®]	Requires documentation of failure with or intolerance to Claritin generic (loratadine) or over the counter generic cetirizine.
Prandimet [®] (repaglinide/metformin)	Coverage requires successful treatment of individual agents of repaglinide and metformin in combination for at least 90 days, as documented by improvements in HbA1c and lack of adverse events.
Pristiq [®] (desvenlafaxine)	Requires documentation of failure of at least 30 days of at least one generic antidepressant and 30 days trial of venlafaxine extended release.

Medication / Drug Class	Criteria
Promacta®	<p>Covered for all FDA approved uses not otherwise excluded by Part D.</p> <p>Initial coverage is provided for Promacta in patients who meet the following criteria:</p> <ul style="list-style-type: none"> • Age 18 years or older • Diagnosis of chronic immune thrombocytopenia purpura defined by diagnosis by or in consultation with a hematologist • Persistent thrombocytopenia defined by platelet count less than 150,000 mcl for minimum 2 months Inadequate response or documented intolerance for therapy with corticosteroids, immunoglobulins, or splenectomy • Current platelet count of less than 30,000 mcl and a prescribed daily dose of 75 mg or less <p>Renewal of therapy is covered for patients who meet the following criteria:</p> <ul style="list-style-type: none"> • Recent platelet count of 30,000 to 150,000 mcl • Daily dose of 75 mg or less <p>Promacta is considered not medically necessary for all other clinical conditions including acute thrombocytopenia, drug-induced thrombocytopenia, for example thrombocytopenia induced by chemotherapy, heparin, or quinidine. Promacta is considered not medically necessary for thrombocytopenia secondary to: cancer, myelodysplastic syndrome, HIV, hepatitis, systemic lupus erythematosus, hemangiomas, massive bleeding, thrombotic thrombocytopenic purpura, or hemolytic uremic syndrome. All requests not meeting criteria will be reviewed by a plan physician for potential use.</p>
Proton pump inhibitors Aciphex®, Nexium®, Prevacid®, Prevacid Solutab®, Protonix®, Zegerid®	Requires documentation of failure with or intolerance to Prilosec OTC or omeprazole.
Pulmonary agents Letairis®, Revatio®, Tracleer®, Ventavis®	Letairis, Revatio, Tracleer and Ventavis are covered for all FDA approved and clinically supported indications. The efficacy of Revatio® has not been evaluated in patients receiving combination therapy. Coverage for Revatio is not provided in situations where patients are receiving nitrate therapy. Doses are limited to 20mg three times daily. Coverage is not provided for sildenafil (Revatio®) in situations where patients are receiving nitrate therapy.
Relistor™ (methylnaltrexone bromide)	<p>For the treatment of opioid-induced constipation in patients with advanced illness who are receiving palliative care, when response to laxative therapy has not been sufficient.</p> <p>Documentation of previous treatment of constipation for at least 5 days duration of each of the following agents: fluids, stool softeners, bulk laxatives, saline laxatives and osmotic laxatives. Also, patients must be on stable doses of opioids for greater than 2 weeks. Maximum initial regimen is 1 box (7 doses), limited to 14 monthly doses. Coverage may not be provided in the following situations:</p> <ul style="list-style-type: none"> • Contraindications to methylnaltrexone, including GI obstruction • Patients not receiving palliative care • Pediatric patients • Patients with comorbid conditions that affect GI motility <p>Additional information: Assessment for possible reduction in dosage after initial treatment period of 3 months is highly recommended. Use of this agent beyond 4 months has not been studied. Patients experiencing withdrawal symptoms while taking methylnaltrexone should consider using an alternative form of therapy.</p>
Remicade® (infliximab infusion therapy)	<p>Covered for members with moderate to severely active Crohn's who have an inadequate response to conventional therapy. Conventional therapy includes, but is not limited to: sulfasalazine, mesalamine or 5-asa agents, corticosteroids, antibiotics, or other drugs that affect the immune system such as azathioprine or 6-mercaptopurine (6-mp). Covered for first-line treatment for members with Crohn's disease associated with fistulas to reduce the number of draining enterocutaneous fistula(s). Covered for the treatment of moderate to severely active rheumatoid arthritis for the reduction of the signs and symptoms associated with the disease for members who have an inadequate response to conventional therapy. Conventional therapy includes but is not limited to: NSAIDs (non-steroidal anti-inflammatory drugs), Cox-2 inhibitors, corticosteroids, methotrexate, or gold injections. Covered for ankylosing spondylitis, psoriatic arthritis and Behcet's Disease. Covered for moderately to severely active ulcerative colitis in patients who have had an inadequate response to conventional therapy.</p>

Medication / Drug Class	Criteria
Sancuso® (granisetron transdermal)	Covered for the prevention and or treatment of nausea and or vomiting associated with chemotherapy and or radiation. Requires treatment with generic ondansetron, and documentation that oral form of granisetron is not effective or is not tolerated.
Tekturna, HCT®	Requires documentation that member has failure of or intolerance to at least one generic ACE-Inhibitor and at least one angiotensin receptor blocker.
TNF-alpha agents (self-injectables) Enbrel™, Cimzia®, Kineret®, Humira®	<p>Requires documentation of FDA approved or supported diagnosis. Covered for rheumatoid arthritis (Enbrel, Humira, Kineret) or psoriatic arthritis (Enbrel, Humira) with previous four month trial of two concurrent DMARDs (one must be methotrexate unless contraindicated).</p> <p>Enbrel is covered ankylosing spondylitis. Enbrel is covered for moderate to severe psoriasis, requiring three months of previous treatment with topical corticosteroids and three months treatment with PUVA. Humira is covered for juvenile idiopathic arthritis, psoriatic arthritis, ankylosing spondylitis, Crohn's disease and plaque psoriasis. Humira is covered for the treatment of adult patients with moderate to severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy and when other systemic therapies are medically less appropriate. Humira should only be administered to patients who will be closely monitored and have regular follow-up visits with a health care provider.</p> <p>Crohn's disease: Cimzia is covered for acute treatment of an exacerbation of moderate to severe Crohn's disease for patients aged 18 years or older when at least one of the following three criteria are met:</p> <ul style="list-style-type: none"> • Treatment with an adequate course of systemic corticosteroids has been ineffective or is contraindicated • The patient has been unable to taper off corticosteroids without experiencing worsening of disease • The patient is experiencing breakthrough disease, for example active disease flares, while stabilized for at least two months on an immunomodulatory medication such as azathioprine, mercaptopurine, cyclosporine, or methotrexate. <p>Either one of the following criteria must also be met:</p> <ul style="list-style-type: none"> • Infliximab is not effective after at least an initial induction period, usually 3 courses of treatment over 6 weeks, or is not tolerated due to documented clinical side effects. • Adalimumab is not effective after at least an initial three dose induction period, or is not tolerated due to documented clinical side effects. <p>Coverage for these agents may also require documentation of evaluation for infection risks, especially tuberculosis.</p>
Trilipix®	Requires documentation of failure or intolerance with gemfibrozil and generic fenofibrate. Limited to one dose per day.
Xenazine® (tetrabenazine)	<p>Covered for the treatment of chorea associated with Huntington's disease. For doses greater than 50 mg per day, documentation of CYP2D6 genotype of the patient will be required.</p> <p>Coverage for Xenazine will not be provided for patients who have hepatic function impairment, patients who are actively suicidal or who have untreated or inadequately treated depression, or patients taking monamine oxidase inhibitors or reserpine.</p>
Wound care Regranex® (becaplermin topical)	<p>Requires that all the following criteria be met:</p> <ul style="list-style-type: none"> • The member has a chronic neuropathic diabetic ulcer of the lower extremity. • There is adequate tissue oxygenation. • There is a full thickness ulcer (e.g., Stage III or IV) extending through the dermis into subcutaneous tissue. • The member is participating in a comprehensive wound care treatment plan including such modalities as debridement, pressure relief (e.g. non-weight bearing) and infection control.