

Molina
Prior Authorization Criteria
ADAGEN

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Adagen is approved for patients who meet the following criteria:

- A. Patient's that are not suitable candidates for or who have failed bone marrow transplantation.
- B. Not intended as a replacement for HLA identical bone marrow transplant therapy or to replace continued close medical supervision and the initiation of appropriate diagnostic tests and therapy (eg, antibiotics, nutrition, oxygen, gammaglobulin) as indicated for intercurrent illnesses.

NON COVERAGE

Adagen® is NOT covered for members with the following criteria:

- A. Patient has diagnosis of severe thrombocytopenia
- B. Patient with bone marrow transplantation

PRESCRIBER RESTRICTIONS

Initiated and monitored by a specialist well-versed in management of ADA deficiency.

COVERAGE DURATION

12 months



Molina
Prior Authorization Criteria
AFINITOR

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D

COVERAGE DURATION

Plan Year

Molina
Prior Authorization Criteria
ALDARA CREAM

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Aldara is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. Occlusive dressing
 - b. Ocular exposure

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
ALDURAZYME

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Aldurazyme® is NOT covered for members with the following criteria:

- A. The patient has laronidase hypersensitivity.

PRESCRIBER RESTRICTIONS

Therapy must be initiated and monitored by a specialist well-versed in management of this condition.

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
ALZHEIMER'S MEDICATIONS

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Alzheimer's medications are NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. Breast-feeding
 - b. GI bleeding
 - c. Jaundice
 - d. Renal failure
 - e. Carbamate hypersensitivity.
- B. If the patient is taking dofetilide.

PRESCRIBER RESTRICTIONS

Neurology reports documenting diagnosis

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
AMITIZA

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Amitiza® is NOT covered for members with the following criteria:

- A. The patient has diarrhea.
- B. The patient has a GI obstruction.

REQUIRED MEDICAL INFORMATION

Documentation showing:

- A. Trial and failure of conventional formulary agents (lactulose and PEG 3350).
- B. If female, documentation showing patient is on a reliable form of contraception.

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
AMPYRA

COVERED USES

- A. All FDA approved indications not otherwise excluded from Part D

COVERAGE POLICY

Ampyra is covered for members who meet the following criteria:

- A. Diagnosis of multiple sclerosis and has documented difficulty walking, no history of seizure disorder, renal function Creatinine Clearance 50mL/min

REQUIRED MEDICAL INFORMATION

- A. Patient has documented difficulty walking, no history of seizure disorder, renal function Creatinine Clearance 50mL/min-

COVERAGE DURATION

6 month approval

Molina
Prior Authorization Criteria
ANAGRELIDE

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Anagrelide is NOT covered for members with the following criteria:

- A. Severe hepatic impairment
- B. Women who are or may become pregnant
- C. If the patient is taking any of the following:
 - a. Anticoagulants
 - b. Platelet Inhibitors
 - c. Rasagiline
 - d. Salicylates

PRESCRIBER RESTRICTIONS

Must be prescribed by a hematologist.

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
ANZEMET

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Anzemet is NOT covered for members who meet the following criteria:

- A. If the patient is taking/receiving any of the following:
 - a. Apomorphine
 - b. Astemizol
 - c. Bepridil
 - d. Cisapride
 - e. Droperidol
 - f. Grepafloxacin
 - g. Levomethadyl
 - h. Probucol
 - i. Terfenadine
 - j. Ziprasidone.

COVERAGE DURATION

2 doses per chemotherapy cycle, one dose per surgical procedure

Molina
Prior Authorization Criteria
ARALAST

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Aralast is NOT covered for members who meet the following criteria:

- A. Members with selective IgA deficiencies and who have known antibody against IgA

PRESCRIBER RESTRICTIONS

Therapy must be initiated by a specialist well-versed in treating Alpha1-PI deficiency.

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
ARANESP ALBUMIN FREE

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Aranesp is covered for members who meet the following criteria:

- A. Approved for patients with treatment of anemia associated with chronic renal failure
 - a. Including patients on dialysis.
 - b. Non-dialysis patients with symptomatic anemia should have a Hgb less than 10g/dL.
- B. Treatment of anemia induced by chemotherapy and biologic agents,
 - a. Excluding members with a diagnosis of acute leukemia.
- C. Treatment of anemia in members with myelodysplastic syndrome with an endogenous erythropoietin level less than 500 mU/ml.
- D. NOT approved for the treatment of anemia in HIV-infected patients due to other factors such as iron or folate deficiency, hemolysis, or gastrointestinal bleeding.

NON COVERAGE

Aranesp is not covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. Albumin hypersensitivity
 - b. Hamster protein hypersensitivity
 - c. Red cell aplasia
 - d. Hemoglobin concentration greater than 12 g/dl or surgery prophylaxis.

REQUIRED MEDICAL INFORMATION

Documentation showing:

- A. Iron Transferrin saturation greater than or equal to 20%
- B. Ferritin greater than or equal to 100 ng/ml
- C. Hematocrit (CRF non-dialysis symptomatic patients):
 - a. HCT less than 30%
- D. Blood Pressure (BP): BP should be controlled adequately before initiation of therapy.
- E. Hemoglobin: Measure twice a week for 2 to 6 weeks after any dosage adjustment to ensure that hemoglobin level has stabilized in response to the dose change.
 - a. Target range: should not exceed 12 g/dL.
- F. Decrease dose if level increases by more than 1g/dL in any 2-week period, or Exceeds recommended target at 8 weeks: if level does not rise by 1g/dL, discontinue therapy.
- G. Concomitant cardiovascular conditions in addition to renal disease: higher levels may be optimal and target hemoglobin may be individualized.
- H. Blood pressure Monitor (particularly with an underlying history of hypertension or cardiovascular disease).

PRESCRIBER RESTRICTIONS

Prescribing physician is a hematologist, oncologist, nephrologist, or infectious disease specialist, or prescribing initiated based upon a consult with one of these specialists.



Molina
Prior Authorization Criteria
ARANESP ALBUMIN FREE
Continued

COVERAGE DURATION
6 months

Molina
Prior Authorization Criteria
ARIXTRA

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

REQUIRED MEDICAL INFORMATION

Documentation showing:

- A. Patient has adequate renal function (creatinine clearance 30 mL/min).
- B. Patient's body weight is great then 50kg.
- C. Patient's liver function tests are within normal limits (ALT and AST less than 35 U/L).

AGE RESTRICTIONS

Mininum of 18 years of age

COVERAGE DURATION

Up to 32 days per incident

Molina
Prior Authorization Criteria
BANZEL

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Banzel® is NOT covered for members who meet the following criteria:

- A. If the patient has short QT syndrome.

COVERAGE DURATION

1 year

Molina
Prior Authorization Criteria
BONIVA INJECTABLE

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Boniva Injection is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. Hypocalcemia
 - b. Phosphonate hypersensitivity.

REQUIRED MEDICAL INFORMATION

Documentation showing intolerance to oral Boniva.

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
BUPHENYL

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Buphenyl® is NOT covered for members with the following criteria:

- A. To treat acute hyperammonemia.

PRESCRIBER RESTRICTIONS

Therapy must be initiated and monitored by a specialist well-versed in the management of these conditions

COVERAGE DURATION

12 months



**Molina
Prior Authorization Criteria
BYETTA**

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
CAMPRAL

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Campral is covered for members who meet the following criteria:

- A. Approved for patients who are abstinent at treatment initiation.
- B. Must be used as part of a comprehensive management program that includes psychosocial support.

NON COVERAGE

Campral® delayed-release tablets are NOT covered for members with the following criteria:

- A. If the patient has renal failure.
- B. Will not be approved for individuals who have not undergone detoxification and not achieved alcohol abstinence prior to Campral treatment.

PRESCRIBER RESTRICTIONS

Must be prescribed by someone involved with member's management program

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
CAMPTOSAR

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Camptosar is NOT covered for members who meet the following criteria:

- A. If the patient is taking/receiving any of the following:
 - a. Atazanavir
 - b. Ketoconazole
 - c. St. John's Wort
 - d. Hypericum perforatum.

PRESCRIBER RESTRICTIONS

Hematologist/Oncologist

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
CAPASTAT

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Culture and Sensitivity report showing susceptibility of bacteria to Capastat

COVERAGE DURATION

6 Months

Molina
Prior Authorization Criteria
CELEBREX

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Celebrex is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. Coronary artery bypass graft surgery (CABG)
 - b. NSAID hypersensitivity
 - c. Salicylate hypersensitivity
 - d. Sulfonamide hypersensitivity.

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
CEREDASE

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Ceredase is covered for members who meet the following criteria:

- A. Approved for use as a long-term enzyme replacement therapy for patients with a confirmed diagnosis of type 1 Gaucher disease who exhibit signs and symptoms that are severe enough to result in 1 or more of the following conditions:
 - a. Moderate to severe anemia
 - b. Thrombocytopenia with bleeding tendency
 - c. Bone disease
 - d. Significant hepatomegaly
 - e. Splenomegaly.

PRESCRIBER RESTRICTIONS

Therapy must be initiated by a specialist well-versed in treatment of this condition,

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
CEREZYME

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Cerezyme is covered for members who meet the following criteria:

- A. Approved for long-term enzyme replacement therapy for patients with a confirmed diagnosis of Type 1 Gaucher disease that results in 1 or more of the following conditions:
 - a. Anemia
 - b. Thrombocytopenia
 - c. Bone disease
 - d. Hepatomegaly
 - e. Splenomegaly

NON COVERAGE

Cerezyme® is NOT covered for members with the following criteria:

- A. If the patient is taking Miglustat.

PRESCRIBER RESTRICTIONS

Therapy must be initiated by a specialist well-versed in the treatment of this condition.

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
CERVARIX

COVERED USES

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Cervarix is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications: yeast hypersensitivity.

AGE RESTRICTIONS

For use in females 10-25 years of age.

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
DACOGEN

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Dacogen is covered for members who meet the following criteria:

- A. Combination with 5-FU and leucovorin.
- B. Must be used as 2nd-line treatment, after 5-FU/Leucovorin and irinotecan.

NON COVERAGE

Dacogen® is NOT covered for members with the following criteria:

- A. If the patient is receiving live vaccines
- B. Patient is pregnant

PRESCRIBER RESTRICTIONS

Hematologist/Oncologist

COVERAGE DURATION

6 months



Molina
Prior Authorization Criteria
DEGARELIX

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D

COVERAGE DURATION

Plan Year

Molina
Prior Authorization Criteria
EFFIENT

COVERED USES

FDA approved indications

- A. All FDA approved uses not otherwise excluded from Part D.

COVERAGE DURATION

Plan Year

Molina
Prior Authorization Criteria
ELAPRASE

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Molina Healthcare will approve Elaprase when the following medical necessity criteria are met:

- A. Criteria for Initiation of Therapy Elaprase (Idursulfase) may be considered medically necessary for all Hunter Syndrome members who meet ALL of the following criteria:
 - a. Prescribed for treatment of Hunter Syndrome
 - b. A definitive diagnosis of Hunter Syndrome documented by laboratory exams and/or reports.
 - c. Dosage prescribed is within the FDA recommended dose of 0.5 mg/kg of body weight administered once weekly as an intravenous (IV) infusion.
 - d. Infusion will be given in a safe setting, with capacity to respond to anaphylactoid reactions

REQUIRED MEDICAL INFORMATION

Prescriber to submit at least one of the following test results:

- A. Screening test:
 - a. Presence or absence of mucopolysaccharides (also called glycosaminoglycans or GAG) in the urine
- B. Enzyme test
 - a. Measures I2S activity in serum, white blood cells, or fibroblasts from skin biopsy
- C. DNA test
 - a. Detects the specific genetic changes that code for the missing enzyme.
- D. Dosage prescribed is within the FDA recommended dose of 0.5 mg/kg of body weight administered once weekly as an intravenous (IV) infusion.

PRESCRIBER RESTRICTIONS

A specialist in the treatment of metabolic diseases.

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
ELOXATIN

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Eloxatin® is NOT covered for members who meet the following criteria:

- A. If the patient is female and she is pregnant.
- B. Known platinum compound hypersensitivity.
- C. If the patient is receiving live vaccines.

PRESCRIBER RESTRICTIONS

Hematologist/Oncologist

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
EMEND

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Emend® is NOT covered for members with the following criteria:

- A. If the patient is taking/receiving any of the following:
 - a. Astemizole
 - b. Cisapride
 - c. Pimozide
 - d. Terfenadine.

COVERAGE DURATION

3 day treatment per round of chemotherapy

Molina
Prior Authorization Criteria
EMSAM

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Emsam is covered for members who meet the following criteria:

- A. Approved for the treatment of major depressive disorder (MDD).
- B. The American Psychiatric Association recommends reserving MAOI therapy for patients who do not respond to other treatments.

NON COVERAGE

EMSAM® is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications:
 - a. Surgery
 - b. MAOI therapy
 - c. pheochromocytoma.
- B. If the patient is taking/receiving any of the following:
 - a. Altretamine
 - b. Bupropion
 - c. Buspirone
 - d. Caffeine
 - e. Carbamazepine
 - f. Cocaine
 - g. Cyclobenzaprine
 - h. Dextromethorphan
 - i. Ethanol
 - j. Furazolidone
 - k. General Anesthetics
 - l. Green Tea
 - m. Guarana
 - n. Isoniazid
 - o. INH
 - p. Kava Kava
 - q. Piper methysticum
 - r. Linezolid
 - s. Local Anesthetics
 - t. Meperidine
 - u. Methadone
 - v. Methylidopa
 - w. Mirtazapine
 - x. Monoamine oxidase inhibitors (MAOIs)
 - y. Oxcarbazepine,
 - z. Propoxyphene
 - aa. Psychostimulants
 - bb. S-adenosyl-L-methionine
 - cc. SAM-e
 - dd. Selective norepinephrine reuptake inhibitors
 - ee. Selective serotonin reuptake inhibitors (SSRIs)
 - ff. Serotonin norepinephrine reuptake inhibitors
 - gg. Serotonin-Receptor Agonists
 - hh. St. John's Wort
 - ii. Hypericum perforatum
 - jj. Sympathomimetics
 - kk. Tramadol
 - ll. Trazodone
 - mm. Tricyclic antidepressants
 - nn. Tryptophan
 - oo. 5-Hydroxytryptophan
 - pp. Yohimbine.

PRESCRIBER RESTRICTIONS

Guidance of a psychiatrist.

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
ENBREL

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Enbrel is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. Agranulocytosis
 - b. benzyl alcohol hypersensitivity
 - c. bleeding
 - d. fever
 - e. hematological disease
 - f. infection
 - g. intramuscular administration
 - h. intravenous administration
 - i. latex hypersensitivity
 - j. sepsis.
- B. If the patient is taking/receiving any of the following:
 - a. Anakinra
 - b. Riloncept.

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
EPOGEN

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Epogen is covered for members who meet the following criteria:

- A. Approved for treatment of Anemia due to End Stage Renal Disease (ESRD) or Chronic Renal Failure (CRF).
- B. Prescribed for treatment of anemia associated with CRF, including both patients on dialysis [end-stage renal disease (ESRD)], and patients not on dialysis.
- C. Non-dialysis members with symptomatic anemia Hgb less than 10g/dL.
- D. Prescribed for treatment of anemia related to therapy with zidovudine (AZT) in HIV-infected patients.
- E. The endogenous serum erythropoietin level is less than or equal to 500 mUnits/mL.
- F. Dose of zidovudine is less than or equal to 4200 mg/week.
- G. Treatment of Anemia induced by Biologic Agents or Chemotherapy.
- H. Prescribed for treatment of anemia induced by chemotherapy or biologic agents
 - a. Excluding members with a diagnosis of acute leukemia.
- I. Reduction of Allogeneic Blood Transfusion in Surgery Patients.
- J. NOT approved for the treatment of anemia in HIV-infected patients due to other factors such as iron or folate deficiency, hemolysis, or gastrointestinal bleeding.

NON COVERAGE

EPO's are not covered for members who meet the following criteria:

- A. If the patient has any of the following contraindication
 - a. albumin hypersensitivity
 - b. benzyl alcohol hypersensitivity
 - c. hamster protein hypersensitivity
 - d. uncontrolled hypertension
 - e. hemoglobin concentration greater than 13 g/dl.

PRESCRIBER RESTRICTIONS

Prescribing physician is a hematologist, oncologist, nephrologist, or infectious disease specialist, or prescribing initiated based upon a consult with one of these specialists.

COVERAGE DURATION

Renewable every 6 months

Molina
Prior Authorization Criteria
ETHYOL

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Amifostine is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications:
 - a. Dehydration
 - b. exfoliative dermatitis
 - c. hypotension
 - d. mannitol hypersensitivity.

PRESCRIBER RESTRICTIONS

Hematologist/Oncologist

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
EXJADE

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Exjade® is NOT covered for members with the following criteria

- A. If the patient is taking/receiving any of the following:
 - a. Deferoxamine
 - b. Iron Dextran
 - c. Iron Salts
 - d. Iron Sucrose
 - e. Polysaccharide-Iron Complex
 - f. Sodium Ferric Gluconate Complex.
- B. Member has not failed or is not intolerant to Desferal

AGE RESTRICTIONS

Patients 2 years of age or older.

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
FABRAZYME

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Fabrazyme® is NOT covered for members with the following criteria:

- A. Known hypersensitivity to mannitol.

REQUIRED MEDICAL INFORMATION

Diagnosis is to be made utilizing alpha galactosidase assays and confirmed by molecular studies

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
FORTEO

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

REQUIRED MEDICAL INFORMATION

Documentation showing:

- A. Bone mineral density that is 2.5 or more standard deviations below that of a "young normal" adult (T-score at or below -2.5).
- B. AND documentation showing Actonel (risedronate) or Fosamax (alendronate) are not effective after at least a 24-month treatment period based on objective documentation except if:
 - a. Actonel or Fosamax are contraindicated based on current medical literature and objective documentation describing the contraindication is provided.
 - b. Actonel or Fosamax are not tolerated due to documented clinical side effects.

COVERAGE DURATION

2 years

Molina
Prior Authorization Criteria
FRAGMIN

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Fragmin is covered for members who meet the following criteria:

- A. Patient has unstable angina or non-Q wave myocardial infarction
- B. AND is at risk for thromboembolic complications ONLY when concurrently administered with aspirin.

NON COVERAGE

Fragmin is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. Bleeding
 - b. GI bleeding
 - c. Hemophilia
 - d. heparin hypersensitivity
 - e. heparin-induced thrombocytopenia (HIT)
 - f. idiopathic thrombocytopenic purpura (ITP)
 - g. porcine protein hypersensitivity
 - h. use prior/post lumbar puncture
 - i. epidural anesthesia
 - j. spinal anesthesia.
- B. If the patient is taking/receiving any of the following:
 - a. anticoagulants
 - b. mifepristone.

REQUIRED MEDICAL INFORMATION

Patient's liver function tests are within normal limits (ALT and AST less than 35 U/L).

AGE RESTRICTIONS

Patient is 18 years of age.

COVERAGE DURATION

3 Months

Molina
Prior Authorization Criteria
GARDASIL

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Gardasil is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. elderly

AGE RESTRICTIONS

(ACIP) recommends that the human papillomavirus vaccine, quadrivalent be routinely given to girls when they are 11 to 12 years old. The ACIP recommendation also allows for vaccination of girls beginning at nine years old and vaccination of women 13 to 26 years old.

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
GEODON

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Geodon is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
- | | |
|-----------------------------|---|
| a. acute MI | h. hypomagnesemia |
| b. AV block | i. intravenous administration |
| c. bundle-branch block | j. MI |
| d. cardiac arrhythmias | k. QT prolongation |
| e. congenital heart disease | l. torsade de pointes |
| f. heart failure | m. dementia-related psychosis in elderly. |
| g. hypokalemia | |
- B. If the patient is taking/ receiving any of the following:
- | | |
|------------------------------|-------------------------------|
| a. Alfuzosin | x. Levofloxacin |
| b. Amoxapine | y. Levomethadyl |
| c. Arsenic trioxide | z. Maprotiline |
| d. Astemizole | aa. Methadone |
| e. Bepridil | bb. Moxifloxacin |
| f. Chloroquine | cc. Nilotinib |
| g. Cisapride | dd. Ondansetron |
| h. Clarithromycin | ee. Palonosetron |
| i. Class IA antiarrhythmics | ff. Pentamidine |
| j. Class III antiarrhythmics | gg. Phenothiazines |
| k. Clozapine | hh. Pimozide |
| l. Cocaine | ii. Probucol |
| m. Dasatinib | jj. Propafenone |
| n. Dolasetron | kk. Sertindole |
| o. Droperidol | ll. Sparfloxacin |
| p. Erythromycin | mm. Sunitinib |
| q. Flecainide | nn. Tacrolimus |
| r. Gatifloxacin | oo. Telithromycin, |
| s. Gemifloxacin | pp. Terfenadine |
| t. Grepafloxacin | qq. Tricyclic antidepressants |
| u. Halofantrine | rr. Troleandomycin |
| v. Haloperidol | ss. vardenafil |
| w. Lapatinib | tt. Vorinostat. |

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
GLEEVEC

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

PRESCRIBER RESTRICTIONS

Hematologist/Oncologist

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
GROWTH HORMONE

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Growth hormones are NOT covered for the following criteria:

- A. If the patient meets any of the following contraindications:
 - a. diabetic retinopathy
 - b. epiphyseal closure
 - c. neoplastic disease
 - d. trauma.
- B. Contraindicated for obese patients if indication is Prader-Willi Syndrome.

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
HALOPERIDOL DECANOATE

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Haloperidol decanoate is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. CNS depression
 - b. Coma
 - c. Parkinson's disease.
- B. If the patient is taking/receiving any of the following:
 - a. Arsenic trioxide
 - b. Astemizole
 - c. Bepridil
 - d. Chloroquine
 - e. Chlorpromazine
 - f. Cisapride
 - g. Class IA antiarrhythmics
 - h. Class III antiarrhythmics
 - i. Droperidol
 - j. Flecainide
 - k. Grepafloxacin
 - l. Halofantrine
 - m. Levomethadyl
 - n. Mesoridazine
 - o. Methadone
 - p. Nilotinib
 - q. Pentamidine
 - r. Pimozide
 - s. Probucol
 - t. Propafenone
 - u. Quinidine
 - v. Sparfloxacin
 - w. Terfenadine
 - x. Thioridazine
 - y. Ziprasidone.

REQUIRED MEDICAL INFORMATION

Documentation showing:

- A. patient has failed oral haloperidol therapy
- B. or patient has demonstrated non compliance to oral therapy

PRESCRIBER RESTRICTIONS

Therapy must be initiated by psychiatry.

COVERAGE DURATION

12 months



Molina
Prior Authorization Criteria
HOME INFUSION THERAPY - ACUTE CARE

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE DURATION

Renewable every 6 months

Molina
Prior Authorization Criteria
HUMIRA

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Humira® is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications:
 - a. Infection
 - b. Influenza
 - c. sepsis.
- B. If the patient is taking/receiving any of the following:
 - a. Abatacept
 - b. Anakinra
 - c. Etanercept
 - d. Infliximab
 - e. Rilonacept.

PRESCRIBER RESTRICTIONS

Rheumatologist, Dermatologist, Gastroenterologist

COVERAGE DURATION

3 months

Molina
Prior Authorization Criteria
IGF DEFICIENCY MEDICATIONS

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

IGF deficiency medications are not covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. benzyl alcohol hypersensitivity
 - b. epiphyseal closure
 - c. intravenous administration
 - d. neonates
 - e. neoplastic disease.

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
IMMUNE GLOBULINS

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Immune globulin is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications: IgA deficiency.

COVERAGE DURATION

6 months



Molina
Prior Authorization Criteria
INTERFERONS (NON-HEPC)

COVERED USES

FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
INVEGA

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Invega® is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. AV block
 - b. bundle-branch block
 - c. cardiac arrhythmias
 - d. QT prolongation
 - e. torsade de pointes
 - f. dementia.
- B. If the member is taking/receiving any of the following:
 - a. Mesoridazine
 - b. Thioridazine.

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Documentation of diagnosis
- B. If diagnosis is schizophrenia:
 - a. Documentation of previous trial/failure on two or more of the following:
 - i. Clozapine
 - ii. Risperidone
 - iii. Seroquel
 - iv. Zyprexa
 - v. Abilify
 - vi. Geodon

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
ISOTRETINOIN

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Isotretinoin is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. Pregnancy
 - b. Papilledema
 - c. paraben hypersensitivity
 - d. retinoid hypersensitivity.

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
ITRACONAZOLE

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Itraconazole is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications:
 - a. Pregnancy
 - b. breast-feeding
 - c. heart failure
 - d. ventricular dysfunction.
- B. If the patient is taking/receiving any of the following:
 - a. Alfuzosin
 - b. Alprazolam
 - c. Astemizole
 - d. Atorvastatin
 - e. Cerivastatin
 - f. Cisapride
 - g. Clorazepate
 - h. Conivaptan
 - i. Dofetilide
 - j. Eplerenone
 - k. Ergot Alkaloids
 - l. Flurazepam
 - m. Levomethadyl
 - n. Lovastatin
 - o. Midazolam
 - p. Nevirapine
 - q. Nisoldipine
 - r. Pimozide
 - s. Quinidine
 - t. Ranolazine
 - u. Red Yeast Rice
 - v. Simvastatin
 - w. Sirolimus
 - x. Terfenadine
 - y. Triazolam
 - z. Vinca alkaloids.

REQUIRED MEDICAL INFORMATION

Documentation showing:

- A. Either a positive KOH stain or positive PAS stain (periodic acid Schiff) or positive fungal culture.
- B. Baseline LFTs indicate AST/ALT higher than 1.5xs the upper limit of normal (recent LFTs must be provided)

COVERAGE POLICY

6 months

Molina
Prior Authorization Criteria
KEPIVANCE

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Kepivance® is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. E. coli protein hypersensitivity.

COVERAGE POLICY

6 months

Molina
Prior Authorization Criteria
KETEK

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Ketek® is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. macrolide hypersensitivity
 - b. history of macrolide induced hepatitis/jaundice
 - c. myasthenia gravis
 - d. QT prolongation
 - e. torsade de pointes.
- B. If the patient is taking/receiving any of the following:
 - a. Astemizole
 - b. Atorvastatin
 - c. Bepridil
 - d. Cisapride
 - e. Class IA antiarrhythmics
 - f. Class III antiarrhythmics
 - g. Droperidol
 - h. Ergot Alkaloids
 - i. Grepafloxacin
 - j. Levomethadyl
 - k. Lovastatin
 - l. Pimozide
 - m. Probucol
 - n. Red Yeast Rice
 - o. Rifampin
 - p. Simvastatin
 - q. Sirolimus
 - r. Terfenadine
 - s. Ziprasidone.

COVERAGE DURATION

14 days

Molina
Prior Authorization Criteria
KINERET

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Kineret® is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. E. coli protein
 - b. latex hypersensitivity.

AGE RESTRICTIONS

Patient is 18-years of age and older

PRESCRIBER RESTRICTIONS

Rheumatologist

COVERAGE DURATION

3 months

Molina
Prior Authorization Criteria
KYTRIL

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Kytril® is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. benzyl alcohol hypersensitivity
 - b. neonates.
- B. If the member is taking apomorphine.

COVERAGE DURATION

2 days / course, multiple courses allowed

Molina
Prior Authorization Criteria
LETAIRIS

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Letairis® is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications:
 - a. pregnancy
 - b. breast-feeding.
- B. Members with severe anemia.

REQUIRED MEDICAL INFORMATION

Documentation of:

- A. Baseline liver function tests (ALT, AST) performed prior to initiation of therapy.
- B. If member is a woman of childbearing potential:
 - a. A baseline negative pregnancy test prior to initiation of therapy.

PRESCRIBER RESTRICTIONS

Pulmonologist or Cardiologist

COVERAGE DURATION

4 months

Molina
Prior Authorization Criteria
LEUPROLIDE PRODUCTS

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Leuprolide is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications:
 - a. benzyl alcohol hypersensitivity
 - b. breast-feeding
 - c. females
 - d. mannitol hypersensitivity
 - e. pregnancy.
- B. If the patient is taking/receiving any of the following:
 - a. Chasteberry
 - b. Chaste tree fruit
 - c. Vitex agnus-castus.

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
LINCOCIN

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D

COVERAGE POLICY

Lincocin® is covered for members who meet the following criteria:

- A. Patient is diagnosed with bacteria that is susceptible to Lincocin.
- B. Patient has culture and sensitivity report that shows susceptibility of bacteria to Lincocin.

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Culture and Sensitivity report showing susceptibility of bacteria to Lincocin

COVERAGE DURATION

14 Days

Molina
Prior Authorization Criteria
LOTROXEX

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Lotronex is covered for members who meet the following criteria:

- A. Approved for female patients only

NON COVERAGE

Lotronex® is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. Colitis
 - b. Constipation
 - c. Crohn's disease
 - d. Diverticulitis
 - e. GI obstruction
 - f. GI perforation
 - g. Hepatic disease
 - h. Thrombophlebitis
 - i. Toxic megacolon
 - j. Ulcerative colitis.
- B. If the member is taking/receiving the following medications:
 - a. Apomorphine
 - b. Fluvoxamine.

PRESCRIBER RESTRICTIONS

Lotronex is prescribed only by physicians who have enrolled in prescribing program

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
LOVAZA

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Lovaza® is NOT covered for members who meet the following criteria:

- A. If the patient has fish hypersensitivity.

REQUIRED MEDICAL INFORMATION

Documentation showing:

- A. Very high (greater than 500 mg/dl) triglyceride (TG) levels in adult patients.
- B. Patient trial and failure (or intolerance to) both gemfibrozil and a fenofibrate preparation

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
LOVENOX

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Lovenox ® is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. Bleeding
 - b. GI bleeding
 - c. Hemophilia
 - d. heparin hypersensitivity
 - e. heparin-induced thrombocytopenia (HIT)
 - f. idiopathic thrombocytopenic purpura (ITP)
 - g. infants
 - h. neonates
 - i. porcine protein hypersensitivity
 - j. use prior/post lumbar puncture
 - k. epidural anesthesia
 - l. spinal anesthesia.
- B. If the member is taking/receiving any of the following: Mifepristone.

AGE RESTRICTIONS

Patient is greater than 18 years of age.

COVERAGE DURATION

30 days

Molina
Prior Authorization Criteria
LYRICA

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE DURATION

6 months



Molina
Prior Authorization Criteria
MULTIPLE SCLEROSIS

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE DURATION

12 months



Molina
Prior Authorization Criteria
MYOZYME

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE DURATION

12 months



Molina
Prior Authorization Criteria
NAGLAZYME

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE DURATION

Renewable every 6 months

Molina
Prior Authorization Criteria
NEUTROPENIA MEDICATIONS

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Neutropenia medications are NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. E. coli hypersensitivity
 - b. benzyl alcohol hypersensitivity
 - c. yeast hypersensitivity
 - d. neonates.

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
NEXAVAR

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

PRESCRIBER RESTRICTIONS

Hematologist/Oncologist

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
NOVANTRONE

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Mitoxantrone is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. breast-feeding
 - b. intraarterial administration
 - c. intramuscular administration
 - d. intrathecal administration
 - e. subcutaneous administration
 - f. neutropenia.

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
NOXAFIL

COVERED USES

- A. All FDA -approved indications not otherwise excluded from Part D.
- B. Also may be used for the treatment of serious fungal infections caused by *Cryptococcus neoformans*, *Fusarium*, *Basidiomycetes*, *Blastomyces*, *Coccidioides*, *Histoplasma*, *Scedosporium*, and *Cryptococcus* species, in patients intolerant of, or refractory to fluconazole, itraconazole or voriconazole.

COVERAGE POLICY

Noxafil is covered for members who meet the following criteria:

- A. Approved for the treatment of oropharyngeal candidiasis in patients who have failed treatment on
 - a. Ketoconazole
 - b. Fluconazole
 - c. Itraconazole
 - d. voriconazole
- B. And for the prophylaxis of invasive *Aspergillus* and *Candida* infections in immunocompromised patients.

NON COVERAGE

Noxafil® is NOT covered for members who meet the following criteria:

- A. If the member is taking/receiving any of the following:
 - a. Astemizole
 - b. Cisapride
 - c. Ergot Alkaloids
 - d. Halofantrine
 - e. Pimozide
 - f. Quinidine
 - g. Red yeast rice
 - h. Sirolimus
 - i. Terfenadine.

AGE RESTRICTIONS

Patient is 13 years of age or older

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
ORFADIN

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

PRESCRIBER RESTRICTIONS

Therapy must be initiated and monitored by a specialist well-versed in the management of this condition.

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
OXSORALEN

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Oxsoralen is covered for members who meet the following criteria:

- A. Approved for the symptomatic control of severe, recalcitrant, disabling psoriasis not responsive to other therapy.
- B. Oxsoralen must be administered only in conjunction with a schedule of controlled doses of long wave UV radiation.

NON COVERAGE

Oxsoralen® is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. Albinism
 - b. Aphakia
 - c. Melanoma
 - d. Porphyria
 - e. skin photosensitivity disorder
 - f. systemic lupus erythematosus (SLE)
 - g. xeroderma pigmentosum
 - h. current skin burns.

REQUIRED MEDICAL INFORMATION

Melanoma has been ruled out by biopsy

COVERAGE POLICY

6 months

Molina
Prior Authorization Criteria
OXYCODONE SR/OXYCONTIN

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Oxycontin is covered for members who meet the following criteria:

- A. Approved only for QD or BID dosing, no prn use

NON COVERAGE

OxyContin® is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. paralytic ileus
 - b. intravenous administration
 - c. severe/acute asthma
 - d. respiratory depression
 - e. opioid-naive patients (doses greater than 20mg per day)
 - f. or history of substance abuse.
- B. If the patient is taking/receiving Naltrexone.

REQUIRED MEDICAL INFORMATION

Documented failure on other formulary long-acting analgesics:

- A. Methadone
- B. Morphine Sulfate ER

PRESCRIBER RESTRICTIONS

Pain management specialist or oncology

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
PASER

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Culture and Sensitivity report showing susceptibility of bacteria to Paser

COVERAGE DURATION

6 Months

Molina
Prior Authorization Criteria
PEGASYS

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Pegasys is covered for members who meet the following criteria:

- A. Combination treatment with SQ interferon and Oral Ribavirin is now the standard of care. FDA approved for treatment-naïve patients only.

NON COVERAGE

Pegasys® is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. benzyl alcohol or E. coli protein hypersensitivity
 - b. infants
 - c. neonates
 - d. intramuscular or intravenous administration
 - e. sepsis
 - f. autoimmune disease
 - g. cardiac disease
 - h. depression
 - i. history of substance abuse or severe psychiatric disorder.

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Recent CBC, hepatic function panel, and renal function lab reports indicating elevated liver enzymes, normal renal function, and documentation of baseline CBC and platelet counts are required.
- B. Recent lab report documenting elevated HCV RNA are required, along with genotype. Liver biopsy results for patients with Genotype 1.
- C. Documentation of recent screening for psychiatric disorders, particularly depression and alcohol abuse. Full psychiatric evaluation for patients with current or positive history of depression or substance abuse.

PRESCRIBER RESTRICTIONS

Request is initiated by a GI or infectious disease specialist.

COVERAGE POLICY

Initial authorization will be given for 12 weeks

Molina
Prior Authorization Criteria
PEG-INTRON

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Peg-Intron is covered for members who meet the following criteria:

- A. Combination treatment with SQ interferon and Oral Ribavirin is now the standard of care. FDA approved for treatment-naïve patients only.

NON COVERAGE

Peg-Intron® is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. benzyl alcohol or E. coli protein hypersensitivity
 - b. infants
 - c. neonates
 - d. intramuscular or intravenous administration
 - e. sepsis
 - f. autoimmune disease
 - g. cardiac disease
 - h. depression
 - i. history of substance abuse
 - j. severe psychiatric disorder.

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Recent CBC, hepatic function panel, and renal function lab reports indicating elevated liver enzymes, normal renal function, and documentation of baseline CBC and platelet counts are required.
- B. Recent lab report documenting elevated HCV RNA are required, along with genotype. Liver biopsy results for patients with Genotype 1.
- C. Documentation of recent screening for psychiatric disorders, particularly depression and alcohol abuse. Full psychiatric evaluation for patients with current or positive history of depression or substance abuse.

PRESCRIBER RESTRICTIONS

Request is initiated by a GI or infectious disease specialist.

COVERAGE DURATION

Initial authorization will be given for 12 weeks

Molina
Prior Authorization Criteria
PENLAC NAIL LACQUER

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Either a positive KOH stain, positive PAS stain (periodic acid Schiff), or positive fungal culture.
- B. Baseline LFTs indicate AST/ALT higher than 1.5xs the upper limit of normal (recent LFTs must be provided)

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
PRISTIQ

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Pristiq® is NOT covered for members who meet the following criteria:

- A. If the member is taking/receiving any of the following:
 - a. Dexfenfluramine
 - b. Duloxetine
 - c. Fenfluramine
 - d. Monoamine oxidase inhibitors (MAOIs)
 - e. Nefazodone
 - f. Phentermine
 - g. Procarbazine
 - h. St. John's Wort
 - i. Tryptophan
 - j. 5-Hydroxytryptophan
 - k. Venlafaxine.

REQUIRED MEDICAL INFORMATION

Documentation showing failure on an adequate course of treatment with Effexor XR

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
PROCRIT

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

EPO's are covered for members who meet the following criteria:

- A. Approved for the treatment of Anemia due to End Stage Renal Disease (ESRD) or Chronic Renal Failure (CRF).
- B. Prescribed for treatment of anemia associated with CRF, including both patients on dialysis [end-stage renal disease (ESRD)], and patients not on dialysis.
- C. Non-dialysis members with symptomatic anemia Hgb less than 10g/dL.
- D. Prescribed for treatment of anemia related to therapy with zidovudine (AZT) in HIV-infected patients.
- E. The endogenous serum erythropoietin level is less than or equal to 500 mUnits/mL.
- F. Dose of zidovudine is less than or equal to 4200 mg/week.
- G. Treatment of Anemia induced by Biologic Agents or Chemotherapy.
- H. Prescribed for treatment of anemia induced by chemotherapy or biologic agents, excluding members with a diagnosis of acute leukemia.
- I. Reduction of Allogeneic Blood Transfusion in Surgery Patients.
- J. NOT approved for the treatment of anemia in HIV-infected patients due to other factors such as iron or folate deficiency, hemolysis, or gastrointestinal bleeding.

NON COVERAGE

EPO's are not covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications
 - a. albumin hypersensitivity
 - b. benzyl alcohol hypersensitivity
 - c. hamster protein hypersensitivity
 - d. uncontrolled hypertension
 - e. hemoglobin concentration greater than 13 g/dl.

PRESCRIBER RESTRICTIONS

Prescribing physician is a hematologist, oncologist, nephrologist, or infectious disease specialist, or prescribing initiated based upon a consult with one of these specialists.

COVERAGE DURATION

Renewable every 6 months

Molina
Prior Authorization Criteria
PROMACTA

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE DURATION

1 year

Molina
Prior Authorization Criteria
PROVIGIL

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Provigil® is NOT covered for members with the following criteria:

- A. If the patient is taking/receiving any of the following:
 - a. Amphetamine
 - b. Dexmethylphenidate
 - c. Dextroamphetamine
 - d. Methylphenidate
 - e. Monoamine oxidase inhibitors (MAOIs)
 - f. Pemoline
 - g. Procarbazine.

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. If diagnosis is OSA:
 - a. A standard diagnostic nocturnal polysomnography (NPSG) test should confirm the diagnosis of OSA.
- B. If diagnosis is narcolepsy or circadian-rhythm disruption:
 - a. Documentation showing patient trial and failure on methylphenidate or amphetamine is required.

AGE RESTRICTIONS

Patient minimum age of 16 years

PRESCRIBER RESTRICTIONS

Request must come from neurology or Requesting physician must be a board certified sleep specialist, ENT, neurologist, or pulmonologist.

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
PULMICORT

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D

REQUIRED MEDICAL INFORMATION

Documentation showing:

- A. Previous trial and failure on any of the following:
 - a. Flovent
 - b. Asmanex
 - c. Qvar
 - d. Aerobid

COVERAGE DURATION

Plan Year

Molina
Prior Authorization Criteria
PULMOZYME

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

If administered via machine in the home setting, would be billable under Medicare Part B.

PRESCRIBER RESTRICTIONS

Pulmonologist

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
RANEXA

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Ranexa is covered for members who meet the following criteria:

- A. Documentation verifying the patient has tried, failed and/or been intolerant (continues to have angina that limits daily activities) to a 30-day trial of
- a. a nitrate AND either
 - b. a beta blocker OR
 - c. a calcium channel blocker. .
 - i. Nitrate:
 1. (eg. isosorbide, Isordil®, Dilatrate SR®, Monoket®, Ismo®, Imdur®, nitroglycerin, Nitro-Time®).
 - ii. Betablockers:
 1. (eg. Toprol XL®, atenolol, Coreg®, propranolol, bisprolol, metoprolol, timolol, acebutolol, nadolol, propranolol).
 - iii. Calcium Channel Blocker:
 1. (eg. amlodipine, nifedipine, nosoldipine, isradipine, diltiazem, nicardipine, felodipine, verapamil, Norvasc®, Exforge®, Caduet®, Lotrel®, Azor®).

NON COVERAGE

Ranexa® is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications:
- a. clinically significant hepatic impairment (Child-Pugh Classes A[mild], B[moderate] or C [severe]).
- B. If the patient is taking/ receiving any of the following:
- | | |
|--------------------|-----------------------------|
| a. Barbiturates | r. Miconazole |
| b. Carbamazepine | s. Nefazodone |
| c. Cerivastatin | t. Nelfinavir |
| d. Chloramphenicol | u. Nevirapine |
| e. Clarithromycin | v. Nilotinib |
| f. Conivaptan | w. Oxcarbazepine |
| g. Cyclosporine | x. Phenytoin |
| h. Dalfopristin | y. Rifabutin |
| i. Quinupristin | z. Rifampin |
| j. Delavirdine | aa. Rifapentine |
| k. Fosphenytoin | bb. Ritonavir |
| l. Imatinib | cc. Saquinavir |
| m. STI-571 | dd. St. John's Wort |
| n. Indinavir | ee. Hypericum perforatum |
| o. Isoniazid INH | ff. Voriconazole |
| p. Itraconazole | gg. On QT-prolonging drugs. |
| q. Ketoconazole | |

PRESCRIBER RESTRICTIONS

Cardiologist

Molina
Prior Authorization Criteria

12 months

COVERAGE DURATION

Molina
Prior Authorization Criteria
REGRANEX

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Regranex® is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. cresol hypersensitivity
 - b. neoplastic disease
 - c. paraben hypersensitivity.

REQUIRED MEDICAL INFORMATION

Ulcer must be less than 10cm²

PRESCRIBER RESTRICTIONS

Must be prescribed by an orthopedic surgeon, podiatrist, or endocrinologist

COVERAGE DURATION

5 months

Molina
Prior Authorization Criteria
RESTASIS

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Restasis® is NOT covered for members who meet the following criteria:

- A. If the patient has an active ocular infection.

PRESCRIBER RESTRICTIONS

Patient is under the care of an ophthalmologist, optometrist, or rheumatologist

COVERAGE DURATION

Renewable every 6 months

Molina
Prior Authorization Criteria
REVATIO

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Revatio is NOT covered for members with the following criteria:

- A. IF the patient has any of the following contraindications: current therapy with organic nitrates or known hypersensitivity to sildenafil.

AGE RESTRICTIONS

Pediatric (less than 18 years of age)

PRESCRIBER RESTRICTIONS

Pulmonologist or Cardiologist

COVERAGE DURATION

4 months

Molina
Prior Authorization Criteria
REVLIMID

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Revlimid is covered for members who meet the following criteria:

- A. Treatment of multiple myeloma in combination with dexamethasone in patients who have failed to respond to at least one prior therapy such as:
 - a. stem cell transplantation
 - b. thalidomide
 - c. dexamethasone
 - d. bortezomib
 - e. melphalan
 - f. doxorubicin.

NON COVERAGE

Revlimid® is NOT covered for members with the following criteria:

- A. The patient is a female patient of child bearing age that is pregnant or has plans for pregnancy/breast-feeding.

PRESCRIBER RESTRICTIONS

Hematologist/Oncologist

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
RIBAVIRIN

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Ribavirin is covered for members who meet the following criteria:

- A. Approved for chronic Hepatitis C Virus (HCV)
- B. Combination treatment with SQ interferon and Oral Ribavirin is now the standard of care.

NON COVERAGE

Ribavirin is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. breast-feeding
 - b. hemoglobinopathy
 - c. pregnancy
 - d. renal failure or impairment
 - e. sickle cell disease
 - f. thalassemia
 - g. cardiac disease.
- B. If the member is taking didanosine.

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Recent CBC, hepatic function panel, and renal function lab reports indicating elevated liver enzymes, normal renal function (creatinine clearance greater than 50 ml/min),
- B. And documentation of baseline CBC and platelet counts are required.
- C. Recent lab report documenting elevated HCV RNA are required, along with genotype. Liver biopsy results for patients with Genotype 1.

PRESCRIBER RESTRICTIONS

Request is initiated by a GI or infectious disease specialist.

COVERAGE DURATION

Initial authorization will be given for 12 weeks

Molina
Prior Authorization Criteria
RISPERDAL CONST

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Risperdal Consta is not covered for members who meet the following criteria:

- A. If the patient is taking any of the following:
 - a. Astemizole
 - b. Bepridil
 - c. Chlorpromazine
 - d. Cisapride
 - e. Droperidol
 - f. Grepafloxacin
 - g. Halofantrine
 - h. Levomethadyl
 - i. Mesoridazine
 - j. Nilotinib
 - k. Pimozide
 - l. Probucol
 - m. Sertindole
 - n. Sparfloxacin
 - o. Terfenadine
 - p. Thioridazine.

COVERAGE DURATION

6 Months

Molina
Prior Authorization Criteria
RITUXAN

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Rituxan® is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications:
 - a. abciximab hypersensitivity
 - b. murine protein hypersensitivity.
- B. If the patient is taking/receiving any of the following:
 - a. Live vaccines.

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Documentation of baseline CBC and platelet counts are required.
- B. Recent Hepatitis B test results.

PRESCRIBER RESTRICTIONS

Hematologist/Oncologist / rheumatologist

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
ROTATEQ

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Rotateq is covered for members who meet the following criteria:

- A. Approved for use in infants to help prevent rotavirus gastroenteritis caused by the serotypes G1, G2, G3, and G4.

NON COVERAGE

RotaTeq® is NOT covered for members who meet the following criteria:

- A. A.If the medication is given by parenteral administration.
- B. If the patient is taking/receiving any of the following:
 - a. Adalimumab
 - b. Anakinra
 - c. Antineoplastic Agents
 - d. Etanercept
 - e. Immunosuppressives
 - f. Infliximab.

AGE RESTRICTIONS

Approved for use in infants between the ages of 6 and 32 weeks of age

COVERAGE DURATION

70 days



**Molina
Prior Authorization Criteria
SABRIL**

COVERED USES

FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE DURATION

Plan Year

Molina
Prior Authorization Criteria
SANCUSO

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Sancuso® is NOT covered for members who meet the following criteria:

- A. A.If the patient has any of the following contraindications:
 - a. benzyl alcohol hypersensitivity
 - b. neonate.
- B. If the patient is taking/receiving
 - a. apomorphine.

COVERAGE DURATION

1 year

Molina
Prior Authorization Criteria
SEROMYCIN

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D

COVERAGE POLICY

Seromycin® is covered for members who meet the following criteria:

- A. Patient is diagnosed with bacteria that is susceptible to Seromycin.
- B. Patient has culture and sensitivity report that shows susceptibility of bacteria to Seromycin.

NON COVERAGE

Seromycin is NOT covered for members who meet the following criteria:

- A. Patient has a seizure disorder
- B. Patient has history of major depression, anxiety, or psychosis

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Culture and Sensitivity report showing susceptibility of bacteria to Seromycin
- B. Documentation of absence of seizure disorder
- C. Documentation of absence of major depression, anxiety, or psychosis

AGE RESTRICTIONS

Patient must be 18 years old or older

COVERAGE DURATION

14 Days



Molina
Prior Authorization Criteria
SMOKING CESSATION PRODUCTS

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
SOMAVERT

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Somavert® is NOT covered for members with the following criteria:

- A. If the medications will be given by intravenous administration.
- B. If the patient has latex hypersensitivity.

PRESCRIBER RESTRICTIONS

Therapy must be initiated by an endocrinologist or other specialist well-versed in the treatment of this condition.

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
SPORANOX

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Sporanox® is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. breast-feeding
 - b. heart failure
 - c. ventricular dysfunction.
 - d. itraconazole coadministration with other drugs metabolized by CYP3A4
 - e. Renal failure
- B. If the patient is taking/receiving any of the following:
 - a. Alfuzosin
 - b. Alprazolam
 - c. Astemizole
 - d. Atorvastatin
 - e. Cerivastatin
 - f. Cisapride
 - g. Clorazepate
 - h. Conivaptan
 - i. Dofetilide
 - j. Eplerenone
 - k. Levomethadyl
 - l. Lovastatin
 - m. Midazolam
 - n. Nisoldipine
 - o. Pimozide
 - p. Quinidine
 - q. Ranolazine
 - r. Simvastatin
 - s. Terfenadine
 - t. Triazolam.

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Either a positive KOH stain, positive PAS stain (periodic acid Schiff), or positive fungal culture.
- B. Baseline LFTs indicate AST/ALT higher than 1.5xs the upper limit of normal (recent LFTs must be provided)

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
SPRYCEL

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Sprycel® is NOT covered for members who meet the following criteria:

- A. If the member is taking/receiving any of the following:
 - a. Clozapine
 - b. Sparfloxacin.

PRESCRIBER RESTRICTIONS

Hematologist/Oncologist

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
STELARA

COVERED USES

- A. All FDA approved indications not otherwise excluded from Part D

COVERAGE DURATION

Stelara is covered for members who meet the following criteria:

- A. Diagnosis of moderate to severe plaque psoriasis
 - a. Must be a candidate for phototherapy or systemic therapy
 - b. Trial/failure or intolerant to at least one corticosteroid
 - c. Trial/failure or intolerant to methotrexate
 - d. Trial/failure or intolerant to Enbrel or Humira
 - e. Must be 18 years old or older
 - f. Must have negative TB test or received treatment if tested positive

AGE RESTRICTIONS

18 years of age or older

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
STREPTOMYCIN

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D

COVERAGE POLICY

Streptomycin is covered for members who meet the following criteria:

- A. Patient is diagnosed with bacteria that is susceptible to streptomycin.
- B. Patient has culture and sensitivity report that shows susceptibility of bacteria to streptomycin.

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Culture and Sensitivity report showing susceptibility of bacteria to streptomycin
- B. Patient creatinine clearance within the past 60 days

COVERAGE DURATION

6 Months

Molina
Prior Authorization Criteria
SUPRAX

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D

COVERAGE POLICY

Suprax® is covered for members who meet the following criteria:

- A. Patient is diagnosed with bacteria that is susceptible to Suprax.
- B. Patient has culture and sensitivity report that shows susceptibility of bacteria to Suprax.
- C. For all diagnoses except gonorrhea:
 - a. Previous trial/failure to at least one first- or second-generation cephalosporine

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Culture and Sensitivity report showing susceptibility of bacteria to Suprax

COVERAGE POLICY

14 Days

Molina
Prior Authorization Criteria
SUTENT

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Sutent is covered for members who meet the following criteria:

- A. Treatment of gastrointestinal stromal tumor after disease progression on or intolerance to Gleevec and renal cell carcinoma uses

PRESCRIBER RESTRICTIONS

Hematologist/Oncologist

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
SYMLIN

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Symlin is covered for members who meet the following criteria:

- A. Therapy will only be approved for insulin-using patients with Type 1 or Type 2 Diabetes who have failed to achieve adequate glycemic control despite individualized insulin management

NON COVERAGE

Symlin® is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications: cresol hypersensitivity, gastroparesis or hypoglycemia unawareness.
- B. If the patient has poor compliance with prescribed self-blood glucose monitoring, HbA1c greater than 9%, recurrent severe hypoglycemia requiring assistance during past 6 months or if the patient requires the use of drugs that stimulate GI motility
- C. Pediatric patients

PRESCRIBER RESTRICTIONS

should be limited to physicians who specialize in diabetes management and are supported by diabetes care teams.

COVERAGE POLICY

12 months

Molina
Prior Authorization Criteria
SYNAREL

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Synarel® is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. breast-feeding
 - b. pregnancy
 - c. undiagnosed vaginal bleeding
 - d. Gonadotropin-Releasing Hormone (GnRH) analogs hypersensitivity.
- B. If the patient is taking/receiving any of the following:
 - a. Chasteberry
 - b. Chaste tree fruit
 - c. Vitex agnus-castus

AGE RESTRICTIONS

For precocious puberty patient must be 10 years old or younger

COVERAGE DURATION

6 months



**Molina
Prior Authorization Criteria
TABLOID**

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
TARCEVA

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

PRESCRIBER RESTRICTIONS

Hematologist/Oncologist

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
TARGRETIN

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Targretin® is NOT covered for members who meet the following criteria:

- A. If the patient is female and is pregnant.
- B. If the patient is taking/receiving any of the following:
 - a. Diethyltoluamide DEET
 - b. Gemfibrozil
 - c. Retinoids
 - d. Vitamin A.

PRESCRIBER RESTRICTIONS

Hematologist/Oncologist

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
TASIGNA

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Tasigna is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. Hypokalemia
 - b. Hypomagnesemia
 - c. long QT syndrome.

PRESCRIBER RESTRICTIONS

Hematologist/Oncologist

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
TERBINAFINE HCL

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Terbinafine is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. Alcoholism
 - b. breast-feeding
 - c. hepatic disease
 - d. hepatitis
 - e. jaundice.

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Either a positive KOH stain, positive PAS stain (periodic acid Schiff), or positive fungal culture.

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
TESTOSTERONE REPLACEMENT

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

testosterone products are NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. breast cancer
 - b. pregnancy
 - c. cardiac disease
 - d. hepatic disease
 - e. intravenous administration
 - f. pregnancy
 - g. prostate cancer
 - h. renal disease
 - i. soya lecithin hypersensitivity
 - j. tartrazine dye hypersensitivity.
- B. If the patient is taking/receiving any of the following:
 - a. 5-Alpha reductase inhibitors
 - b. Goserelin
 - c. Leuprolide
 - d. Saw palmetto
 - e. serenoa repens.

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
THALOMID

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Thalomid® is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications:
 - a. breast-feeding
 - b. pregnancy
 - c. neoplastic disease.

PRESCRIBER RESTRICTIONS

Hematologist/Oncologist, Infectious Disease

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
TOPAMAX

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

PRESCRIBER RESTRICTIONS

Neurologist

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
TORISEL

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Torisel® is NOT covered for members who meet the following criteria:

- A. If the patient is female and breast-feeding.
- B. If the patient is taking/receiving any of the following:
 - a. St. John's Wort
 - b. Hypericum perforatum
 - c. Grapefruit juice.

PRESCRIBER RESTRICTIONS

Hematologist/Oncologist

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
TRACLEER

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Tracleer is NOT covered for members with the following criteria:

- A. A female patient of child bearing age that is pregnant or has plans for pregnancy
- B. taking Cyclosporin A, Glyburide, or hypersensitivity to Tracleer.

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Documentation of baseline liver function tests (ALT, AST) performed prior to initiation of therapy.
- B. If member is a woman of childbearing potential:
 - a. Documentation of a baseline negative pregnancy test prior to initiation of therapy.

PRESCRIBER RESTRICTIONS

Pulmonologist or Cardiologist

COVERAGE DURATION

4 months

Molina
Prior Authorization Criteria
TRECTOR

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D

COVERAGE POLICY

Trector® is covered for members who meet the following criteria:

- A. Patient is diagnosed with bacteria that is susceptible to Trector.
- B. Patient has culture and sensitivity report that shows susceptibility of bacteria to Trector.

NON COVERAGE

Trector is NOT covered for members who meet the following criteria:

- A. Patients with hepatic encephalopathy

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Culture and Sensitivity report showing susceptibility of bacteria to Trector
- B. Documentation showing patient does NOT have encephalopathy

COVERAGE DURATION

6 Months

Molina
Prior Authorization Criteria
TRETINOIN

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Tretinoin is NOT covered for members with the following criteria:

- A. A patient with paraben hypersensitivity or retinoid hypersensitivity
- B. If the patient is taking/receiving any of the following:
 - a. Retinoids
 - b. Vitamin A.

COVERAGE POLICY

6 months

Molina
Prior Authorization Criteria
TYKERB

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Tykerb is to be used with capecitabine and is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications of capecitabine:
 - a. dihydropyridine dehydrogenase deficiency (DPD).
 - b. Renal failure
 - c. Or renal impairment.

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Documentation showing prior therapy including
 - a. an anthracycline
 - b. a taxane
 - c. and trastuzumab.

PRESCRIBER RESTRICTIONS

Hematologist/Oncologist

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
TYZEKA

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. serum aminotransferases (ALT or AST).
- B. Documentation showing previous trial and failure on
 - a. Epivir HBV
 - b. Baraclude
 - c. Hepsera.

COVERAGE DURATION

6 months



Molina
Prior Authorization Criteria
ULORIC

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D

COVERAGE DURATION

Plan Year

Molina
Prior Authorization Criteria
VFEND

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Vfend® is NOT covered for members who meet the following criteria:

- A. If the patient is taking/receiving any of the following:

- | | |
|--------------------|-------------------------|
| a. Astemizole | k. Rifabutin |
| b. Atorvastatin | l. Rifampin |
| c. Barbiturates | m. Rifapentine |
| d. Carbamazepine | n. Ritonavir |
| e. Cisapride | o. Sirolimus |
| f. Ergot Alkaloids | p. St. John's Wort |
| g. Pimozide | q. Hypericum perforatum |
| h. Quinidine | r. Terfenadine |
| i. Ranolazine | s. Vinca alkaloids. |
| j. Red Yeast Rice | |

COVERAGE DURATION

1 month

Molina
Prior Authorization Criteria
VIBATIV

COVERED USES

- A. All FDA approved indications not otherwise excluded from Part D

COVERAGE POLICY

Vibativ is covered for members who meet the following criteria:

- A. Diagnosis of suspected or confirmed methicillin resistant staph aureus and trial/failure with IV vancomycin (unless contraindicated)

REQUIRED MEDICAL INFORMATION

- A. Documentation showing trial/failure with IV vancomycin (unless contraindicated)

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
VIMPAT

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D

COVERAGE POLICY

Vimpat® is covered for members who meet the following criteria:

- A. A. Patient will receive Vimpat as an adjunctive anticonvulsant.

REQUIRED MEDICAL INFORMATION

The following copies of chart notes/laboratory reports are required:

- A. Documentation showing that Vimpat will be given as an adjunctive anticonvulsant
- B. Documentation showing that the patient has had a previous trial/failure/contraindication to two or more of the following:
 - a. Carbamazepine
 - b. Divalproex
 - c. Gabapentin
 - d. Lamotrigine
 - e. Levetiracetam
 - f. Oxcarbazepine
 - g. Phenytoin
 - h. Pregabalin
 - i. Tiagabine
 - j. Topiramate
 - k. Valproic acid
 - l. Zonisamide

AGE RESTRICTIONS

Covered for 17 years and older

COVERAGE DURATION

Plan Year

Molina
Prior Authorization Criteria
XENAZINE

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Xenazine® is NOT covered for members who meet the following criteria:

- A. A.If the patient has any of the following contraindications:
 - a. hepatic disease
 - b. torsade de pointes.
- B. If the patient is taking/receiving any of the following:
 - a. Monoamine oxidase inhibitors
 - b. Reserpine.

COVERAGE DURATION

1 year

Molina
Prior Authorization Criteria
XOLAIR

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Xolair® is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications:
 - a. hamster protein hypersensitivity
 - b. omalizumab hypersensitivity.

REQUIRED MEDICAL INFORMATION

- A. Member has documented allergy to a perennial airborne allergen, confirmed by skin testing or in vitro activity to the allergen. Allergy tests are required to identify patients who may be candidates for Omalizumab therapy. The FDA advisory committee defines having allergic asthma as testing positive to at least one perennial aeroallergen according to either a skin test (e.g., prick/puncture test, intracutaneous test) or a blood test (e.g., RAST) and having an IgE level between 30 and 700 IU/mL.
- B. Member has an FEV1 less than 80% predicted Member has a pre-treatment serum IgE level equal to or greater than 30 IU/mL and less than or equal to 700 IU/mL.
- C. The use of Xolair® in patients with IgE levels less than 30 and greater than 700 IU/mL has not been adequately studied and should not be used.
- D. Member weighs between 30 and 150 kg (approximately 66 to 330 pounds).

AGE RESTRICTIONS

Member is 12 years of age or older

PRESCRIBER RESTRICTIONS

Requesting or administering physician is an asthma specialist (allergist, immunologist, or pulmonologist) with significant training and experience in the diagnosis and treatment of asthma and allergies

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
XYREM

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Xyrem® is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications:
 - a. Alcoholism
 - b. breast-feeding
 - c. coma
 - d. eclampsia
 - e. ethanol intoxication
 - f. pregnancy
 - g. succinic semialdehyde dehydrogenase deficiency
 - h. CNS Depression
 - i. Depression
 - j. respiratory depression
 - k. respiratory insufficiency
 - l. history of substance abuse
 - m. driving or operating machinery.
- B. If the patient is taking/receiving any of the following:
 - a. Anxiolytics
 - b. Sedatives
 - c. Hypnotics
 - d. Barbiturates
 - e. Benzodiazepines
 - f. Ethanol.

AGE RESTRICTIONS

Must be older than 16 years of age

PRESCRIBER RESTRICTIONS

Request must come from neurology

COVERAGE DURATION

Renewable every three months

Molina
Prior Authorization Criteria
ZAVESCA

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Zavesca® is NOT covered for members with the following criteria:

- A. If the patient has any of the following contraindications:
 - a. Pregnancy
 - b. Labor
 - c. obstetric delivery
 - d. renal failure.
- B. The efficacy and safety of Zavesca has not been evaluated in patients with severe type 1 Gaucher disease, defined as a hemoglobin concentration below 9g/dL, a platelet count below 50 X 10⁹/L, or active bone disease.

REQUIRED MEDICAL INFORMATION

Documentation showing patient is not a candidate for enzyme replacement therapy (eg, because of constraints such as allergy, hypersensitivity, or poor venous access).

PRESCRIBER RESTRICTIONS

Therapy must be initiated and monitored by a specialist well-versed in the management of this condition.

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
ZEMPLAR

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Zemplar® is NOT covered for members with the following criteria:

- A. Hypercalcemia
- B. Vitamin D toxicity
- C. Concurrent use with Vitamin D analogs.

REQUIRED MEDICAL INFORMATION

- A. Documentation to support medical necessity for the use of Zemplar requires:
 - a. baseline serum PTH
 - b. calcium and phosphate levels.
- B. To initiate Zemplar therapy the patient must meet the following criteria:
 - a. Initial therapy:
 - i. Intact Parathyroid Hormone (iPTH) greater than 240 pg/ml or (greater than 4 times the upper limit of normal)
 - ii. AND Corrected serum calcium less than 10.5 mg/dl
 - iii. AND Corrected Ca X P less than 70
 - iv. AND Failure or contraindication of Rocaltrol/Calcijex/Hectorol oral or injection therapy by: Demonstrating iPTH levels greater than 180 pg/mL (greater than 3 times the upper limit) despite adequate therapy
 - v. OR Developing hypercalcemia (serum calcium greater than 11.5 mg/dl) despite adequate therapy and discontinuance of calcium based phosphate binders. Maintenance therapy (renewals): Intact Parathyroid Hormone (iPTH) greater than 120 pg/ml or 2 times upper limit
 - vi. AND Corrected serum calcium less than 11.5 mg/dl
 - vii. AND Corrected Ca X P less than 75

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
ZENAPAX

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

NON COVERAGE

Zenapax is NOT covered for members who meet the following criteria:

- A. If the patient has any of the following contraindications: murine protein hypersensitivity or infection.

COVERAGE DURATION

12 months

Molina
Prior Authorization Criteria
ZOLINZA

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE DURATION

6 months

Molina
Prior Authorization Criteria
ZYMAR

COVERED USES

FDA approved indications

- A. All FDA approved indications not otherwise excluded from Part D.

COVERAGE POLICY

Zymar is covered for members who meet the following criteria:

- A. Approved for treatment of
 - a. bacterial keratitis
 - b. Endophthalmitis
 - c. prophylaxis for ocular surgeries:

COVERAGE DURATION

Renewable every month

Molina Prior Authorization Criteria

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