

PROTOCOL V

Subject: Drug Prior Authorization (PA)

Effective Date: 04/00, Revised Date: 08/05, Revised 04/06, Revised 12/06, Revised 2/08, Revised 4/09, Revised 3/10

Neighborhood Health Partnership's pharmacy benefit manager is UnitedHealth Pharmaceutical Solutions, which uses Medco Health Solutions, Inc. (Medco) for certain pharmacy benefit services. In order to promote appropriate utilization, NHP requires a PA for selected medications dispensed through the pharmacy (prescription drug benefit) and/or incident to a physician's service (medical benefit) to be eligible for coverage. PA criteria have been established with input from physicians and consideration of current medical literature. The PA list and criteria are dynamic and reflect the P&T Committee's review and responsiveness to the needs of plan members and network physicians. For a plan member to receive coverage for a medication requiring PA, the physician must provide clinical information to Medco. (if the medication is to be dispensed by a participating pharmacy), or to NHP UM (if the medication is to be provided incident to a physician's service). PA does not guarantee coverage. The following is the list of medications which require PA, in addition to infusions and chemotherapeutic agents, regardless of the indication.

DRUG NAME	CRITERIA	PA THROUGH PBM DRUG AVAILABLE AT PHARMACY	PA THROUGH NHP DRUG AVAILABLE AT PHYSICIAN OFFICE ONLY
Actiq (fentanyl)	Coverage is provided only for the management of breakthrough cancer pain in patients with malignancies who are already receiving and who are tolerant to opioid therapy, for their underlying persistent cancer pain.	X	
Alpha Interferons and Ribavarin	Coverage is provided for a broad range of indications such as chronic hepatitis, hairy cell leukemia, and non- Hodgkins lymphoma	X	
Alferon	Coverage is provided for intralesional treatment of refractory or recurring external condylomata acuminata in patients 18 years of age or older		X
Amevive	Coverage is provided for treatment of adults with moderate to severe plaque psoriasis		X
Amitiza (requires PA eff. 04/08)		X	
Avodart	Coverage is provided for males with benign prostatic hyperplasia	X	
Botox Dysport Myobloc	Coverage is provided for treatment of cervical dystonia, strabismus and blepharospasm associated with dystonia, spasmodic dystonia (laryngeal dystonia), hand dystonia (writer's, musician's or typist's cramp), hand tremor, voice tremor, cerebral palsy associated spasticity, stroke associated spasticity, multiple sclerosis associated spasticity, chronic anal fissures, achalasia, hyperhidrosis, piriformis syndrome, hemifacial spasm, sialorrhea, detrusor-sphincter dyssynergia, and oromandibular dystonia.		X

DRUG NAME	CRITERIA	PA THROUGH PBM DRUG AVAILABLE AT PHARMACY	PA THROUGH NHP DRUG AVAILABLE AT PHYSICIAN OFFICE ONLY
Celebrex	Coverage is provided for patients who have tried and failed three generic NSAIDs	X	
Cerezyme	Coverage is provided for Enzyme Replacement		X
Diflucan	Coverage is provided for one course of treatment for onychomycosis. Unlimited courses of treatment for any other fungal infection	X	
Differin	Coverage is provided for the treatment of acne vulgaris or actinic keratoses for patients greater than age 25	X	
Enbrel	Coverage is provided for treatment of moderately to severely active rheumatoid arthritis. Treatment of psoriatic arthritis and ankylosing spondylitis. Treatment of moderate to severe plaque psoriasis.	X	
Epogen, Procrit, Aranesp	Coverage is provided for the diagnosis of anemia associated with chronic renal failure; HIV-infected patients with diagnosis of anemia; diagnosis of malignancy where anemia is due to the effect of chemotherapy or a complication of the cancer and the patient is not receiving chemotherapy	X If dispensed through pharmacy	X If administered through MD office
Fentora	Coverage is provided only for the management of breakthrough cancer pain in patients with malignancies who are already receiving and who are tolerant to opioid therapy, for their underlying persistent cancer pain.	X	
Ferrelecit	Coverage is provided for the treatment of iron deficiency in patients undergoing hemodialysis and receiving supplemental erythropoietin therapy	X	

<p>Growth Hormones (Somatropin)</p> <p>Increlex</p> <p>Serostim</p> <p>Zorbtive</p>	<p>Coverage is provided for the treatment of documented growth hormone deficiency, including pediatric growth hormone deficiency and adult growth hormone deficiency syndrome, and other disorders affecting growth in children, including gonadal dysgenesis, growth failure secondary to chronic renal failure/insufficiency in children who have not received a renal transplant, Prader-Willi syndrome, and growth failure in children born small for gestational age</p> <p>Coverage is provided in situations where the patient is being treated for severe primary IGF-1 deficiency or with growth hormone gene deletion who have developed neutralizing antibodies to growth hormone.</p> <p>Coverage is provided for the treatment of wasting associated with AIDS</p> <p>Covered is provided for treatment of short bowel syndrome.</p>	<p>X</p>	
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DRUG NAME	CRITERIA	PA THROUGH PBM DRUG AVAILABLE AT PHARMACY	PA THROUGH NHP DRUG AVAILABLE AT PHYSICIAN OFFICE ONLY
Humira	Coverage is provided to reduce the signs and symptoms and inhibit the progression of structural damage in adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response to DMARDs when prescribed by a rheumatologist	X	
Kineret	Coverage is provided for treatment of moderately to severely active rheumatoid arthritis, in patients 18 years of age or older who have failed one or more disease modifying antirheumatic drugs (DMARDs).	X	
Lamisil	Coverage is provided for one course of treatment for onychomycosis. Unlimited courses of treatment for any other fungal infection	X	
Lotronex	Coverage is provided for treatment of severe diarrheapredominant irritable bowel syndrome, when the patient is female at least 18 years old and has failed conventional therapy.	X	
Neupogen/ Neulasta	Coverage is provided for treatment of neutropenia and in bone marrow transplantation	X If dispensed through pharmacy	X If administered through MD office
Proton Pump Inhibitors (Tier 3 brands)	Coverage is provided for patients who have tried and failed Tier 2 brands	X	
Prolastin	Coverage is provided for a diagnosis of congenital alpha 1-antitrypsin deficiency with emphysema		X
Proscar	Coverage is provided for males with benign prostatic hyperplasia	X	
Provigil	Coverage is provided for narcolepsy, idiopathic hypersomnolence, multiple sclerosis-related fatigue, and shift work disorder	X	
Raptiva	Coverage is provided for treatment of chronic plaque psoriasis in adults	X	
Regranex	Coverage is provided for the treatment of lower extremity diabetic neuropathic ulcers	X	
Remicade Orencia	Coverage is provided for the treatment of moderate to severe rheumatoid arthritis (RA), rapidly advancing, progressive RA, moderate to severe psoriatic arthritis, moderate to severe Crohn's disease, fistulizing Crohn's disease, ankylosing spondylitis, and ulcerative colitis		X

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Restasis	Coverage is provided for treatment of keratoconjunctivitis sicca or for corneal inflammatory conditions where the use of extemporaneously compounded cyclosporine ophthalmic preparations would be required	X	
Retin A, Avita	Coverage is provided for treatment of medical skin conditions (e.g., treatment of acne vulgaris, actinic keratoses, precancerous skin lesion). PA required for patients >25 years.	X	
Revatio	Coverage is provided for treatment of pulmonary arterial hypertension	X	
Stimulants amphetamine salts (Adderall/Adderall methylphenidate (Ritalin/Ritalin SR/Ritalin LA, Concerta, Metadate CD/Metadate ER), dextroamphetamine (Dexedrine), methamphetamine (Dexosyn), dexmethylphenidate (Focalin), atomoxetine (Strattera)	Coverage is provided for treatment of attention deficit hyperactivity disorder, narcolepsy and idiopathic somnolence, fatigue associated with multiple sclerosis, and refractory depression.	X	
Synvisc, Synvisc-One, Euflexxa, Othovisc Hyalgan & Supartz	Coverage is provided for mild to moderate osteoarthritis not responsive to analgesics or other conservative therapy. Patient must not be markedly obese or have large effusions. Only approved for osteoarthritis of the knees List as preferred Buy and Bill or Specialty Pharmacy Required to go through Specialty Pharmacy		X
Synagis & Respigam	Coverage is provided for RSV		X
Sporanox	Coverage is provided for one course of treatment for onychomycosis. Unlimited courses of treatment for any other fungal infection	X	

Suboxene/Subutex (requires PA eff. 04/08)		X	
Tazorac	Coverage is provided for treatment of plaque psoriasis and acne vulgaris	X	
Tracleer	Coverage is provided for treatment of pulmonary arterial hypertension	X	
DRUG NAME	CRITERIA	PA THROUGH PBM DRUG AVAILABLE AT PHARMACY	PA THROUGH NHP DRUG AVAILABLE AT PHYSICIAN OFFICE ONLY
Ventavis	Coverage is provided for treatment of pulmonary arterial hypertension	X	
Wellbutrin SR	Coverage is provided for treatment of depression	X	
Wellbutrin XL	Coverage is provided for treatment of depression	X	
Xolair	Coverage is provided for treatment of moderate to severe persistent asthma in adults and adolescents who have a positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids	X	
Zavesca	Coverage is provided for treatment of adult patients with mild to moderate type I Gaucher disease for whom enzyme replacement therapy is not a therapeutic option	X	
Zoladex	Coverage is provided for treatment of prostate cancer, endometriosis and advanced breast cancer	X	
Zyvox	Coverage is provided for treatment of infections caused by susceptible strains of Vancomycin-Resistant Enterococcus faecium; nosocomial pneumonia caused by Staphylococcus aureus, or Streptococcus pneumoniae; complicated skin and skin structure infections, including diabetic foot infections, without concomitant osteomyelitis, caused by Staphylococcus aureus, Streptococcus pyogenes, or Streptococcus agalactiae; uncomplicated skin and skin structure infections caused by Staphylococcus aureus (methicillin-susceptible only) or Streptococcus pyogenes; community-acquired pneumonia caused by Streptococcus pneumoniae, or Staphylococcus aureus (methicillin-susceptible strains only).	X	

**Note: Not intended as claims coverage guidelines*

**Drugs which are considered to be self-injectable are not covered in the physician's office*

Medco Drug PA Requests

Medco Drug PA Requests

Telephone: (800)753-2851

Fax: (800)837-0959

(all fax requests are responded to in 24 hours)

NHP Drug PA Requests

Telephone: (877)488-5576

Fax: (800)731-6984

