

## UCare Prior Authorization Criteria for Medicare Part D

Note: 1) The criteria listed are the minimum to approve coverage for purposes of utilization management. In all cases it is expected that drugs will be used in conformity with FDA guidance regarding dosage, contraindications, warnings and clinical monitoring even though these are not included in the criteria. 2) "Treatment Failure" means that an accepted treatment has been tried for a reasonable time and has either not been tolerated or has not produced a satisfactory clinical response.

DRUGS	PRIOR AUTHORIZATION CRITERIA
<b>Actiq (fentanyl)</b>	Approve 12 months of therapy with Actiq if the following criteria have been met: <ol style="list-style-type: none"> <li>1. The patient has a diagnosis of cancer or other terminal pain; AND</li> <li>2. The patient is opioid tolerant (has been on morphine 60mg/day, fentanyl patch 25mcg/hr, oxycodone 30mg/day, hydromorphone 8mg/day or an equianalgesic dose of another opioid for a week or longer).</li> </ol>
<b>Androgel and Androderm (testosterone)</b>	Approve 12 months of therapy with Androgel or Androderm if the following criteria have been met: <ol style="list-style-type: none"> <li>1. Testosterone replacement therapy in males for conditions associated with a deficiency or absence of endogenous testosterone:               <ol style="list-style-type: none"> <li>a) Hypogonadism (congenital or acquired) – testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals. These men usually have low serum testosterone levels and gonadotropins (FSH, LH) above the normal range; OR</li> <li>b) Hypogonadotropic hypogonadism (congenital or acquired) – idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. These men have low testosterone serum levels but have gonadotropins in the normal or low range.</li> </ol> </li> </ol>
<b>Avonex or Rebif (interferon beta-1a)</b>	Approve 12 months of therapy with Avonex or Rebif if the following criteria have been met: <ol style="list-style-type: none"> <li>1. The patient has a diagnosis of relapsing-remitting multiple sclerosis; OR</li> <li>2. The patient has a diagnosis of secondary progressive multiple sclerosis and is currently taking Avonex or Rebif.</li> </ol>
<b>Betaseron (interferon beta-1b)</b>	Approve 12 months of therapy with Betaseron if the following criteria have been met: <ol style="list-style-type: none"> <li>1. The patient has a diagnosis of relapsing-remitting multiple sclerosis; OR</li> <li>2. The patient has a diagnosis of secondary progressive multiple sclerosis and is currently taking Betaseron.</li> </ol>

<b>Byetta (exenatide)</b>	<p>Approve 12 months of therapy with Byetta if the following criteria have been met:</p> <ol style="list-style-type: none"> <li>1. The patient has a diagnosis of Type 2 diabetes mellitus; AND</li> <li>2. The patient has received treatment with metformin (alone or in combination with a sulfonylurea or thiazolidinedione) and failed to achieve adequate glycemic control; OR</li> <li>3. The patient has received treatment with a sulfonylurea (alone or in combination with metformin) and failed to achieve adequate glycemic control; OR</li> <li>4. The patient has received treatment with a thiazolidinedione (alone or in combination with metformin) and failed to achieve adequate glycemic control; OR</li> <li>5. All three of the above classes of medications (metformin, sulfonylurea, thiazolidinedione) are contraindicated for this patient (e.g., due to drug interactions or because the patient was unable to tolerate treatment).</li> </ol>
<b>Cimzia (cerolizumab pegol)</b>	<p>Approve 12 weeks of therapy with Cimzia if the following criteria have been met:</p> <ol style="list-style-type: none"> <li>1. The patient has a diagnosis of Crohn's disease; AND</li> <li>2. The patient is 18 years of age; AND</li> <li>3. The patient is not concurrently on other TNF-blockers (Enbrel, Humira, Remicade) or Kineret; AND</li> <li>4. The member has tried corticosteroids OR corticosteroids are contraindicated OR the patient is currently on corticosteroids (to avoid increasing the corticosteroid dose).</li> </ol> <p>Approve 12 months of therapy with Cimzia if the following criteria have been met:</p> <ol style="list-style-type: none"> <li>1. The patient has a diagnosis of Crohn's disease; AND</li> <li>2. The patient is 18 years of age; AND</li> <li>3. The patient is not concurrently on other TNF-blockers (Enbrel, Humira, Remicade) or Kineret; AND</li> <li>1. The patient responded to the first 12 weeks of therapy Or the patient is already in remission and Cimzia is being added to maintain remission.</li> </ol>
<b>Copaxone (glatiramer)</b>	<p>Approve 12 months of therapy with Copaxone if the following criteria have been met:</p> <ol style="list-style-type: none"> <li>1. The patient has a diagnosis of relapsing-remitting multiple sclerosis; OR</li> <li>2. The patient has a diagnosis of secondary progressive multiple sclerosis.</li> </ol>
<b>Enbrel (etanercept)</b>	<p>Approve 12 months of therapy with Enbrel if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The patient has a diagnosis of one of the following: juvenile rheumatoid arthritis (JRA), rheumatoid arthritis (RA), psoriatic arthritis, ankylosing spondylitis (AS) or plaque psoriasis; AND</li> <li>2. The patient is at least 18 years of age for any diagnosis other than juvenile arthritis; AND</li> <li>3. For a patient with arthritis, the patient has tried and failed at least one of the following: leflunomide (Arava), hydroxychloroquine (Plaquenil), methotrexate, sulfasalazine (Azulfidine), d-penicillamine</li> </ol>

	<p>(Cuprimine), or azathioprine (Imuran) OR the patient is currently taking methotrexate; OR</p> <p>4. For a patient with a diagnosis of plaque psoriasis, the patient has tried at least one antipsoriatic therapy (e.g., topical steroids, PUVA).</p>
<b>Forteo (teriparatide)</b>	<p>Approve 12 months of therapy (1 syringe per 28 days) with Forteo if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The patient is at least 18 years of age; AND</li> <li>2. The patient has a T score for bone density below -2.5 with microarchitectural deterioration; OR</li> <li>3. The patient has a history of osteoporotic fracture; OR</li> <li>4. The patient has multiple risk factors for fracture.</li> <li>5. The patient has tried and failed conventional therapy. Conventional therapies include treatment with: raloxifene (Evista), alendronate (Fosamax), risedronate (Actonel), ibandronate (Boniva) and calcitonin (Fortical, Miacalcin).</li> </ol> <p>Note – The maximum duration of treatment is 2 years.</p>
<b>Humira (adalimumab)</b>	<p>Approve 12 months of therapy with Humira if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The patient has a diagnosis of one of the following: juvenile rheumatoid arthritis (JRA), rheumatoid arthritis (RA), psoriatic arthritis, ankylosing spondylitis (AS), plaque psoriasis, or Crohn’s disease; AND</li> <li>2. The patient is at least 18 years of age for any diagnosis other than juvenile arthritis; AND</li> <li>3. For a patient with arthritis, the patient has tried and failed at least one of the following: leflunomide (Arava), hydroxychloroquine (Plaquenil), methotrexate, sulfasalazine (Azulfidine), d-penicillamine (Cuprimine), or azathioprine (Imuran); OR</li> <li>4. For a patient with a diagnosis of plaque psoriasis, the patient has tried at least one antipsoriatic therapy (e.g., topical steroids, PUVA); OR</li> <li>5. For patient’s with Crohn’s disease, the patient has had an inadequate response to conventional therapy OR a loss of response to or inability to tolerate infliximab (Remicade).</li> </ol>
<b>Kineret (anakinra)</b>	<p>Approve 12 months of therapy with Kineret if the following criteria are met:</p> <ol style="list-style-type: none"> <li>1. The patient has a diagnosis of rheumatoid arthritis; AND</li> <li>2. The patient is at least 18 years of age; AND</li> <li>3. The patient has tried and failed at least one of the following: leflunomiide (Arava), hydroxychloroquine (Plaquenil), methotrexate, sulfasalazine (Azulfidine), d-penicillamine (Cuprimine), or azathioprine (Imuran).</li> </ol>

<b>Lotronex (alosectron)</b>	Approve 12 months of therapy for Lotronex if the following criteria have been met: <ol style="list-style-type: none"> <li>1. The treating physician has enrolled in the GlaxoSmithKline prescribing program for Lotronex; AND</li> <li>2. The patient has a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS); AND</li> <li>3. The patient has tried and failed conventional therapy.</li> </ol>
<b>Provigil (modafinil)</b>	Approve 12 months of therapy with Provigil if the following criteria are met: <ol style="list-style-type: none"> <li>1. The patient has a diagnosis of excessive daytime sleepiness due to narcolepsy; OR</li> <li>1. The patient has a diagnosis of obstructive sleep apnea/hypopnea syndrome; OR</li> <li>2. The patient has a shift work sleep disorder; OR</li> <li>3. The patient has severe fatigue associated with multiple sclerosis.</li> </ol>
<b>Revatio (sildenafil)</b>	Approve 12 months of therapy for Revatio if the following criteria is met: <ol style="list-style-type: none"> <li>1. The patient has a diagnosis of pulmonary arterial hypertension (PAH) (WHO Group 1).</li> </ol>
<b>Tretinoins</b>	Approve 12 months of therapy with tretinoin if the following criteria are met: <ol style="list-style-type: none"> <li>1. The patient has a diagnosis of acne vulgaris OR acne rosacea OR actinic keratosis.</li> </ol>
<b>Xolair (omalizumab)</b>	Approve 12 months of therapy with Xolair for patients who meet the following criteria: <ol style="list-style-type: none"> <li>1. The patient is at least 12 years of age; AND</li> <li>2. The patient has a diagnosis of moderate to severe persistent asthma; AND</li> <li>3. The patient has had a positive skin test or <i>in vitro</i> reactivity to a perennial aeroallergen; AND</li> <li>4. The patient has been inadequately controlled with inhaled corticosteroids; AND</li> <li>5. The patient's baseline IgE serum level is between 30 and 700 IU/mL.</li> </ol>
<b>Zyvox (linezolid)</b>	Approve a one time course of therapy with Zyvox if the following criteria are met: <ol style="list-style-type: none"> <li>1. Therapy was initiated in an institutional setting and additional drug is required to complete therapy; OR</li> <li>2. Culture and sensitivity testing demonstrate that the bacteria are susceptible to Zyvox AND <ol style="list-style-type: none"> <li>a) The patient experienced a failure on alternative antimicrobial therapy OR</li> <li>b) The patient has an intolerance, allergy or contraindication to alternative antimicrobial therapies.</li> </ol> </li> </ol>