

Prior Authorization Requirements

Effective: 11/01/2016

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ALECTINIB

DRUG NAME

ALECENSA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

POSITIVE FOR ANAPLASTIC LYMPHOMA KINASE (ALK) FUSION ONCOGENE

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

BELEODAQ (S)

DRUG NAME

BELEODAQ

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PERIPHERAL T-CELL LYMPHOMA AND PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO AT LEAST ONE PRIOR THERAPY (E.G., CONVENTIONAL CHEMOTHERAPY)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

CABOMETYX

DRUG NAME

CABOMETYX

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PATIENT HAS RECEIVED PRIOR ANTIANGIOGENIC THERAPY (E.G., SUTENT (SUNITINIB), VOTRIENT (PAZOPANIB), INLYTA (AXITINIB), NEXAVAR (SORAFENIB))

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

CORLANOR (S)

DRUG NAME

CORLANOR

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

SICK SINUS SYNDROME, SINOATRIAL BLOCK OR 3RD DEGREE AV BLOCK, UNLESS A FUNCTIONING DEMAND PACEMAKER IS PRESENT. RESTING HEART RATE LESS THAN 60 BPM PRIOR TO TREATMENT.

REQUIRED MEDICAL INFORMATION

LEFT VENTRICULAR EJECTION FRACTION (LVEF), ELECTROCARDIOGRAM (ECG)

AGE RESTRICTIONS

NONE

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PATIENT DOES NOT HAVE A DEMAND PACEMAKER THAT IS SET TO A RATE OF 60 BEATS PER MINUTE OR GREATER. PATIENT IS CURRENTLY BEING TREATED WITH OR HAS A CONTRAINDICATION TO ONE OF THE FOLLOWING BETA-BLOCKERS: METOPROLOL SUCCINATE, BISOPROLOL, OR CARVEDILOL.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

COSENTYX (S)

DRUG NAME

COSENTYX (2 SYRINGES) | COSENTYX PEN (2 PENS)

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECT THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PLAQUE PSORIASIS: ACHIEVED OR MAINTAINED CLEAR OR MINIMAL DISEASE OR A DECREASE IN PSORIASIS AREA AND SEVERITY INDEX (PASI) OF AT LEAST 50% OR MORE. PSORIATIC ARTHRITIS (PSA): RENEWAL: PATIENT HAS EXPERIENCED OR MAINTAINED A 20% OR GREATER IMPROVEMENT IN TENDER JOINT COUNT OR SWOLLEN JOINT COUNT WHILE ON THERAPY. ANKYLOSING SPONDYLITIS: RENEWAL CRITERIA: PATIENT HAS EXPERIENCED OR MAINTAINED AN IMPROVEMENT OF AT LEAST 50% OR 2 UNITS (SCALE OF 1 TO 10) IN THE BATH ANKYLOSING SPONDYLITIS DISEASE ACTIVITY INDEX (BASDAI).

AGE RESTRICTIONS

18 YEARS AND OLDER

PRESCRIBER RESTRICTIONS

THERAPY PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST

COVERAGE DURATION

INITIAL: 4 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

FOR MODERATE TO SEVERE PLAQUE PSORIASIS: TRIAL WITH HUMIRA AND ENBREL. RENEWAL REQUIRES THAT THE PATIENT HAS ACHIEVED CLEAR OR

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

MINIMAL DISEASE OR A DECREASE IN PASI (PSORIASIS AREA AND SEVERITY INDEX) OF AT LEAST 50% OR MORE. INITIAL PSA: PREVIOUS TRIAL WITH HUMIRA AND AT LEAST ONE OF THE FOLLOWING DMARDS (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENTS SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. INITIAL ANKYLOSING SPONDYLITIS: PREVIOUS TRIAL WITH HUMIRA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

COTELLIC (S)

DRUG NAME

COTELLIC

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

DAKLINZA

DRUG NAME

DAKLINZA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

NONE

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

COVERAGE DURATION

12 WEEKS OR 24 WEEKS (BASED ON FDA APPROVED INDICATIONS AND AASLD TREATMENT GUIDELINES)

OTHER CRITERIA

GUIDELINE CRITERIA ARE BASED ON AMERICAN ASSOCIATION FOR THE STUDY OF LIVER DISEASES AND INFECTIOUS DISEASE SOCIETY OF AMERICA (AASLD/IDSA) TREATMENT GUIDELINES AND BEST AVAILABLE EVIDENCE. NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). APPROVAL REQUIRES PATIENT HAS EVIDENCE OF HEPATITIS C INFECTION (AT LEAST 2 DETECTABLE HCV RNA LEVELS OVER THE PAST 6 MONTHS) OR PATIENT HAS AT LEAST ONE

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

DETECTABLE HCV RNA LEVEL OVER THE PAST 6 MONTHS AND HAS PREVIOUS EVIDENCE OF INFECTION (E.G., PREVIOUS PRESCRIPTION FOR TREATMENT OF HEPATITIS C). MUST BE USED IN COMBINATION WITH SOVALDI. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER) MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, OR RIFAMPIN. TREATMENT NAIVE PATIENTS WITH GENOTYPE 1 OR 3 WITHOUT CIRRHOSIS: APPROVE 12 WEEKS. TREATMENT NAIVE PATIENTS WITH GENOTYPE 2 WHO CANNOT TOLERATE RIBAVIRIN: APPROVE 12 WEEKS. TREATMENT NAIVE PATIENTS WITH GENOTYPE 1 OR 3 WITH CIRRHOSIS: 24 WEEKS. TREATMENT EXPERIENCED PATIENTS WITH GENOTYPE 1 WITHOUT CIRRHOSIS WITH PREVIOUS FAILURE OF HCV NS3 PROTEASE INHIBITOR, PREVIOUS PEGIFN/RBV FAILURE, OR PREVIOUS OLYSIO/SOVALDI FAILURE: 12 WEEKS. TREATMENT EXPERIENCED PATIENTS WITH GENOTYPE 1 AND CIRRHOSIS WITH PREVIOUS FAILURE OF HCV NS3 PROTEASE INHIBITOR, PREVIOUS PEGIFN/RBV FAILURE, OR PREVIOUS OLYSIO/SOVALDI FAILURE: 24 WEEKS. GENOTYPE 2, INTERFERON INELIGIBLE PATIENTS WITH PREVIOUS FAILURE OF SOVALDI/RBV: APPROVE 24 WEEKS. PATIENTS WITH GENOTYPE 3 WITHOUT CIRRHOSIS AND PREVIOUS FAILURE OF PEGIFN/RBV: 12 WEEKS. PATIENTS WITH GENOTYPE 3 WITH CIRRHOSIS AND PREVIOUS FAILURE OF PEGIFN/RBV: 24 WEEKS. INTERFERON INELIGIBLE PATIENTS WITH GENOTYPE 3 WITH PREVIOUS FAILURE OF SOVALDI/RBV: 24 WEEKS. INTERFERON INELIGIBILITY INCLUDES CONCURRENT DIAGNOSIS OF AUTOIMMUNE HEPATITIS OR KNOWN HYPERSENSITIVITY REACTION SUCH AS URTICARIA, ANGIOEDEMA, BRONCHOSPASM AND ANAPHYLAXIS TO ALPHA INTERFERONS OR ANY COMPONENT OF THE PRODUCT, DOCUMENTATION OF DEPRESSION, DECOMPENSATED HEPATIC DISEASE, A BASELINE NEUTROPHIL COUNT BELOW 1500 PER MICROLITER, A BASELINE PLATELET COUNT BELOW 90,000, OR A BASELINE HEMOGLOBIN BELOW 10G/DL THAT HAS NOT RESPONDED TO TREATMENT.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

DARZALEX (S)

DRUG NAME

DARZALEX

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

CONCURRENT THERAPY WITH A PROTEASOME INHIBITOR AND AN IMMUNOMODULATORY AGENT

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ELBASVIR/GRAZOPREVIR

DRUG NAME

ZEPATIER

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

MODERATE TO SEVERE LIVER IMPAIRMENT (CHILD PUGH B OR C)

REQUIRED MEDICAL INFORMATION

HCV RNA LEVEL. FOR GENOTYPE 1A TESTING FOR NS5A RESISTANCE-ASSOCIATED POLYMORPHISMS.

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

COVERAGE DURATION

12 WEEKS TO 16 WEEKS BASED ON THE AASLD TREATMENT GUIDANCE.

OTHER CRITERIA

GUIDELINE CRITERIA ARE BASED ON AMERICAN ASSOCIATION FOR THE STUDY OF LIVER DISEASES AND INFECTIOUS DISEASE SOCIETY OF AMERICA (AASLD/IDSA) TREATMENT GUIDELINES AND BEST AVAILABLE EVIDENCE. NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). APPROVAL REQUIRES PATIENT HAS EVIDENCE OF HEPATITIS C INFECTION (AT LEAST 2 DETECTABLE

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

HCV RNA LEVELS) OVER THE PAST 6 MONTHS OR PATIENT HAS AT LEAST ONE DETECTABLE HCV RNA LEVEL OVER THE PAST 6 MONTHS AND HAS PREVIOUS EVIDENCE OF INFECTION (E.G., PREVIOUS PRESCRIPTION FOR TREATMENT OF HEPATITIS C). PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: PHENYTOIN, CARBAMAZEPINE, RIFAMPIN, EFAVIRENZ, ATAZANAVIR, DARUNAVIR, LOPINAVIR, SAQUINAVIR, TIPRANAVIR, CYCLOSPORINE, NAFCILLIN, KETOCONAZOLE, MODAFINIL, BOSENTAN, ETRAVIRINE, ELVITEGRAVIR/COBICISTAT/EMTRICITABINE/TENOFOVIR, ATORVASTATIN AT DOSES ABOVE 20MG PER DAY OR ROSUVASTATIN AT DOSES GREATER THAN 10MG PER DAY. NO CONCURRENT USE WITH SOVALDI.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

EMPLICITI (S)

DRUG NAME

EMPLICITI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ENTRESTO (S)

DRUG NAME

ENTRESTO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

CONCURRENT USE OF ANGIOTENSIN-CONVERTING ENZYME INHIBITORS [ACEI] (BENAZEPRIL, CAPTOPRIL, ENALAPRIL, FOSINOPRIL, LISINOPRIL, MOEXIPRIL, PERINDOPRIL, QUINAPRIL, RAMIPRIL, TRANDALOPRIL) OR ANGIOTENSIN II RECEPTOR BLOCKERS [ARB] (SUCH AS OLMESARTAN, VALSARTAN, CANDESARTAN, IRBESARTAN, LOSARTAN, TELMISARTAN). NO PRIOR HISTORY OF ANGIOEDEMA RELATED TO ACEI OR ARB THERAPY.

REQUIRED MEDICAL INFORMATION

LEFT VENTRICULAR EJECTION FRACTION (LVEF)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

MUST HAVE LEFT VENTRICULAR EJECTION FRACTION (LVEF) OF 40% OR LESS. PREVIOUS HEART FAILURE TREATMENT WITH ANGIOTENSIN-CONVERTING ENZYME INHIBITORS [ACEI] (BENAZEPRIL, CAPTOPRIL, ENALAPRIL, FOSINOPRIL, LISINOPRIL, MOEXIPRIL, PERINDOPRIL, QUINAPRIL, RAMIPRIL, TRANDALOPRIL) OR ANGIOTENSIN II RECEPTOR BLOCKERS [ARB] SUCH AS OLMESARTAN, VALSARTAN, CANDESARTAN, IRBESARTAN, LOSARTAN, TELMISARTAN.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

EPCLUSA

DRUG NAME

EPCLUSA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDS A GUIDANCE.

EXCLUSION CRITERIA

CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDS A GUIDANCE. NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED BY THE MANUFACTURER: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, HIV REGIMEN THAT CONTAINS EFAVIRENZ, ROSUVASTATIN AT DOSES ABOVE 10MG, TIPRANA VIR/RITONA VIR OR TOPOTECAN. PATIENT MUST NOT HAVE SEVERE RENAL IMPAIRMENT, ESRD OR ON HEMODIALYSIS

REQUIRED MEDICAL INFORMATION

HCV RNA LEVEL.

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

COVERAGE DURATION

CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDS A GUIDANCE.

OTHER CRITERIA

CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDS A GUIDANCE.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ESBRIET

DRUG NAME

ESBRIET

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

PATIENT WITH USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

NOT APPROVED FOR PATIENTS WITH KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, AND CANCER). NOT APPROVED IF THE PATIENT HAS NOT OBTAINED LIVER FUNCTION TESTS. NOT APPROVED IF THE PATIENT CURRENTLY SMOKE CIGARETTES.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

EXJADE (S)

DRUG NAME

JADENU

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. MYELODYSPLASTIC SYNDROME IN A PATIENT WITH LOW OR INTERMEDIATE-1 DISEASE OR IS A POTENTIAL TRANSPLANT PATIENT AND WHO HAS RECEIVED MORE THAN 20 RED BLOOD CELL TRANSFUSIONS.

EXCLUSION CRITERIA

CREATININE CLEARANCE LESS THAN 40 ML/MINUTE. PLATELET COUNT LESS THAN 50 X 10⁹/L. POOR PERFORMANCE STATUS. SEVERE (CHILD-PUGH CLASS C) HEPATIC IMPAIRMENT. HIGH-RISK MYELODYSPLASTIC SYNDROMES. ADVANCED MALIGNANCIES. GASTROINTESTINAL ULCERATION OR HEMORRHAGE.

REQUIRED MEDICAL INFORMATION

PATIENT HAS A DIAGNOSIS OF ONE OF THE FOLLOWING: A) CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS AND PATIENT HAS A BASELINE FERRITIN LEVEL MORE THAN 1,000 MCG/L AND THE PATIENT HAS REQUIRED THE TRANSFUSION OF AT LEAST 100 ML/KG PACKED RED BLOOD CELLS OR B) CHRONIC IRON OVERLOAD DUE TO NON-TRANSFUSION-DEPENDENT THALASSEMIA (NTDT) AND LIVER IRON CONCENTRATION (LIC) IS 5 MG OF IRON PER GRAM OF LIVER DRY WEIGHT (MG FE/G DW) OR HIGHER AND SERUM FERRITIN LEVEL IS GREATER THAN 300 MCG/L OR C) MYELODYSPLASTIC SYNDROME (MDS) AND THE PATIENT HAS LOW OR INTERMEDIATE-1 DISEASE OR IS A POTENTIAL TRANSPLANT PATIENT AND PATIENT HAS RECEIVED MORE THAN 20 RED BLOOD CELL TRANSFUSIONS

AGE RESTRICTIONS

2 YEARS OF AGE OR OLDER FOR CHRONIC IRON OVERLOAD DUE TO TRANSFUSIONS. 10 YEARS OF AGE OR OLDER FOR CHRONIC IRON OVERLOAD DUE TO NTDT

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

NTDT - 6 MONTHS. TRANSFUSION-DEPENDENT ANEMIA, MDS - 12 MONTHS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

OTHER CRITERIA

FOR RENEWAL OF CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS AND MDS, THE EXPERIENCED A REDUCTION IN SERUM FERRITIN LEVEL OR LIC. FOR RENEWAL OF CHRONIC IRON OVERLOAD DUE TO NTDT, PATIENT HAS LIC 3 MG FE/G DW OR HIGHER AND PATIENT EXPERIENCED A REDUCTION IN SERUM FERRITIN LEVEL OR LIC.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

FARYDAK (S)

DRUG NAME

FARYDAK

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL AND RENEWAL: 24 WEEKS EACH (48 WEEKS TOTAL)

OTHER CRITERIA

RENEWAL: PATIENT HAS TOLERATED THE FIRST 8 CYCLES OF THERAPY WITHOUT UNRESOLVED SEVERE OR MEDICALLY SIGNIFICANT TOXICITY.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

GLYXAMBI (S)

DRUG NAME

GLYXAMBI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

END STAGE RENAL DISEASE (ESRD), CURRENTLY REQUIRING DIALYSIS.

REQUIRED MEDICAL INFORMATION

THE MEMBER HAS A DIAGNOSIS OF TYPE 2 DIABETES MELLITUS AND HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO METFORMIN OR METFORMIN-CONTAINING PRODUCTS.

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS EXPERIENCED AN IMPROVEMENT IN HEMOGLOBIN A1C (HBA1C) WITH THERAPY.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

IBRANCE (S)

DRUG NAME

IBRANCE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ICLUSIG (S)

DRUG NAME

ICLUSIG

COVERED USES

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
CHRONIC MYELOGENOUS LEUKEMIA IN PATIENTS WITH THE T315I MUTATION.**

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CHRONIC MYELOGENOUS LEUKEMIA (CML) AND PATIENT HAS TRIED AND FAILED OR HAS AN INTOLERANCE TO TWO FIRST-LINE TYROSINE KINASE INHIBITORS OR DIAGNOSIS OF CML AND THE PATIENT HAS A KNOWN T315I MUTATION OR DIAGNOSIS OF PHILADELPHIA CHROMOSOME-POSITIVE ACUTE LYMPHOBLASTIC LEUKEMIA AND THE PATIENT HAS TRIED AND FAILED OR HAD AN INTOLERANCE TO TWO PREVIOUS TYROSINE KINASE INHIBITORS.

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

INVOKAMET (S)

DRUG NAME

INVOKAMET

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

RENAL IMPAIRMENT (ESTIMATED GLOMERULAR FILTRATION RATE [EGFR] LESS THAN 45 ML/MIN/1.73 M2), END STAGE RENAL DISEASE (ESRD), CURRENTLY REQUIRING DIALYSIS, METABOLIC KETOACIDOSIS (INCLUDING DIABETIC KETOACIDOSIS), ELEVATED SERUM CREATININE: 1.5 MG/DL OR HIGHER IN MALES OR 1.4 MG/DL OR HIGHER IN FEMALES.

REQUIRED MEDICAL INFORMATION

THE PATIENT HAS A DIAGNOSIS OF TYPE 2 DIABETES MELLITUS AND HAS HAD AN INADEQUATE RESPONSE TO DIET AND EXERCISE ALONE AND THE PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE TO METFORMIN OR METFORMIN-CONTAINING PRODUCTS

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS EXPERIENCED AN IMPROVEMENT IN HEMOGLOBIN A1C (HBA1C) WITH THERAPY. NOTE: MEMBERS WITH AN EGFR OF 45 TO LESS THAN 60 ML/MIN/1.73 M2 WILL BE APPROVED FOR THE 50 MG CANAGLIFLOZIN STRENGTHS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

IRESSA (S)

DRUG NAME

IRESSA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

JARDIANCE (S)

DRUG NAME

JARDIANCE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

RENAL IMPAIRMENT (ESTIMATED GLOMERULAR FILTRATION RATE [EGFR] LESS THAN 45 ML/MIN/1.73 M2), END STAGE RENAL DISEASE (ESRD), CURRENTLY REQUIRING DIALYSIS, DIABETIC KETOACIDOSIS

REQUIRED MEDICAL INFORMATION

THE PATIENT HAS A DIAGNOSIS OF TYPE 2 DIABETES MELLITUS AND HAS HAD AN INADEQUATE RESPONSE TO DIET AND EXERCISE ALONE AND THE PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO METFORMIN OR METFORMIN-CONTAINING PRODUCTS

AGE RESTRICTIONS

18 YEARS OR AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS EXPERIENCED AN IMPROVEMENT IN HEMOGLOBIN A1C (HBA1C) WITH THERAPY.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

KANUMA

DRUG NAME

KANUMA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

**BLOOD TEST OR DRIED BLOOD SPOT TEST INDICATING LOW OR ABSENT
LYSOSOMAL ACID LIPASE DEFICIENCY (LAL) ENZYME ACTIVITY, OR A GENETIC
TEST INDICATING THE PRESENCE OF ALTERED LIPA GENE(S)**

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

KEVEYIS

DRUG NAME

KEVEYIS

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

HEPATIC INSUFFICIENCY, PULMONARY OBSTRUCTION, OR A HEALTH CONDITION THAT WARRANTS CONCURRENT USE OF HIGH-DOSE ASPIRIN

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

18 YEARS AND OLDER

PRESCRIBER RESTRICTIONS

PRESCRIPTION IS WRITTEN BY OR CURRENTLY SUPERVISED BY A NEUROLOGIST

COVERAGE DURATION

INITIAL: 2 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

LENVIMA (S)

DRUG NAME

LENVIMA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

LONSURF

DRUG NAME

LONSURF

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTIONS

N/A

PRESCRIBER RESTRICTIONS

N/A

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

N/A

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

LYNPARZA

DRUG NAME

LYNPARZA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

NATPARA (S)

DRUG NAME

NATPARA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

NINLARO (S)

DRUG NAME

NINLARO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

NUCALA

DRUG NAME

NUCALA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

CONCURRENT USE OF XOLAIR

REQUIRED MEDICAL INFORMATION

BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE LAST 6 WEEKS OR GREATER THAN OR EQUAL TO 300 CELLS/MCL WITHIN THE LAST 12 MONTHS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY MEDICINE

COVERAGE DURATION

INITIAL 24 WEEKS. RENEWAL 12 MONTHS

OTHER CRITERIA

INITIAL THERAPY: PATIENT CURRENTLY TREATED WITH A MAXIMALLY TOLERATED DOSE OF INHALED CORTICOSTEROIDS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION WHICH INCLUDES ANY OF THE FOLLOWING: LONG-ACTING INHALED BETA2-AGONIST, LONG-ACTING MUSCARINIC ANTAGONIST, A LEUKOTRIENE RECEPTOR ANTAGONIST, THEOPHYLLINE, OR ORAL CORTICOSTEROID. RENEWAL REQUIRES DOCUMENTATION THAT THE PATIENT HAS EXPERIENCED AT LEAST A 25 PERCENT REDUCTION IN ASTHMA EXACERBATIONS (FOR EXAMPLE, HOSPITALIZATIONS, URGENT OR EMERGENT CARE VISITS, USE OF RESCUE MEDICATIONS, ETC.) FROM BASELINE AND A

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

REDUCTION IN ORAL CORTICOSTEROID DOSE (IF THE PATIENT WAS ON A MAINTENANCE REGIMEN OF ORAL CORTICOSTEROIDS AT THE INITAITON OF TREATMENT).



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

OBETICHOLIC ACID

DRUG NAME

OCALIVA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

PATIENTS WITH COMPLETE BILIARY OBSTRUCTION.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ODOMZO

DRUG NAME

ODOMZO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

BASELINE SERUM CREATINE KINASE (CK) AND SERUM CREATININE LEVELS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ORKAMBI (S)

DRUG NAME

ORKAMBI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS. BASELINE FEV1

AGE RESTRICTIONS

12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A PLUMONOLOGIST OR CF EXPERT

COVERAGE DURATION

INITIAL: 6 MONTHS RENEWAL: 12 MONTHS

OTHER CRITERIA

INITIAL: BASELINE FEV1 OF AT LEAST 40%. NOT CONCURRENTLY TAKING KALYDECO THERAPY. STABLE DISEASE AS DEFINED BY PREVIOUS OR CURRENT TREATMENT WITH ANOTHER AGENT USED IN THE TREATMENT OF CYSTIC FIBROSIS. RENEWAL: MAINTAINED OR IMPROVEMENT IN FEV1 OR BODY MASS INDEX (BMI) OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

PA BVD ORAL CORTICOSTEROID

DRUG NAME

**CORTEF | CORTISONE ACETATE | DEXAMETHASONE | DEXAMETHASONE INTENSOL |
HYDROCORTISONE | MEDROL | METHYLPREDNISOLONE | MILLIPRED | ORAPRED
ODT | PREDNISOLONE SODIUM PHOS ODT | PREDNISOLONE SODIUM PHOSPHATE |
PREDNISONONE | PREDNISONONE INTENSOL | RAYOS | VERIPRED 20**

COVERED USES

**THIS DRUG MAY BE COVERED UNDER MEDICARE DEPENDING UPON THE
CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE
USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.**

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

PA_BVDONLY

DRUG NAME

ABELCET | ABRAXANE | ACETYLCYSTEINE | ACYCLOVIR SODIUM | ADRUCIL | AKYNZEO | ALBUTEROL SULFATE | ALIMTA | ALKERAN | AMBISOME | AMIFOSTINE | AMINO ACIDS | AMINOPHYLLINE | AMINOSYN II | AMINOSYN II WITH ELECTROLYTES | AMINOSYN M | AMINOSYN WITH ELECTROLYTES | AMINOSYN-HBC | AMINOSYN-PF | AMINOSYN-RF | AMIODARONE HCL | AMMONIUM CHLORIDE | AMPHOTERICIN B | AMPICILLIN SODIUM | AMPICILLIN-SULBACTAM | ANZEMET | ARRANON | ASTAGRAF XL | ATGAM | AVELOX IV | AZACTAM-ISO-OSMOTIC DEXTROSE | AZASAN | AZATHIOPRINE | BACIIM | BACITRACIN | BETHKIS | BICNU | BLEOMYCIN SULFATE | BROVANA | BUDESONIDE | BUSULFEX | CALCITRIOL | CAMPTOSAR | CANCIDAS | CARBOPLATIN | CARNITOR | CARNITOR SF | CEFAZOLIN SODIUM | CEFAZOLIN SODIUM-DEXTROSE | CEFOXITIN | CEFOXITIN SODIUM | CEFTRIAZONE | CEFUROXIME SODIUM | CELLCEPT | CHLORAMPHENICOL SOD SUCCINATE | CHLOROTHIAZIDE SODIUM | CIDOFOVIR | CIPRO I.V. | CIPROFLOXACIN | CIPROFLOXACIN-D5W | CISPLATIN | CLADRIBINE | CLEOCIN PHOSPHATE IN D5W | CLINDAMYCIN PHOSPHATE | CLINDAMYCIN PHOSPHATE-D5W | CLINIMIX | CLINIMIX E | CLINISOL | CLOLAR | COLISTIMETHATE | COSMEGEN | CROMOLYN SODIUM | CUBICIN | CYCLOPHOSPHAMIDE | CYCLOSPORINE | CYCLOSPORINE MODIFIED | CYKLOKAPRON | CYTARABINE | CYTOVENE | DACARBAZINE | DALVANCE | DAUNORUBICIN HCL | DEPACON | DEXRAZOXANE | DEXTROSE 10%-0.2% NACL | DEXTROSE 10%-0.45% NACL | DEXTROSE 2.5%-0.45% NACL | DEXTROSE 5%-0.2% NACL | DEXTROSE 5%-0.2% NACL-KCL | DEXTROSE 5%-0.225% NACL | DEXTROSE 5%-0.225% NACL-KCL | DEXTROSE 5%-0.33% NACL | DEXTROSE 5%-0.33% NACL-KCL | DEXTROSE 5%-0.45% NACL | DEXTROSE 5%-0.45% NACL-KCL | DEXTROSE 5%-0.9% NACL | DEXTROSE 5%-1/2NS-KCL | DEXTROSE 5%-NS-KCL | DEXTROSE 5%-POTASSIUM CHLORIDE | DEXTROSE IN LACTATED RINGERS | DEXTROSE IN WATER | DIHYDROERGOTAMINE MESYLATE | DILTIAZEM HCL | DOCETAXEL | DORIBAX | DOXERCALCIFEROL | DOXIL | DOXORUBICIN HCL | DOXORUBICIN HCL LIPOSOME | DURAMORPH | ELITEK | ELLENCE | EMEND | ENGERIX-B ADULT | ENGERIX-B PEDIATRIC-ADOLESCENT | ENVARUS XR | EPIRUBICIN HCL | ERAXIS (WATER DILUENT) | ERWINAZE | ERYTHROCIN LACTOBIONATE | ESOMEPRAZOLE SODIUM | ETOPOPHOS | FAMOTIDINE | FASLODEX | FLUCONAZOLE-NACL | FLUDARABINE PHOSPHATE | FLUOROURACIL | FOMEPIZOLE | FREAMINE HBC | GABLOFEN | GANCICLOVIR SODIUM | GEMCITABINE HCL | GEMZAR | GENGRAF | GENTAMICIN SULFATE | GRANISETRON HCL | H.P. ACTHAR | HECTOROL | HEPARIN SODIUM | HEPARIN SODIUM IN 0.45% NACL | HEPARIN SODIUM-D5W | HEPATAMINE | HYCAMTIN | IDAMYCIN PFS |

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

IDARUBICIN HCL | IFEX | IFOSFAMIDE | IMIPENEM-CILASTATIN SODIUM | IMOVAX
RABIES VACCINE | IMURAN | INTRALIPID | INVANZ | IONOSOL B WITH DEXTROSE 5%
| IONOSOL MB-DEXTROSE 5% | IPRATROPIUM BROMIDE | IPRATROPIUM-
ALBUTEROL | ISOLYTE P WITH DEXTROSE | ISOLYTE S | KEPIVANCE | LABETALOL
HCL | LACTATED RINGERS | LEVALBUTEROL CONCENTRATE | LEVALBUTEROL HCL
| LEVETIRACETAM | LEVOCARNITINE | LEVOFLOXACIN-D5W | LIDOCAINE |
LINCOCIN | LINCOMYCIN HCL | LINEZOLID | LIORESAL INTRATHECAL |
MELPHALAN HCL | MEROPENEM | MERREM | MESNA | MESNEX | METHOTREXATE |
METRONIDAZOLE | MIACALCIN | MITOMYCIN | MOXIFLOXACIN | MUSTARGEN |
MYCAMINE | MYCOPHENOLATE MOFETIL | MYCOPHENOLIC ACID | MYFORTIC |
NAFCILLIN | NAFCILLIN SODIUM | NEBUPENT | NEORAL | NEPHRAMINE | NEXIUM I.V.
| NIPENT | NITROGLYCERIN | NORMOSOL-M AND DEXTROSE | NORMOSOL-R AND
DEXTROSE | NORMOSOL-R PH 7.4 | NUTRILIPID | OCTAGAM | ONCASPAR |
ONDANSETRON HCL | ONDANSETRON ODT | OXACILLIN | OXALIPLATIN |
PACLITAXEL | PAMIDRONATE DISODIUM | PARICALCITOL | PENICILLIN GK-ISO-
OSM DEXTROSE | PERFOROMIST | PIPERACILLIN-TAZOBACTAM | PLASMA-LYTE 148
| PLASMA-LYTE 56 IN DEXTROSE | PLASMA-LYTE A PH 7.4 | POLYMYXIN B SULFATE |
POTASSIUM CHL-NORMAL SALINE | POTASSIUM CHLORIDE | POTASSIUM CHLORIDE
IN D5LR | POTASSIUM CHLORIDE-NACL | PREMARIN | PREMASOL | PRIMAXIN |
PROCALAMINE | PROGRAF | PROLEUKIN | PROPRANOLOL HCL | PROSOL |
PULMICORT | RABAVERT | RAPAMUNE | RECOMBIVAX HB | RIFADIN | RIFAMPIN |
RINGERS INJECTION | ROCALTROL | SANCUSO | SANDIMMUNE | SIMULECT |
SIROLIMUS | SODIUM CHLORIDE | SODIUM DIURIL | SODIUM LACTATE |
SULFAMETHOXAZOLE-TRIMETHOPRIM | SYNERCID | TACROLIMUS | TAXOTERE |
TEFLARO | THYMOGLOBULIN | TOBI | TOBRAMYCIN | TOBRAMYCIN SULFATE |
TOPOSAR | TOPOTECAN HCL | TPN ELECTROLYTES II | TRANEXAMIC ACID |
TRAVASOL | TREANDA | TREXALL | TRISENOX | TROPHAMINE | TWINRIX | TYGACIL |
UNASYN | VALPROATE SODIUM | VANCOMYCIN HCL | VARUBI | VERAPAMIL HCL |
VFEND IV | VIMPAT | VINBLASTINE SULFATE | VINCASAR PFS | VINCRISTINE
SULFATE | VINOURELBINE TARTRATE | VIRAZOLE | VORICONAZOLE | XOPENEX |
XOPENEX CONCENTRATE | ZANOSAR | ZEMPLAR | ZINACEF | ZINECARD | ZOFRAN |
ZOFRAN ODT | ZOSYN | ZUPLLENZ | ZYVOX

COVERED USES

THIS DRUG MAY BE COVERED UNDER MEDICARE DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

PIMAVANSERIN

DRUG NAME

NUPLAZID

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL 12 MONTHS. RENEWAL 12 MONTHS.

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

PRALUENT

DRUG NAME

PRALUENT PEN | PRALUENT SYRINGE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST

COVERAGE DURATION

INITIAL: 3 MONTHS RENEWAL 12 MONTHS

OTHER CRITERIA

MUST HAVE AN LDL CHOLESTEROL LEVEL GREATER THAN 100MG/DL ON MAXIMAL DRUG TREATMENT FOR AT LEAST 3 MONTHS AND ONE OF THE FOLLOWING DIAGNOSES: (1) HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH) DETERMINED BY SIMON BROOME DIAGNOSTIC CRITERIA FOR HEFH OR A SCORE OF 6 OR GREATER ON THE DUTCH LIPID NETWORK CRITERIA FOR HEFH OR (2) ASCVD AS SUBSTANTIATED BY PHYSICIAN ATTESTATION. PATIENT MUST NOT HAVE HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA DIAGNOSIS. PATIENT MUST NOT HAVE CONCURRENT USE OF REPATHA OR OTHER PCSK9 AGENT. INITIAL THERAPY: FOR STATIN TOLERANT PATIENTS: MUST BE TAKING THE FOLLOWING FOR AT LEAST 3 MONTHS1) MAXIMUM TOLERATED DOSE OF ANY STATIN WITH DOCUMENTATION OF FAILURE. PATIENT MUST INTEND TO CONTINUE MAXIMAL STATIN ONCE PRALUENT IS STARTED. FOR STATIN INTOLERANT PATIENTS: MUST HAVE

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

DOCUMENTATION OF STATIN FAILURE OR INTOLERANCE. PATIENTS WITH CONTRAINDICATIONS TO STATINS INCLUDING ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT OR HYPERSENSITIVITY REACTIONS WILL BE APPROVED FOR PRALUENT THERAPY WITHOUT REQUIREMENT OF DOCUMENTATION OF STATIN INTOLERANCE. DOCUMENTATION OF STATIN FAILURE OR INTOLERANCE MUST BE PROVIDED BY PRESCRIBER. RENEWAL CRITERIA: RECEIVING PRIOR PRALUENT THERAPY FOR AT LEAST 12 WEEKS AND NO CLAIMS FOR REPATHA, JUXTAPID, OR KYNAMRO SINCE PRALUENT APPROVAL.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

REPATHA

DRUG NAME

REPATHA PUSHTRONEX | REPATHA SURECLICK | REPATHA SYRINGE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

HEFH OR ASCVD: 18 YEARS OF AGE AND OLDER.HOFH: 13 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTIONS

CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST

COVERAGE DURATION

INITIAL: 3 MONTHS RENEWAL 12 MONTHS

OTHER CRITERIA

FOR HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH) OR ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD): MUST HAVE LDL LEVEL GREATER THAN 100MG/DL ON MAXIMAL DRUG TREATMENT (MDT) FOR AT LEAST 3 MONTHS AND A DIAGNOSIS OF ONE OF THE FOLLOWING: (1) HEFH DETERMINED BY SIMON BROOME DIAGNOSTIC (SBD) CRITERIA OR A SCORE OF 6 OR GREATER ON THE DUTCH LIPID NETWORK (DLN) OR (2) ASCVD AS SUBSTANTIATED BY PHYSICIAN ATTESTATION. FOR HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HOFH): GENETIC CONFIRMATION OR A CLINICAL DIAGNOSIS BASED ON A HISTORY OF AN UNTREATED LDL-C CONCENTRATION GREATER THAN 500 MG/DL TOGETHER WITH EITHER XANTHOMA BEFORE 10 YEARS OF AGE OR EVIDENCE OF HEFH IN BOTH PARENTS. NO CONCURRENT USE OF OTHER PCSK9 INHIBITORS. INITIAL THERAPY: FOR STATIN TOLERANT PTS:

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

TAKING MAXIMALLY TOLERATED DOSE (MTD) OF ANY STATIN. FOR STATIN INTOLERANT PTS WITH HEFH OR ASCVD: MUST HAVE DOCUMENTATION OF STATIN FAILURE OR INTOLERANCE PROVIDED BY PRESCRIBER. PTS WITH CONTRAINDICATIONS TO STATINS INCLUDING ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT OR HYPERSENSITIVITY REACTIONS WILL BE APPROVED FOR REPATHA THERAPY WITHOUT DOCUMENTED STATIN INTOLERANCE. FOR STATIN INTOLERANT PTS WITH HOFH: MUST HAVE DOCUMENTATION OF STATIN FAILURE OR INTOLERANCE PROVIDED BY PRESCRIBER. PATIENT MUST INTEND TO CONTINUE ON CURRENT LIPID-LOWERING THERAPY, WITH THE EXCEPTION OF JUXTAPID AND KYNAMRO, ONCE REPATHA IS STARTED. RENEWAL CRITERIA: RECEIVING PRIOR REPATHA THERAPY FOR AT LEAST 12 WKS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SIGNAFOR LAR (S)

DRUG NAME

SIGNIFOR LAR

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PATIENT WITH DIAGNOSIS OF ACROMEGALY WHO HAVE HAD AN INADEQUATE RESPONSE TO SURGERY AND/OR FOR WHOM SURGERY IS NOT AN OPTION.

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT WITH DIAGNOSIS OF ACROMEGALY WHO HAVE HAD AN INADEQUATE RESPONSE TO SURGERY AND/OR FOR WHOM SURGERY IS NOT AN OPTION

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

STRENSIQ

DRUG NAME

STRENSIQ

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SYNJARDY

DRUG NAME

SYNJARDY

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

RENAL IMPAIRMENT (ESTIMATED GLOMERULAR FILTRATION RATE [EGFR] LESS THAN 45 ML/MIN/1.73 M2), END STAGE RENAL DISEASE (ESRD), CURRENTLY REQUIRING DIALYSIS, DIABETIC KETOACIDOSIS.

REQUIRED MEDICAL INFORMATION

THE MEMBER HAS A DIAGNOSIS OF TYPE 2 DIABETES MELLITUS AND HAS HAD AN INADEQUATE RESPONSE TO DIET AND EXERCISE ALONE AND THE MEMBER HAS TRIED AND HAD AN INADEQUATE RESPONSE TO METFORMIN OR METFORMIN-CONTAINING PRODUCTS.

AGE RESTRICTIONS

18 YEARS OR AGE OR OLDER.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS.

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS EXPERIENCED AN IMPROVEMENT IN HEMOGLOBIN A1C (HBA1C) WITH THERAPY.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TAGRISSO (S)

DRUG NAME

TAGRISSO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TALTZ

DRUG NAME

TALTZ AUTOINJECTOR | TALTZ SYRINGE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PLAQUE PSORIASIS: ACHIEVED OR MAINTAINED CLEAR OR MINIMAL DISEASE OR A DECREASE IN PSORIASIS AREA AND SEVERITY INDEX (PASI) OF AT LEAST 50% OR MORE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PLAQUE PSORIASIS (PSO): THERAPY PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.

COVERAGE DURATION

INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TECENTRIQ

DRUG NAME

TECENTRIQ

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TECHNIVIE (S)

DRUG NAME

TECHNIVIE

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

CIRRHOSIS, MODERATE OR SEVERE LIVER IMPAIRMENT (CHILD-PUGH B OR C)

REQUIRED MEDICAL INFORMATION

NONE

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

COVERAGE DURATION

12 WEEKS

OTHER CRITERIA

GUIDELINE CRITERIA ARE BASED ON AMERICAN ASSOCIATION FOR THE STUDY OF LIVER DISEASES AND INFECTIOUS DISEASE SOCIETY OF AMERICA (AASLD/IDSA) TREATMENT GUIDELINES AND BEST AVAILABLE EVIDENCE. NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). APPROVAL REQUIRES PATIENT HAS EVIDENCE OF HEPATITIS C INFECTION (AT LEAST 2 DETECTABLE HCV RNA LEVELS OVER THE PAST 6 MONTHS) OR PATIENT HAS AT LEAST ONE

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

DETECTABLE HCV RNA LEVEL OVER THE PAST 6 MONTHS IF PATIENT HAS PREVIOUS EVIDENCE OF INFECTION (E.G., PREVIOUS PRESCRIPTION FOR TREATMENT OF HEPATITIS C). MUST BE USED CONCURRENTLY WITH RIBAVIRIN UNLESS PATIENT IS TREATMENT NADVE AND HAS CONTRAINDICATION TO RIBAVIRIN. NO PRIOR USE (FAILURE OF A FULL COURSE OF THERAPY) OR CONCURRENT USE OF ANY HCV PROTEASE INHIBITOR SUCH AS OLYSIO (SIMPREVIR), VICTRELIS (BOCEPREVIR) OR INCIVEK (TELAPREVIR) OR ANY NS5B POLYMERASE INHIBITOR INCLUDING SOVALDI (SOFOSBUVIR) OR ANY NS5B POLYMERASE INHIBITOR/NS5A INHIBITOR SUCH AS HARVONI (LEDIPASVIR/SOFOSBUVIR) OR USE OF VIEKIRA PAK. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER): ALFUZOSIN, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, RIFAMPIN, ERGOTAMINE DIHYDROERGOTAMINE, ERGONOVINE, METHYLERGONOVINE, ETHINYL ESTRADIOL CONTAINING MEDICATIONS (SUCH AS COMBINED ORAL CONTRACEPTIVES, NUVARING, ORTHO EVRA OR XULANE TRANSDERMAL PATCH SYSTEM), LOVASTATIN, SIMVASTATIN, PIMOZIDE, EFAVIRENZ (ATRIPLA, SUSTIVA), REVATIO (SILDENAFIL DOSE OF 20MG AND/OR DOSED TID FOR PAH), TRIAZOLAM, ORAL MIDAZOLAM, LOPINAVIR/RITONAVIR, RILVIRAPINE, SALMETEROL.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

UPTRAVI

DRUG NAME

UPTRAVI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DOCUMENTED CONFIRMATORY PAH DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PREVIOUS OR CURRENT TREATMENT WITH A PHOSPHODIESTERASE-5 INHIBITOR (E.G., REVATIO [SILDENAFIL] OR ADCIRCA [TADALAFIL]) AND AN ENDOTHELIN RECEPTOR ANTAGONIST (E.G., TRACLEER [BOSENTAN], LETAIRIS [AMBRISENTAN], OR OPSUMIT [MACITENTAN]), OR A CONTRAINDICATION TO ALL OF THESE AGENTS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

VENCLEXTA

DRUG NAME

VENCLEXTA | VENCLEXTA STARTING PACK

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

VIBERZI

DRUG NAME

VIBERZI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

YONDELIS -(S)

DRUG NAME

YONDELIS

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ZYDELIG (S)

DRUG NAME

ZYDELIG

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

THE PATIENT HAS ONE OF THE FOLLOWING DIAGNOSES: A) CHRONIC LYMPHOCYTIC LEUKEMIA AND THE MEDICATION WILL BE USED IN COMBINATION WITH RITUXIMAB AND THE PATIENT HAS RELAPSED ON AT LEAST ONE PRIOR THERAPY (E.G., PURINE ANALOGUES [FLUDARABINE, PENTOSTATIN, CLADRIBINE], ALKYLATING AGENTS [CHLORAMBUCIL, CYCLOPHOSPHAMIDE], OR MONOCLONAL ANTIBODIES [RITUXIMAB]) AND THE PATIENT DOES NOT HAVE ANY CO-MORBIDITIES THAT PREVENTS THE USE OF CYTOTOXIC CHEMOTHERAPY (I.E. SEVERE NEUTROPENIA OR THROMBOCYTOPENIA, CREATININE CLEARANCE LESS THAN 60 ML/MINUTE), B) FOLLICULAR LYMPHOMA AND THE PATIENT HAS RELAPSED ON AT LEAST TWO PRIOR SYSTEMIC THERAPIES (E.G., RITUXIMAB, ALKYLATING AGENTS [CYCLOPHOSPHAMIDE, CHLORAMBUCIL], ANTHRACYCLINES [DOXORUBICIN, DAUNORUBICIN], PURINE ANALOGS [FLUDARABINE]), OR C) SMALL LYMPHOCYTIC LYMPHOMA AND THE PATIENT HAS RELAPSED ON AT LEAST TWO PRIOR SYSTEMIC THERAPIES(E.G., RITUXIMAB, ALKYLATING AGENTS [CYCLOPHOSPHAMIDE, CHLORAMBUCIL], ANTHRACYCLINES [DOXORUBICIN, DAUNORUBICIN], PURINE ANALOGS [FLUDARABINE]).

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

AAT INHIBITORS (S)

DRUG NAME

ARALAST NP | GLASSIA | PROLASTIN C | ZEMAIRA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

IGA DEFICIENCY WITH KNOWN ANTI-IGA ANTIBODY

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF EMPHYSEMA AND PATIENT HAS ALPHA-1 PROTEINASE INHIBITOR DEFICIENCY AND PATIENT HAS A HIGH-RISK PHENOTYPE (PIZZ, PIZ(NULL), PI(NULL) (NULL), OR OTHER PHENOTYPE ASSOCIATED WITH SERUM ALPHA-1 ANTITRYPSIN CONCENTRATIONS OF LESS THAN 11 UM/L (80 MG/DL) AND FEV1 LEVEL IS BETWEEN 30% AND 65% OF PREDICTED AND THE PATIENT HAS EXPERIENCED A RAPID DECLINE IN LUNG FUNCTION (I.E. REDUCTION OF FEV1 MORE THAN 120 ML/YEAR) THAT WARRANTS TREATMENT

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ACITRETIN (S)

DRUG NAME

ACITRETIN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

SEVERELY IMPAIRED LIVER OR KIDNEY FUNCTION. CHRONIC ABNORMALLY ELEVATED BLOOD LIPID VALUES. CONCOMITANT USE OF METHOTREXATE OR TETRACYCLINES. PREGNANCY. FEMALES OF CHILD-BEARING POTENTIAL WHO INTEND TO BECOME PREGNANT DURING THERAPY OR AT ANY TIME FOR AT LEAST 3 YEARS AFTER DISCONTINUING THERAPY. FEMALES OF CHILD-BEARING POTENTIAL WHO WILL NOT USE RELIABLE CONTRACEPTION WHILE UNDERGOING TREATMENT AND FOR AT LEAST 3 YEARS FOLLOWING DISCONTINUATION. FEMALES OF CHILD-BEARING POTENTIAL WHO DRINK ALCOHOL DURING TREATMENT OR FOR TWO MONTHS AFTER CESSATION OF THERAPY.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF SEVERE PSORIASIS

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ACTEMRA IV (S)

DRUG NAME

ACTEMRA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS).

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING: A) MODERATE TO SEVERE RHEUMATOID ARTHRITIS AND PATIENT HAD INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS FOR AT LEAST 3 CONSECUTIVE MONTHS, OR B) SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS AND PATIENT HAD INADEQUATE RESPONSE OR INTOLERANCE TO AT LEAST ONE ORAL SYSTEMIC AGENT (I.E. NSAID, CORTICOSTEROID) C) POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS AND PATIENT HAS HAD AN INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS FOR AT LEAST 3 CONSECUTIVE MONTHS

AGE RESTRICTIONS

RA - 18 YEARS OF AGE OR OLDER. SJIA AND PJIA - 2 YEARS OF AGE OR OLDER.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PATIENT HAS BEEN TESTED FOR TB AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED PER GUIDELINES. FOR RENEWAL, PATIENT HAS STABLE DISEASE OR HAS IMPROVED ON THERAPY (FOR RA, IMPROVEMENT IN TENDER/SWOLLEN

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

JOINT COUNT, IMPROVEMENT IN ACR SCORING. FOR SJIA, ABSENCE OF FEVER, REDUCTION IN NUMBER OF AFFECTED JOINTS, IMPROVEMENT IN FUNCTIONAL ABILITY. FOR PJIA, REDUCTION IN DISEASE FLARES, IMPROVEMENT IN ACR SCORING)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ACTEMRA SC (S)

DRUG NAME

ACTEMRA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS).

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF MODERATE TO SEVERE RHEUMATOID ARTHRITIS AND PATIENT HAD INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS FOR AT LEAST 3 CONSECUTIVE MONTHS

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PATIENT HAS BEEN TESTED FOR TB AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED PER GUIDELINES. FOR RENEWAL, PATIENT HAS STABLE DISEASE OR HAS IMPROVED ON THERAPY (FOR RA, IMPROVEMENT IN TENDER/SWOLLEN JOINT COUNT, IMPROVEMENT IN ACR SCORING)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ACTIQ (S)

DRUG NAME

ACTIQ | FENTANYL CITRATE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

MANAGEMENT OF ACUTE OR POST-OPERATIVE PAIN, INCLUDING HEADACHE/MIGRAINE, DENTAL PAIN, OR USE IN THE EMERGENCY ROOM. OPIOID NON-TOLERANT PATIENTS.

REQUIRED MEDICAL INFORMATION

PATIENT MEETS THE FOLLOWING: A) DIAGNOSIS OF CANCER AND USE IS FOR BREAKTHROUGH CANCER PAIN, B) PATIENT IS OPIOID TOLERANT AND TAKING AT LEAST 60 MG MORPHINE/DAY, AT LEAST 25 MCG TRANSDERMAL FENTANYL/HOUR, AT LEAST 30 MG OF OXYCODONE DAILY, AT LEAST 8 MG ORAL HYDROMORPHONE DAILY OR AN EQUIANALGESIC DOSE OF ANOTHER OPIOID FOR A WEEK OR LONGER, C) AT LEAST ONE OTHER FORMULARY SHORT-ACTING STRONG NARCOTIC ANALGESIC ALTERNATIVES (OTHER THAN FENTANYL) HAVE BEEN INEFFECTIVE, NOT TOLERATED, OR CONTRAINDICATED, D) PRESCRIBER AND PATIENT ARE REGISTERED IN THE TRANSMUCOSAL IMMEDIATE RELEASE FENTANYL (TIRF) RISK EVALUATION AND MITIGATION STRATEGY ACCESS PROGRAM AND FOR BRAND REQUESTS, A GENERIC TRANSMUCOSAL FENTANYL CITRATE HAS BEEN INEFFECTIVE OR NOT TOLERATED.

AGE RESTRICTIONS

16 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

NOT COVERED FOR MEMBERS ENROLLED IN A MEDICARE APPROVED HOSPICE PROGRAM

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ADAGEN (S)

DRUG NAME

ADAGEN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

SEVERE THROMBOCYTOPENIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ADENOSINE DEAMINASE (ADA) DEFICIENCY IN A PATIENT WITH SEVERE COMBINED IMMUNODEFICIENCY DISEASE (SCID) AND PATIENT IS NOT A SUITABLE CANDIDATE FOR, OR WHO HAS FAILED, BONE MARROW TRANSPLANTATION.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ADCIRCA (S)

DRUG NAME

ADCIRCA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

RECEIVING NITRATE THERAPY (INCLUDES INTERMITTENT USE)

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION WHO GROUP I WITH NEW YORK HEART ASSOCIATION (NYHA) FUNCTIONAL CLASS II OR III THAT WAS CONFIRMED BY RIGHT HEART CATHETERIZATION.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL - 6 MONTHS. RENEWAL - 12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ADEMPAS (S)

DRUG NAME

ADEMPAS

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

CONCOMITANT ADMINISTRATION WITH NITRATES OR NITRIC OXIDE DONORS (SUCH AS AMYL NITRATE) IN ANY FORM. CONCOMITANT ADMINISTRATION WITH PHOSPHODIESTERASE INHIBITORS, INCLUDING SPECIFIC PDE-5 INHIBITORS (SUCH AS SILDENAFIL, TADALAFIL, OR VARDENAFIL) OR NON-SPECIFIC PDE INHIBITORS (SUCH AS DIPYRIDAMOLE OR THEOPHYLLINE). PREGNANCY.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION WHO GROUP I WITH NEW YORK HEART ASSOCIATION FUNCTIONAL CLASS II OR III AND DIAGNOSIS WAS CONFIRMED BY RIGHT HEART CATHETERIZATION OR PATIENT HAS A DIAGNOSIS OF CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH, WHO GROUP 4) AND PATIENT HAS PERSISTENT OR RECURRENT DISEASE AFTER SURGICAL TREATMENT (E.G., PULMONARY ENDARTERECTOMY) OR HAS CTEPH THAT IS INOPERABLE AND FEMALE PATIENTS ARE ENROLLED IN THE ADEMPAS REMS PROGRAM

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS - INITIAL. 12 MONTHS - RENEWAL

OTHER CRITERIA

FOR RENEWAL, MEDICATION WAS EFFECTIVE (I.E. IMPROVED 6 MINUTE WALK DISTANCE, OXYGEN SATURATION, ETC.)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

AFINITOR (S)

DRUG NAME

AFINITOR

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ADVANCED METASTATIC RENAL CELL CARCINOMA AND PATIENT HAS FAILED THERAPY (DISEASE PROGRESSED) WITH SUTENT OR NEXAVAR OR DIAGNOSIS OF PROGRESSIVE PANCREATIC NEUROENDOCRINE TUMORS (PNET) THAT ARE UNRESECTABLE, LOCALLY ADVANCED OR METASTATIC OR DIAGNOSIS OF RENAL ANGIOMYOLIPOMA WITH TUBEROUS SCLEROSIS COMPLEX (TSC) AND PATIENT DOES NOT REQUIRE IMMEDIATE SURGERY OR DIAGNOSIS OF ADVANCED HORMONE RECEPTOR-POSITIVE, HER2-NEGATIVE BREAST CANCER AND PATIENT IS A POSTMENOPAUSAL WOMAN AND PATIENT HAS FAILED TREATMENT WITH FEMARA OR ARIMIDEX AND THE MEDICATION WILL BE USED IN COMBINATION WITH AROMASIN OR DIAGNOSIS OF SUBEPENDYMAL GIANT CELL ASTROCYTOMA (SEGA) ASSOCIATED WITH TSC THAT REQUIRES THERAPEUTIC INTERVENTION BUT IS NOT A CANDIDATE FOR CURATIVE SURGICAL RESECTION.

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER FOR RCC, PNET, AND RENAL ANGIOMYOLIPOMA WITH TSC. 1 YEAR OF AGE OR OLDER FOR SEGA

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

AFINITOR DISPERZ (S)

DRUG NAME

AFINITOR DISPERZ

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF SUBEPENDYMAL GIANT CELL ASTROCYTOMA (SEGA) ASSOCIATED WITH TUBEROUS SCLEROSIS COMPLEX (TSC) THAT REQUIRES THERAPEUTIC INTERVENTION BUT IS NOT A CANDIDATE FOR CURATIVE SURGICAL RESECTION.

AGE RESTRICTIONS

1 YEAR OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ALDURAZYME (S)

DRUG NAME

ALDURAZYME

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF HURLER OR HURLER-SCHEIE FORM OF MUCOPOLYSACCHARIDOSIS I (MPS I) OR DIAGNOSIS OF SCHEIE FORM OF MPS I WITH MODERATE TO SEVERE SYMPTOMS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

AMITIZA (S)

DRUG NAME

AMITIZA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

MECHANICAL GASTROINTESTINAL OBSTRUCTION.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF IRRITABLE BOWEL SYNDROME-CONSTIPATION FOR AT LEAST 12 NON-CONSECUTIVE WEEKS AND PATIENT HAS TRIED AND FAILED INCREASING FLUID AND FIBER INTAKE AND PATIENT HAS TRIED AND FAILED OR HAS AN INTOLERANCE TO OSMOTIC LAXATIVES, STIMULANT LAXATIVES OR PROBIOTICS AND PATIENT IS FEMALE OR DIAGNOSIS OF CHRONIC IDIOPATHIC CONSTIPATION FOR AT LEAST 3 MONTHS AND PATIENT HAS TRIED AND FAILED INCREASING FLUID AND FIBER INTAKE AND PATIENT HAS TRIED AND FAILED OR HAS AN INTOLERANCE TO OSMOTIC LAXATIVES, STIMULANT LAXATIVES OR STOOL SOFTENERS OR DIAGNOSIS OF CHRONIC OPIOID-INDUCED CONSTIPATION DUE TO NON-CANCER PAIN AND PATIENT HAS TRIED AND FAILED A STOOL SOFTENER AND A STIMULANT LAXATIVE AND PATIENT IS NOT BEING TREATED WITH METHADONE

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL - 4 MONTHS. RENEWAL - 12 MONTHS

OTHER CRITERIA

FOR RENEWAL, THE PATIENT HAS EXPERIENCED AN INCREASE IN THE NUMBER OF BOWEL MOVEMENTS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

AMPYRA (S)

DRUG NAME

AMPYRA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

HISTORY OF SEIZURE. MODERATE OR SEVERE RENAL IMPAIRMENT (CREATININE CLEARANCE LESS THAN OR EQUAL TO 50 ML/MINUTE).

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF MULTIPLE SCLEROSIS AND PATIENT IS AMBULATORY (ABLE TO WALK AT LEAST 25 FEET) AND PATIENT HAS WALKING IMPAIRMENT

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL - 3 MONTHS. RENEWAL - 12 MONTHS

OTHER CRITERIA

FOR RENEWAL, WALKING SPEED HAS IMPROVED FROM BASELINE.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

APOKYN (S)

DRUG NAME

APOKYN

COVERED USES

ALL-FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

USE WITH 5HT3-ANTAGONIST (E.G., ONDANSETRON, GRANISETRON, DOLASETRON, PALONOSETRON, ALOSETRON)

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ADVANCED PARKINSON'S DISEASE AND PATIENT IS EXPERIENCING ACUTE INTERMITTENT HYPOMOBILITY (DEFINED AS OFF EPISODES CHARACTERIZED BY MUSCLE STIFFNESS, SLOW MOVEMENTS, OR DIFFICULTY STARTING MOVEMENTS) AND THERAPY IS ADJUNCTIVE TO CONCURRENT ANTI-PARKINSON'S TREATMENT SUCH AS CARBIDOPA/LEVODOPA, PRAMIPEXOLE, ROPINIROLE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, THE PATIENT IS BENEFITTING FROM THERAPY (E.G., IMPROVEMENT IN MOTOR FUNCTION)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ARANESP (S)

DRUG NAME

ARANESP

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ANEMIA DUE TO MYELODYSPLASTIC SYNDROME.

EXCLUSION CRITERIA

UNCONTROLLED HYPERTENSION. PURE RED CELL APLASIA THAT BEGINS AFTER ESA TREATMENT.

REQUIRED MEDICAL INFORMATION

PRE-TREATMENT HEMOGLOBIN LEVEL LESS THAN 10 G/DL AND PATIENT HAS ADEQUATE IRON STORES PRIOR TO INITIATION OF THERAPY DEFINED AS FERRITIN MORE THAN 100 MCG/L OR SERUM TRANSFERRIN SATURATION GREATER THAN 20% AND OTHER CAUSES OF ANEMIA SUCH AS IRON DEFICIENCY, FOLATE DEFICIENCY OR B12 DEFICIENCY, HEMOLYSIS, GASTROINTESTINAL BLEEDING, OTHER ACTIVE OR OCCULT BLEEDING, OR UNDERLYING HEMATOLOGIC DISEASE (SUCH AS SICKLE CELL ANEMIA, THALASSEMIA, AND PORPHYRIA) HAVE BEEN RULED OUT AND DIAGNOSIS OF ONE OF THE FOLLOWING: A) ANEMIA DUE TO CHRONIC KIDNEY DISEASE (CKD) WITH OR WITHOUT HEMODIALYSIS, OR B) ANEMIA IN PATIENTS WITH NON-MYELOID MALIGNANCIES WHERE ANEMIA IS DUE TO THE EFFECT OF CONCOMITANT MYELOSUPPRESSIVE CHEMOTHERAPY AND TWO ADDITIONAL MONTHS OF CHEMOTHERAPY IS ANTICIPATED C) ANEMIA DUE TO MYELODYSPLASTIC SYNDROME (MDS) AND ENDOGENOUS SERUM ERYTHROPOIETIN LEVEL IS 500 MUNIT/ML OR LESS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

CKD - PRESCRIBED BY A NEPHROLOGIST OR HEMATOLOGIST. NON-MYELOID MALIGNANCIES, MDS - PRESCRIBED BY AN ONCOLOGIST/HEMATOLOGIST.

COVERAGE DURATION

INITIAL: 4 MONTHS. RENEWAL: CKD-12 MONTHS, NON-MYELOID MALIGNANCIES - 4 MONTHS

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

OTHER CRITERIA

FOR RENEWAL OF CKD, FOR DIALYSIS PATIENTS: HB LESS THAN 11 G/DL OR PHYSICIAN WILL DECREASE OR INTERRUPT DOSE. FOR NON-DIALYSIS PATIENTS: HB LESS THAN 10 G/DL OR PHYSICIAN WILL DECREASE OR INTERRUPT DOSE. FOR RENEWAL OF NON-MYELOID MALIGNANCIES: CONCURRENT MYELOSUPPRESSIVE CHEMOTHERAPY AND HB IS 12G/DL OR LESS AND THERE IS MEASURABLE RESPONSE AFTER EIGHT WEEKS (DEFINED AS AN INCREASE IN HB 1 G/DL OR MORE OR A REDUCTION IN RED BLOOD CELL TRANSFUSION REQUIREMENTS). FOR RENEWAL OF MDS, HB IS 12G/DL OR LESS AND THERE IS MEASURABLE RESPONSE AFTER EIGHT WEEKS (DEFINED AS AN INCREASE IN HB 1.5 G/DL OR MORE OR A REDUCTION IN RED BLOOD CELL TRANSFUSION REQUIREMENTS) OR PATIENT WILL HAVE A CONCOMITANT TRIAL OF G-CSF AND, IF PATIENT HAD CONCOMITANT TRIAL OF GRANULOCYTE COLONY-STIMULATING FACTOR (G-CSF), PATIENT HAD A MEASURABLE RESPONSE AS DEFINED ABOVE AFTER 8 WEEKS OF G-CSF THERAPY. EXCLUDED FOR ESRD PATIENTS ON DIALYSIS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ARCALYST (S)

DRUG NAME

ARCALYST

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CRYOPYRIN-ASSOCIATED PERIOD SYNDROMES (CAPS), INCLUDING FAMILIAL COLD AUTO-INFLAMMATORY SYNDROME (FCAS) AND/OR MUCKLEWELLS SYNDROME (MWS).

AGE RESTRICTIONS

12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH OR RECOMMENDATION OF, AN IMMUNOLOGIST, ALLERGIST, DERMATOLOGIST, RHEUMATOLOGIST, NEUROLOGIST, OR OTHER MEDICAL SPECIALIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT EXPERIENCED DISEASE STABILITY OR IMPROVEMENT.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

AUBAGIO (S)

DRUG NAME

AUBAGIO

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. FIRST CLINICAL EPISODE WITH MRI FEATURES CONSISTENT WITH MULTIPLE SCLEROSIS.

EXCLUSION CRITERIA

SEVERE HEPATIC IMPAIRMENT. CURRENT TREATMENT WITH LEFLUNOMIDE. PATIENTS WHO ARE PREGNANT OR WOMEN OF CHILDBEARING POTENTIAL NOT USING RELIABLE CONTRACEPTION.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF RELAPSING FORMS OF MULTIPLE SCLEROSIS (E.G., RELAPSING-REMITTING MS OR PROGRESSIVE-RELAPSING MS) OR PATIENT HAS EXPERIENCED A FIRST CLINICAL EPISODE AND HAS MRI FEATURES CONSISTENT WITH MULTIPLE SCLEROSIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS EXPERIENCED AN OBJECTIVE RESPONSE TO THERAPY (I.E. NO OR SLOWED PROGRESSION OF DISEASE)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

AVASTIN (S)

DRUG NAME

AVASTIN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

GASTROINTESTINAL PERFORATION. WOUND DEHISCENCE. SERIOUS HEMORRHAGE OR RECENT HEMOPTYSIS.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING: A) FIRST-LINE OR SECOND-LINE TREATMENT OF METASTATIC CARCINOMA OF THE COLON OR RECTUM IN COMBINATION WITH IV 5-FLUOROURACIL-BASED CHEMOTHERAPY B) SECOND-LINE TREATMENT OF METASTATIC COLORECTAL CANCER IN COMBINATION WITH FLUOROPYRIMIDINE-IRINOTECAN- OR FLUOROPYRIMIDINE-OXALIPLATIN-BASED CHEMOTHERAPY AFTER PROGRESSION ON A FIRST-LINE AVASTIN-CONTAINING REGIMEN. C) FIRST-LINE TREATMENT OF UNRESECTABLE, LOCALLY ADVANCED, RECURRENT OR METASTATIC NON-SQUAMOUS NON-SMALL CELL LUNG CANCER IN COMBINATION WITH CARBOPLATIN AND PACLITAXEL, D) GLIOBLASTOMA WITH PROGRESSIVE DISEASE FOLLOWING PRIOR THERAPY AND THE MEDICATION WILL BE USED AS A SINGLE AGENT, E) METASTATIC RENAL CELL CARCINOMA IN COMBINATION WITH INTERFERON ALFA. F.) CERVICAL CANCER, IN COMBINATION WITH PACLITAXEL AND CISPLATIN OR PACLITAXEL AND TOPOTECAN IN PERSISTENT, RECURRENT, OR METASTATIC DISEASE AND G.) FOR PLATINUM-RESISTANT RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE OR PRIMARY PERITONEAL CANCER, IN COMBINATION WITH PACLITAXEL, PEGYLATED LIPOSOMAL DOXORUBICIN OR TOPOTECAN.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

AVONEX (S)

DRUG NAME

AVONEX | AVONEX PEN

COVERED USES

ALL-FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF RELAPSING FORM OF MULTIPLE SCLEROSIS OR DIAGNOSIS OF FIRST CLINICAL EPISODE AND MRI FEATURES CONSISTENT WITH MULTIPLE SCLEROSIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS EXPERIENCED AN OBJECTIVE RESPONSE TO THERAPY (I.E. NO OR SLOWED PROGRESSION OF DISEASE)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

BARACLUDE (S)

DRUG NAME

BARACLUDE | ENTECAVIR

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CHRONIC HEPATITIS B AND PATIENT IS HBSAG-POSITIVE FOR AT LEAST 6 MONTHS AND FOR HBEAG-POSITIVE PATIENTS, SERUM HBV DNA GREATER THAN 20,000 IU/ML (105 COPIES PER ML) AND FOR HBEAG-NEGATIVE PATIENTS, SERUM HBV DNA GREATER THAN 2,000 IU/ML (104 COPIES/ML) AND PATIENT HAS EVIDENCE OF PERSISTENT ELEVATIONS IN SERUM AMINOTRANSFERASE (ALT OR AST) AT LEAST 2 TIMES THE UPPER LIMIT OF NORMAL OR HISTOLOGICALLY ACTIVE DISEASE (I.E. NECROINFLAMMATION ON BIOPSY) AND PATIENT IS RECEIVING ANTI-RETROVIRAL THERAPY IF THE PATIENT HAS HIV CO-INFECTION

AGE RESTRICTIONS

2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT MUST BE HBEAG NEGATIVE AND HAVE NOT HAD HBSAG CLEARANCE OR HBEAG POSITIVE AND HAVE DETECTABLE HBV DNA AND HAVE NOT BEEN ANTI-HBE FOR AT LEAST 6 MONTHS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

BENLYSTA (S)

DRUG NAME

BENLYSTA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

RECEIVING OTHER BIOLOGIC THERAPY OR INTRAVENOUS CYCLOPHOSPHAMIDE

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ACTIVE, AUTOANTIBODY-POSITIVE (ACCEPTABLE ASSAYS INCLUDE ANA, ANTI-DS-DNA, ANTI-SM, ETC.) SYSTEMIC LUPUS ERYTHEMATOSUS AND PATIENT IS CURRENTLY RECEIVING ONE OR MORE OF THE FOLLOWING STANDARD THERAPIES: CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, IMMUNOSUPPRESSANTS

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

BETASERON (S)

DRUG NAME

BETASERON

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF RELAPSING FORM OF MULTIPLE SCLEROSIS OR DIAGNOSIS OF FIRST CLINICAL EPISODE AND MRI FEATURES CONSISTENT WITH MULTIPLE SCLEROSIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS EXPERIENCED AN OBJECTIVE RESPONSE TO THERAPY (I.E. NO OR SLOWED PROGRESSION OF DISEASE)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

BONIVA IV (S)

DRUG NAME

BONIVA | IBANDRONATE SODIUM

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PATIENT IS A POSTMENOPAUSAL FEMALE WITH OSTEOPOROSIS AND PATIENT HAS A DOCUMENTED TRIAL AND FAILURE OF AN ORAL BISPHOSPHONATE, WHERE FAILURE IS DEFINED AS NEW FRACTURES IN COMPLIANT PATIENT ON THERAPY FOR AT LEAST 6 MONTHS, FAILURE TO PRODUCE A CLINICALLY SIGNIFICANT CHANGE IN BIOCHEMICAL MARKERS OF BONE TURNOVER, OR A SIGNIFICANT LOSS OF BONE MINERAL DENSITY ON FOLLOW-UP SCANS AFTER 12-24 MONTHS OF THERAPY OR DOCUMENTED CONTRAINDICATION OR INTOLERANCE TO ORAL BISPHOSPHONATE THERAPY OR IS UNABLE TO COMPLY WITH APPROPRIATE ADMINISTRATION RECOMMENDATIONS FOR ORAL BISPHOSPHONATE THERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

BOSULIF (S)

DRUG NAME

BOSULIF

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOGENOUS LEUKEMIA AND RESISTANCE, RELAPSE, INADEQUATE RESPONSE TO PRIOR THERAPY WITH A TYROSINE KINASE INHIBITOR (TKI) AND IF PATIENT HAD MUTATION TESTING, PATIENT DOES NOT HAVE T315I OR V299L MUTATION OR INTOLERANT TO PRIOR TKI THERAPY

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

BUPRENORPHINE/NALOXONE (S)

DRUG NAME

BUNAVAIL | BUPRENORPHINE-NALOXONE | SUBOXONE | ZUBSOLV

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PATIENT HAS A DIAGNOSIS OF OPIOID DEPENDENCE AND PRESCRIPTION IS A PART OF AN OVERALL TREATMENT PROGRAM (E.G. SELF-HELP GROUPS, COUNSELING, PROVIDE ONGOING CARE, VOCATIONAL TRAINING) AND PATIENT IS NOT RECEIVING ANY OTHER OPIOIDS SINCE STARTING THERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBER IS CERTIFIED THROUGH SAMHSA (SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION) TO PRESCRIBE SUBOXONE AND PROVIDE REGISTRATION NUMBER

COVERAGE DURATION

INITIAL - 3 MONTHS. RENEWAL - 9 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT MEETS ALL INITIAL CRITERIA.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

BUTRANS (S)

DRUG NAME

BUTRANS

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

**SIGNIFICANT RESPIRATORY DEPRESSION OR SEVERE BRONCHIAL ASTHMA.
KNOWN OR SUSPECTED PARALYTIC ILEUS.**

REQUIRED MEDICAL INFORMATION

PATIENT IS NOT IN HOSPICE CARE AND PATIENT HAS A DIAGNOSIS OF SEVERE PAIN REQUIRING CONTINUOUS, AROUND-THE-CLOCK OPIOID ANALGESIC FOR AN EXTENDED PERIOD OF TIME (AT LEAST 2 WEEKS) AND PATIENT TRIED AND FAILED, IS UNABLE TO TOLERATE TWO GENERIC EXTENDED-RELEASE OPIOID PRODUCT AND/OR OPIOID COMBINATION PRODUCT, UNLESS THE PATIENT HAS DOCUMENTED SWALLOWING DIFFICULTIES.

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

NOT COVERED FOR MEMBERS ENROLLED IN A MEDICARE APPROVED HOSPICE PROGRAM

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

CAPRELSA (S)

DRUG NAME

CAPRELSA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

CONGENITAL LONG QT SYNDROME

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF SYMPTOMATIC OR PROGRESSIVE MEDULLARY THYROID CANCER WITH UNRESECTABLE LOCALLY ADVANCED OR METASTATIC DISEASE

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

CARBAGLU (S)

DRUG NAME

CARBAGLU

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

**DIAGNOSIS OF N-ACETYL GLUTAMATE SYNTHASE (NAGS) DEFICIENCY AND
PATIENT IS EXPERIENCING EITHER ACUTE OR CHRONIC HYPERAMMONEMIA**

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

CAYSTON (S)

DRUG NAME

CAYSTON

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

**DIAGNOSIS OF CYSTIC FIBROSIS AND PATIENT HAS EVIDENCE OF P. AERUGINOSA
IN THE LUNGS**

AGE RESTRICTIONS

7 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

**FOR RENEWAL, PATIENT IS BENEFITING FROM TREATMENT (I.E. IMPROVEMENT IN
LUNG FUNCTION [FEV1], DECREASED NUMBER OF PULMONARY EXACERBATIONS)**

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

CERDELGA (S)

DRUG NAME

CERDELGA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

CEREZYME (S)

DRUG NAME

CEREZYME

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF TYPE 1 GAUCHER DISEASE

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

CESAMET (S)

DRUG NAME

CESAMET

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CHEMOTHERAPY-INDUCED NAUSEA AND VOMITING AND PATIENT HAS TRIED AND FAILED AT LEAST ONE CONVENTIONAL ANTIEMETIC TREATMENTS (E.G., APREPITANT/FOSAPREPITANT, T-HYDROXYTRIPTAMINE-3 SEROTONIN RECEPTOR ANTAGONISTS SUCH AS ONDANSETRON) AND PATIENT HAS TRIED AND FAILED DRONABINOL

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

PART B IF RELATED TO CANCER TREATMENT AND IS A FULL REPLACEMENT FOR IV ANTIEMETIC WITHIN 48 HRS OF CANCER TREATMENT. PART D IF RELATED TO CANCER TREATMENT AFTER THE 48-HOUR PERIOD, OR FOR ANY OTHER MEDICALLY ACCEPTED DIAGNOSIS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

CIALIS (S)

DRUG NAME

CIALIS

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ERECTILE DYSFUNCTION WITHOUT DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

TRIAL OF A FORMULARY ALPHA BLOCKER SUCH AS DOXAZOSIN, TERAZOSIN, OR TAMSULOSIN AND FINASTERIDE. APPLIES TO 2.5MG AND 5MG STRENGTHS ONLY.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

CIMZIA (S)

DRUG NAME

CIMZIA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS)

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING: A) MODERATE TO SEVERE RHEUMATOID ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS FOR AT LEAST 3 CONSECUTIVE MONTHS B) MODERATE TO SEVERE CROHN'S DISEASE AND PATIENT HAD AN INADEQUATE RESPONSE TO, IS INTOLERANT TO, OR IS CONTRAINDICATED TO CONVENTIONAL THERAPY WITH ONE OR MORE OF THE FOLLOWING: CORTICOSTEROIDS (I.E. PREDNISONE, METHYLPREDNISOLONE) OR NON-BIOLOGIC DMARDS (I.E. AZATHIOPRINE, METHOTREXATE, MERCAPTOPYRINE, ETC.) C) PSORIATIC ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE TO, OR CONTRAINDICATION TO METHOTREXATE D) ANKYLOSING SPONDYLITIS AND PATIENT HAD AN INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-STEROIDAL ANTI-INFLAMMATORY DRUGS

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

16 WEEKS (CD), 12 WEEKS (OTHERS). RENEWAL 12 MONTHS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

OTHER CRITERIA

PATIENT HAS BEEN TESTED FOR TB AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED. FOR RENEWAL, PATIENT HAS OBTAINED A CLINICAL RESPONSE TO THERAPY (E.G., FOR CD, SYMPTOMATIC REMISSION. FOR RA, IMPROVEMENT IN TENDER/SWOLLEN JOINT COUNT, IMPROVEMENT IN ACR SCORING. FOR PSA, IMPROVEMENT IN NUMBER OF SWOLLEN/TENDER JOINTS, PAIN, STIFFNESS. FOR AS, IMPROVEMENT IN AS SYMPTOMS, SUCH AS STIFFNESS AND BACK PAIN) OR PATIENT'S CONDITION HAS STABILIZED.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

CINRYZE (S)

DRUG NAME

BERINERT | CINRYZE | RUCONEST

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

HISTORY OF LIFE-THREATENING IMMEDIATE HYPERSENSITIVITY REACTIONS, INCLUDING ANAPHYLAXIS TO THE PRODUCT.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

CLINDAMYCIN/TRETINOIN (S)

DRUG NAME

CLINDAMYCIN PHOS-TRETINOIN | VELTIN | ZIANA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REGIONAL ENTERITIS, ULCERATIVE COLITIS, HISTORY OF ANTIBIOTIC-ASSOCIATED COLITIS

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PA APPLIES TO PATIENTS OLDER THAN 26 YEARS OF AGE

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, MEDICATION HAS BEEN EFFECTIVE IN TREATING THE PATIENT'S CONDITION.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

COMETRIQ (S)

DRUG NAME

COMETRIQ

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

GASTROINTESTINAL PERFORATION. FISTULA. SEVERE HEMORRHAGE.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PROGRESSIVE, METASTATIC MEDULLARY THYROID CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

COPAXONE (S)

DRUG NAME

COPAXONE | GLATOPA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF RELAPSING-REMITTING MULTIPLE SCLEROSIS OR DIAGNOSIS OF FIRST CLINICAL EPISODE WITH MRI FEATURES CONSISTENT WITH MULTIPLE SCLEROSIS

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS NO OR SLOWED DISEASE PROGRESSION.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

CYRAMZA (S)

DRUG NAME

CYRAMZA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

CYSTARAN (S)

DRUG NAME

CYSTARAN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PATIENT HAS A DIAGNOSIS OF CYSTINOSIS AND PATIENT HAS CORNEAL CYSTINE CRYSTAL ACCUMULATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

DACOGEN (S)

DRUG NAME

DACOGEN | DECITABINE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PATIENT HAS A DIAGNOSIS OF MYELODYSPLASTIC SYNDROME.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

DALIRESP (S)

DRUG NAME

DALIRESP

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

MODERATE TO SEVERE LIVER IMPAIRMENT (CHILD-PUGH B OR C)

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) (DEFINED AS FEV1 LESS THAN OR EQUAL TO 50% OF PREDICTED AND FEV1/FORCED VITAL CAPACITY [FVC] LESS THAN 0.7) ASSOCIATED WITH CHRONIC BRONCHITIS AND HISTORY OF COPD EXACERBATIONS WHICH REQUIRES THE USE OF SYSTEMIC CORTICOSTEROIDS, ANTIBIOTICS, OR HOSPITAL ADMISSION AND MEDICATION WILL BE USED WITH A LONG-ACTING INHALED BRONCHODILATOR (I.E. LONG-ACTING ANTICHOLINERGIC, OR LONG-ACTING BETA AGONIST IN COMBINATION WITH INHALED CORTICOSTEROID).

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

DIFFERIN (S)

DRUG NAME

ADAPALENE | DIFFERIN

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PA APPLIES TO PATIENTS OLDER THAN 26 YEARS OF AGE

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, MEDICATION HAS BEEN EFFECTIVE IN TREATING THE PATIENT'S CONDITION.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

DRONABINOL (S)

DRUG NAME

DRONABINOL | MARINOL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CHEMOTHERAPY-INDUCED NAUSEA AND VOMITING AND PATIENT HAS TRIED AND FAILED CONVENTIONAL ANTIEMETIC TREATMENTS (E.G., APREPITANT/FOSAPREPITANT, T-HYDROXYTRIPTAMINE-3 SEROTONIN RECEPTOR ANTAGONISTS) OR PATIENT HAS A DIAGNOSIS OF ANOREXIA ASSOCIATED WITH WEIGHT LOSS DUE TO AIDS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

PART B IF RELATED TO CANCER TREATMENT AND IS A FULL REPLACEMENT FOR IV ANTIEMETIC WITHIN 48 HRS OF CANCER TREATMENT. PART D IF RELATED TO CANCER TREATMENT AFTER THE 48-HOUR PERIOD, OR FOR ANY OTHER MEDICALLY ACCEPTED DIAGNOSIS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

EGRIFTA (S)

DRUG NAME

EGRIFTA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

PREGNANT. ACTIVE MALIGNANCY (NEWLY DIAGNOSED OR RECURRENT).

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF EXCESS ABDOMINAL FAT SECONDARY TO HIV INFECTION WITH LIPODYSTROPHY AND PATIENT HAS BEEN RECEIVING ANTIRETROVIRAL THERAPY AND WAIST CIRCUMFERENCE GREATER THAN 37.4 INCHES (MEN) OR GREATER THAN 37 INCHES (WOMEN) AND WAIST-TO-HIP RATIO GREATER THAN 0.94 (MEN) OR GREATER THAN 0.88 (WOMEN)

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

FOR RENEWAL, DOCUMENTATION THAT THE PATIENT HAS EXPERIENCED A REDUCTION FROM BASELINE IN VISCERAL ADIPOSE TISSUE AS MEASURED BY WAIST CIRCUMFERENCE.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ELAPRASE (S)

DRUG NAME

ELAPRASE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF HUNTER SYNDROME (MUCOPOLYSACCARIDOSIS II OR MPS II)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ELIGARD (S)

DRUG NAME

ELIGARD

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ADVANCED OR METASTATIC PROSTATE CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

EMSAM (S)

DRUG NAME

EMSAM

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

PHEOCHROMOCYTOMA. PATIENT IS TAKING OR WILL TAKE ANY OF THE FOLLOWING: SSRIS, SNRIS, TRICYCLIC ANTIDEPRESSANTS (TCAS), BUPROPION, BUSPIRONE, MEPERIDINE, TRAMADOL, METHADONE, PENTAZOCINE, DEXTROMETHORPHAN, ST. JOHN'S WORT, MIRTAZAPINE, CYCLOBENZAPRINE, ORAL SELEGILINE, OTHER MAOIS, OXCARBAZEPINE, CARBAMAZEPINE, AND/OR SYMPATHOMIMETIC AMINES

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER AND PATIENT HAD ADEQUATE TRIAL WITH AT LEAST 2 GENERIC ORAL ANTIDEPRESSANTS FROM DIFFERING CLASSES (AT LEAST ONE SHOULD BE FROM THE FOLLOWING LIST: SELECTIVE SEROTONIN REUPTAKE INHIBITORS, SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS, MIRTAZAPINE, OR BUPROPION UNLESS CONTRAINDICATED), UNLESS UNABLE TO TAKE ANY ORAL MEDICATION AND PATIENT HAD AN ADEQUATE WASHOUT PERIOD (FOR PATIENTS PREVIOUSLY ON AGENTS REQUIRING A WASHOUT PERIOD) AND PATIENTS EXCEEDING DOSES OVER 6MG/24 HOURS WILL BE ON A TYRAMINE RESTRICTED DIET (I.E. AVOID AGED/SPOILED/FERMENTED MEAT AND CHEESE, TAP BEER, FAVA BEANS, OR ANY FOODS WITH HIGH AMOUNTS OF TYRAMINE)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, THE PATIENT HAS IMPROVED OR STABILIZED ON EMSAM.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ENBREL (S)

DRUG NAME

ENBREL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS)

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING : A) MODERATE TO SEVERE RHEUMATOID ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS FOR AT LEAST 3 CONSECUTIVE MONTHS B) MODERATE TO SEVERE POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS) FOR AT LEAST 3 CONSECUTIVE MONTHS C) PSORIATIC ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE, OR CONTRAINDICATION TO METHOTREXATE D) ANKYLOSING SPONDYLITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO ONE OR MORE NSAIDS E) MODERATE TO SEVERE CHRONIC PLAQUE PSORIASIS (AFFECTING MORE THAN 5% OF BODY SURFACE AREA OR AFFECTING CRUCIAL BODY AREAS SUCH AS THE HANDS, FEET, FACE, OR GENITALS) AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO CONVENTIONAL THERAPY WITH AT LEAST ONE OF THE FOLLOWING: PHOTOTHERAPY (INCLUDING BUT NOT LIMITED TO ULTRAVIOLET A WITH A PSORALEN [PUVA] AND/OR RETINOIDS [REPUVA] FOR AT LEAST ONE CONTINUOUS MONTH OR ONE OR MORE ORAL SYSTEMIC TREATMENTS (I.E. METHOTREXATE, CYCLOSPORINE, ACITRETIN, SULFASALAZINE) FOR AT LEAST 3 CONSECUTIVE MONTHS.

AGE RESTRICTIONS

2 YEARS OF AGE OR OLDER FOR JIA. 18 YEARS OF AGE OR OLDER FOR ALL OTHER INDICATIONS

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL 3 MONTHS (PLAQUE PSORIASIS), 12 MONTHS (OTHERS). RENEWAL 12 MONTHS.

OTHER CRITERIA

PATIENT HAS BEEN TESTED FOR TB AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED. FOR RENEWAL, PATIENT HAS STABLE DISEASE OR HAS IMPROVED WHILE ON THERAPY (E.G., FOR PJIA, REDUCTION IN DISEASE FLARES, IMPROVEMENT IN ACR SCORING. FOR RA, IMPROVEMENT IN TENDER/SWOLLEN JOINT COUNT, IMPROVEMENT IN ACR SCORING. FOR PSA, IMPROVEMENT IN NUMBER OF SWOLLEN/TENDER JOINTS, PAIN, STIFFNESS. FOR AS, IMPROVEMENT IN AS SYMPTOMS, SUCH AS STIFFNESS AND BACK PAIN).

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

EPIDUO (S)

DRUG NAME

EPIDUO | EPIDUO FORTE

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PA APPLIES TO PATIENTS OLDER THAN 26 YEARS OF AGE

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, MEDICATION HAS BEEN EFFECTIVE IN TREATING THE PATIENT'S CONDITION.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

EPOETIN ALFA (S)

DRUG NAME

EPOGEN | PROCRIT

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ANEMIA SECONDARY TO HEPATITIS C. ANEMIA SECONDARY TO MYELODYSPLASTIC SYNDROME.

EXCLUSION CRITERIA

UNCONTROLLED HYPERTENSION. PURE RED CELL APLASIA THAT BEGINS AFTER ESA TREATMENT.

REQUIRED MEDICAL INFORMATION

PRE-TREATMENT HEMOGLOBIN LEVEL LESS THAN 10 G/DL (UNLESS, FOR PERIOPERATIVE BLOOD LOSS HB SHOULD BE GREATER THAN 10 BUT LESS THAN OR EQUAL TO 13 G/DL) AND PATIENT HAS ADEQUATE IRON STORES PRIOR TO INITIATION OF THERAPY DEFINED AS FERRITIN MORE THAN 100 MCG/L OR SERUM TRANSFERRIN SATURATION GREATER THAN 20% AND OTHER CAUSES OF ANEMIA SUCH AS IRON DEFICIENCY, FOLATE DEFICIENCY OR B12 DEFICIENCY, HEMOLYSIS, GASTROINTESTINAL BLEEDING, OTHER ACTIVE OR OCCULT BLEEDING, OR UNDERLYING HEMATOLOGIC DISEASE (SUCH AS SICKLE CELL ANEMIA, THALASSEMIA, AND PORPHYRIA) HAVE BEEN RULED OUT AND DIAGNOSIS OF ONE OF THE FOLLOWING: A) ANEMIA DUE TO CHRONIC KIDNEY DISEASE (CKD) WITH OR WITHOUT HEMODIALYSIS, OR B) ANEMIA IN A PATIENT WITH NON-MYELOID MALIGNANCIES WHERE ANEMIA IS DUE TO THE EFFECT OF CONCOMITANT MYELOSUPPRESSIVE CHEMOTHERAPY AND TWO ADDITIONAL MONTHS OF CHEMOTHERAPY IS ANTICIPATED, C) TREATMENT OF ANEMIA IN A PATIENT AT HIGH RISK FOR PERIOPERATIVE BLOOD LOSS FROM ELECTIVE, NONCARDIAC, NONVASCULAR SURGERY TO REDUCE THE NEED FOR ALLOGENEIC BLOOD TRANSFUSION, D) ANEMIA IN ZIDOVUDINE-TREATED HIV INFECTION WITH SERUM ERYTHROPOIETIN LEVELS 500 MUNIT/ML OR LESS AND ZIDOVUDINE DOSES 4,200 MG/WEEK OR LESS E) ANEMIA SECONDARY TO HEPATITIS C THERAPY AND PATIENT IS RECEIVING RIBAVIRIN AND INTERFERON/PEGINTERFERON F) ANEMIA DUE TO MYELODYSPLASTIC SYNDROME AND ENDOGENOUS SERUM ERYTHROPOIETIN LEVEL IS 500 MUNIT/ML OR LESS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

CKD - PRESCRIBED BY A NEPHROLOGIST OR HEMATOLOGIST. NON-MYELOID MALIGNANCIES , MDS - PRESCRIBED BY AN ONCOLOGIST/HEMATOLOGIST. SURGERY - PRESCRIBED BY A SURGEON. HIV - PRESCRIBED BY AN INFECTIOUS DISEASE SPECIALIST. HCV - ID SPECIALIST OR GASTROENTEROLOGIST

COVERAGE DURATION

INITIAL: 4 MOS (OTHERS). RENEWAL: CKD-12 MOS, OTHERS -4 MOS. SX-3 MOS

OTHER CRITERIA

FOR RENEWAL OF CKD, FOR DIALYSIS PATIENTS: HB LESS THAN 11 G/DL OR PHYSICIAN WILL DECREASE OR INTERRUPT DOSE AND FOR NON-DIALYSIS PATIENTS: HB LESS THAN 10 G/DL OR PHYSICIAN WILL DECREASE OR INTERRUPT DOSE. FOR RENEWAL OF NON-MYELOID MALIGNANCIES: CONCURRENT MYELOSUPPRESSIVE CHEMOTHERAPY AND HB IS 12G/DL OR LESS AND THERE IS MEASURABLE RESPONSE AFTER EIGHT WEEKS (DEFINED AS AN INCREASE IN HB 1 G/DL OR MORE OR A REDUCTION IN RED BLOOD CELL TRANSFUSION REQUIREMENTS). FOR RENEWAL OF ZIDOVUDINE-TREATED HIV, HB IS 12G/DL OR LESS AND ZIDOVUDINE DOSE REMAINS 4,200 MG/WEEK OR LESS AND THERE IS A MEASURABLE RESPONSE AFTER EIGHT WEEKS (DEFINED AS AN INCREASE IN HB OR A REDUCTION IN RBC TRANSFUSION REQUIREMENTS OR DOCUMENTED DOSE ESCALATION [UP TO MAX OF 300 UNITS/KG/DOSE]). FOR RENEWAL OF MDS, HB IS 12 G/DL OR LESS AND PATIENT HAD HB RISE OF 1.5G/DL OR A DECREASE IN RBC TRANSFUSION REQUIREMENTS AFTER AT LEAST 8 WEEKS OF TREATMENT OR PATIENT WILL HAVE A CONCOMITANT TRIAL WITH G-CSF AND IF PATIENT HAD CONCOMITANT TRIAL WITH G-CSF, PATIENT HAD A MEASUREABLE RESPONSE TO THERAPY AFTER AT LEAST 8 WEEKS. FOR RENEWAL OF HCV, HB 12 OR LESS AND CONCURRENT RIBAVIRIN/INTERFERON OR PEGYLATED INTERFERON/RIBAVIRIN THERAPY. ESRD PATIENTS ON DIALYSIS EXCLUDED.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ERBITUX (S)

DRUG NAME

ERBITUX

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING: A) LOCALLY OR REGIONALLY ADVANCED SQUAMOUS CELL CARCINOMA OF THE HEAD AND NECK IN COMBINATION WITH RADIATION THERAPY B) RECURRENT LOCOREGIONAL DISEASE OR METASTATIC SQUAMOUS CELL CARCINOMA OF THE HEAD AND NECK IN COMBINATION WITH PLATINUM-BASED THERAPY WITH 5-FLUOROURACIL AS FIRST-LINE TREATMENT C) RECURRENT OR METASTATIC SQUAMOUS CELL CARCINOMA OF THE HEAD AND NECK FOR WHOM PRIOR PLATINUM-BASED THERAPY HAS FAILED AND THE MEDICATION WILL BE USED AS A SINGLE AGENT, D) K-RAS MUTATION-NEGATIVE (WILD-TYPE) EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR)-EXPRESSING, METASTATIC COLORECTAL CANCER AS DETERMINED BY AN FDA-APPROVED TEST AND THE MEDICATION WILL BE USED: IN COMBINATION WITH FOLFIRI FOR FIRST-LINE TREATMENT, IN COMBINATION WITH IRINOTECAN IN PATIENTS WHO ARE REFRACTORY TO IRINOTECAN-BASED CHEMOTHERAPY, OR AS A SINGLE AGENT IN PATIENTS WHO HAVE FAILED OXALIPLATIN- AND IRINOTECAN-BASED CHEMOTHERAPY OR WHO ARE INTOLERANT TO IRINOTECAN.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ERIVEDGE (S)

DRUG NAME

ERIVEDGE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF METASTATIC BASAL CELL CARCINOMA OR DIAGNOSIS OF LOCALLY ADVANCED BASAL CELL CARCINOMA THAT HAS RECURRED FOLLOWING SURGERY OR WHEN THE PATIENT IS NOT A CANDIDATE FOR SURGERY AND RADIATION

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

EXALGO (S)

DRUG NAME

EXALGO | HYDROMORPHONE ER

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

SIGNIFICANT RESPIRATORY DEPRESSION. ACUTE OR SEVERE BRONCHIAL ASTHMA. KNOWN OR SUSPECTED PARALYTIC ILEUS. GASTROINTESTINAL OBSTRUCTION.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF SEVERE PAIN REQUIRING CONTINUOUS, AROUND-THE-CLOCK OPIOID ANALGESIC FOR AN EXTENDED PERIOD OF TIME AND PATIENT HAS TRIED AND FAILED OR UNABLE TO TOLERATE AT LEAST TWO GENERIC EXTENDED-RELEASE OPIOID PRODUCTS, SUCH AS: OXYMORPHONE ER, MORPHINE ER, FENTANYL, METHADONE, TRAMADOL ER AND PATIENT IS OPIOID TOLERANT, TAKING AT LEAST 60 MG ORAL MORPHINE PER DAY, 25 MCG TRANSDERMAL FENTANYL PER HOUR, 30 MG ORAL OXYCODONE PER DAY, 8 MG ORAL HYDROMORPHONE PER DAY, 25 MG ORAL OXYMORPHONE PER DAY, OR AN EQUIANALGESIC DOSE OF ANOTHER OPIOID FOR A WEEK OR LONGER.

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

NOT COVERED FOR MEMBERS ENROLLED IN A MEDICARE APPROVED HOSPICE PROGRAM

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

EXJADE (S)

DRUG NAME

EXJADE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. MYELODYSPLASTIC SYNDROME IN A PATIENT WITH LOW OR INTERMEDIATE-1 DISEASE OR IS A POTENTIAL TRANSPLANT PATIENT AND WHO HAS RECEIVED MORE THAN 20 RED BLOOD CELL TRANSFUSIONS.

EXCLUSION CRITERIA

CREATININE CLEARANCE LESS THAN 40 ML/MINUTE. PLATELET COUNT LESS THAN 50 X 10⁹/L. POOR PERFORMANCE STATUS. SEVERE (CHILD-PUGH CLASS C) HEPATIC IMPAIRMENT. HIGH-RISK MYELODYSPLASTIC SYNDROMES. ADVANCED MALIGNANCIES. GASTROINTESTINAL ULCERATION OR HEMORRHAGE.

REQUIRED MEDICAL INFORMATION

PATIENT HAS A DIAGNOSIS OF ONE OF THE FOLLOWING: A) CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS AND PATIENT HAS A BASELINE FERRITIN LEVEL MORE THAN 1,000 MCG/L AND THE PATIENT HAS REQUIRED THE TRANSFUSION OF AT LEAST 100 ML/KG PACKED RED BLOOD CELLS OR B) CHRONIC IRON OVERLOAD DUE TO NON-TRANSFUSION-DEPENDENT THALASSEMIA (NTDT) AND LIVER IRON CONCENTRATION (LIC) IS 5 MG OF IRON PER GRAM OF LIVER DRY WEIGHT (MG FE/G DW) OR HIGHER AND SERUM FERRITIN LEVEL IS GREATER THAN 300 MCG/L OR C) MYELODYSPLASTIC SYNDROME (MDS) AND THE PATIENT HAS LOW OR INTERMEDIATE-1 DISEASE OR IS A POTENTIAL TRANSPLANT PATIENT AND PATIENT HAS RECEIVED MORE THAN 20 RED BLOOD CELL TRANSFUSIONS

AGE RESTRICTIONS

2 YEARS OF AGE OR OLDER FOR CHRONIC IRON OVERLOAD DUE TO TRANSFUSIONS. 10 YEARS OF AGE OR OLDER FOR CHRONIC IRON OVERLOAD DUE TO NTDT

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

NTDT - 6 MONTHS. TRANSFUSION-DEPENDENT ANEMIA, MDS - 12 MONTHS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

OTHER CRITERIA

FOR RENEWAL OF CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS AND MDS, THE EXPERIENCED A REDUCTION IN SERUM FERRITIN LEVEL OR LIC. FOR RENEWAL OF CHRONIC IRON OVERLOAD DUE TO NTDT, PATIENT HAS LIC 3 MG FE/G DW OR HIGHER AND PATIENT EXPERIENCED A REDUCTION IN SERUM FERRITIN LEVEL OR LIC.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

EXTAVIA (S)

DRUG NAME

EXTAVIA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF RELAPSING FORM OF MULTIPLE SCLEROSIS OR DIAGNOSIS OF FIRST CLINICAL EPISODE AND MRI FEATURES CONSISTENT WITH MULTIPLE SCLEROSIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS EXPERIENCED AN OBJECTIVE RESPONSE TO THERAPY (I.E. NO OR SLOWED PROGRESSION OF DISEASE)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

FABIOR (S)

DRUG NAME

FABIOR

COVERED USES

ALL FDA-APPROVED INDICATION NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

PREGNANCY.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ACNE VULGARIS AND PATIENT HAS TRIED AN ADEQUATE TRIAL (AT LEAST TWO WEEKS) WITH AT LEAST ONE OTHER TOPICAL ACNE PRODUCT (E.G., BENZOYL PEROXIDE, SALICYLIC ACID, CLINDAMYCIN, ERYTHROMYCIN, ADAPALENE, AZELAIC ACID, AND/OR TRETINOIN) AND FEMALES OF CHILD-BEARING POTENTIAL ARE USING ADEQUATE BIRTH CONTROL MEASURES DURING THERAPY

AGE RESTRICTIONS

12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

FABRAZYME (S)

DRUG NAME

FABRAZYME

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF FABRY DISEASE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

FARXIGA (S)

DRUG NAME

FARXIGA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

RENAL IMPAIRMENT (ESTIMATED GLOMERULAR FILTRATION RATE [EGFR] LESS THAN 60 ML/MIN/1.73 M2), END STAGE RENAL DISEASE (ESRD), CURRENTLY REQUIRING DIALYSIS, DIABETIC KETOACIDOSIS

REQUIRED MEDICAL INFORMATION

THE MEMBER HAS A DIAGNOSIS OF TYPE 2 DIABETES MELLITUS AND HAS HAD AN INADEQUATE RESPONSE TO DIET AND EXERCISE ALONE AND THE MEMBER HAS TRIED AND HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO METFORMIN OR METFORMIN-CONTAINING PRODUCTS.

AGE RESTRICTIONS

18 YEARS OR AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS EXPERIENCED AN IMPROVEMENT IN HEMOGLOBIN A1C (HBA1C) WITH THERAPY.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

FENTANYL (S)

DRUG NAME

ABSTRAL | FENTORA | LAZANDA | SUBSYS

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

MANAGEMENT OF ACUTE OR POST-OPERATIVE PAIN, INCLUDING HEADACHE/MIGRAINE, DENTAL PAIN, OR USE IN THE EMERGENCY ROOM. OPIOID NON-TOLERANT PATIENTS.

REQUIRED MEDICAL INFORMATION

PATIENT MEETS THE FOLLOWING: A) DIAGNOSIS OF CANCER AND USE IS FOR BREAKTHROUGH CANCER PAIN, B) PATIENT IS OPIOID TOLERANT AND TAKING AT LEAST 60 MG MORPHINE/DAY, AT LEAST 25 MCG TRANSDERMAL FENTANYL/HOUR, AT LEAST 30 MG OF OXYCODONE DAILY, AT LEAST 8 MG ORAL HYDROMORPHONE DAILY OR AN EQUIANALGESIC DOSE OF ANOTHER OPIOID FOR A WEEK OR LONGER, C) AT LEAST ONE OTHER FORMULARY SHORT-ACTING STRONG NARCOTIC ANALGESIC ALTERNATIVES (OTHER THAN FENTANYL) HAVE BEEN INEFFECTIVE, NOT TOLERATED, OR CONTRAINDICATED, D) PRESCRIBER AND PATIENT ARE REGISTERED IN THE TRANSMUCOSAL IMMEDIATE RELEASE FENTANYL (TIRF) RISK EVALUATION AND MITIGATION STRATEGY ACCESS PROGRAM, E) FOR BRAND REQUESTS, GENERIC TRANSMUCOSAL FENTANYL CITRATE HAS BEEN INEFFECTIVE OR NOT TOLERATED.

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

NOT COVERED FOR MEMBERS ENROLLED IN A MEDICARE APPROVED HOSPICE PROGRAM

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

FERRIPROX (S)

DRUG NAME

FERRIPROX

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF TRANSFUSIONAL IRON OVERLOAD DUE TO THALASSEMIA SYNDROMES AND PATIENT HAS FAILED PRIOR CHELATION THERAPY WITH DESFERAL OR EXJADE (FAILURE IS DEFINED AS A SERUM FERRITIN LEVEL GREATER THAN 2,500 MCG/L) OR PATIENT HAS A CONTRAINDICATION OR INTOLERANCE TO DESFERAL OR EXJADE AND PATIENT HAS AN ABSOLUTE NEUTROPHIL COUNT GREATER THAN 1.5 X 10⁹/L.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS EXPERIENCED AT LEAST A 20% REDUCTION IN SERUM FERRITIN LEVELS AND HAS AN ABSOLUTE NEUTROPHIL COUNT GREATER THAN 0.5 X 10⁹/L

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

FIRAZYR (S)

DRUG NAME

FIRAZYR

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF HEREDITARY ANGIOEDEMA AND MEDICATION WILL BE USED FOR THE TREATMENT OF ACUTE ATTACKS.

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

FIRMAGON (S)

DRUG NAME

FIRMAGON

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ADVANCED OR METASTATIC PROSTATE CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

FLECTOR (S)

DRUG NAME

FLECTOR

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

PREVIOUSLY EXPERIENCED ASTHMA, URTICARIA, OR ALLERGIC-TYPE REACTIONS AFTER TAKING ASPIRIN OR OTHER NSAIDS. USE FOR THE TREATMENT OF PERI-OPERATIVE PAIN IN THE SETTING OF CORONARY ARTERY BYPASS GRAFT (CABG) SURGERY. APPLICATION TO NON-INTACT OR DAMAGED SKIN.

REQUIRED MEDICAL INFORMATION

PATIENT IS EXPERIENCING ACUTE LOCALIZED PAIN DUE TO MINOR STRAINS, SPRAINS AND CONTUSIONS AND PATIENT HAD EXPERIENCED TREATMENT FAILURE WITH AT LEAST 2 PRESCRIPTION STRENGTH ORAL NSAIDS OR PATIENT HAS A DOCUMENTED SWALLOWING DISORDER OR HAS A HISTORY OF PEPTIC ULCER DISEASE/GASTROINTESTINAL BLEEDING OR PATIENT IS MORE THAN 65 YEARS OF AGE WITH ONE ADDITIONAL RISK FACTOR FOR GASTROINTESTINAL ADVERSE EVENT (E.G., USE OF ANTICOAGULANTS OR CHRONIC CORTICOSTEROIDS)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

FOLOTYN (S)

DRUG NAME

FOLOTYN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF RELAPSED OR REFRACTORY PERIPHERAL T-CELL LYMPHOMA (PTCL)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

FORTEO (S)

DRUG NAME

FORTEO

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PATIENT HAS A DIAGNOSIS OF ONE OF THE FOLLOWING: A) OSTEOPOROSIS IN A POSTMENOPAUSAL FEMALE, B) PRIMARY OR HYPOGONADAL OSTEOPOROSIS IN A MALE, OR C) OSTEOPOROSIS ASSOCIATED WITH SUSTAINED SYSTEMIC GLUCOCORTICOID THERAPY AND PATIENT IS CONSIDERED TO BE AT HIGH-RISK FOR FRACTURE BY MEETING ONE OR MORE OF THE FOLLOWING: A) HISTORY OF OSTEOPOROTIC FRACTURE, B) MULTIPLE RISK FACTORS FOR FRACTURE (INCLUDING OLDER AGE (POSTMENOPAUSAL WOMAN OR MAN GREATER THAN 50 YEARS OF AGE), FEMALE GENDER, LOW BODY MASS INDEX (LESS THAN 19 KG/M²), RHEUMATOID ARTHRITIS, SMOKER, ALCOHOL INTAKE MORE THAN 3 DRINKS/DAY, PARENTAL HISTORY OF HIP FRACTURE, ORAL GLUCOCORTICOID THERAPY OR PATIENT EVER TOOK PREDNISONE AT A DOSE OF 5 MG OR HIGHER), AND PATIENT HAS DOCUMENTED TRIAL AND FAILURE OF BISPHOSPHONATE OR DOCUMENTED CONTRAINDICATION OR INTOLERANCE TO BISPHOSPHONATE THERAPY. PATIENT HAS NOT RECEIVED MORE THAN 2 YEARS OF THERAPY WITH FORTEO.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

GAMASTAN S/D (S)

DRUG NAME

GAMASTAN S-D

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

HISTORY OF HYPERSENSITIVITY (INCLUDING ANAPHYLAXIS OR SEVERE SYSTEMIC REACTION) TO IMMUNE GLOBULIN OR ANY COMPONENT OF THE PREPARATION. SEVERE THROMBOCYTOPENIA OR COAGULATION DISORDER WHERE IM INJECTIONS ARE CONTRAINDICATED.

REQUIRED MEDICAL INFORMATION

MEDICATION WILL BE GIVEN THROUGH THE INTRAMUSCULAR ROUTE AND THE MEDICATION WILL BE USED FOR PASSIVE IMMUNIZATION OR POST-EXPOSURE PROPHYLAXIS FOR ONE OF THE FOLLOWING INFECTIONS/DISEASES: HEPATITIS A, MEASLES, RUBELLA, VARICELLA.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

1 MONTH

OTHER CRITERIA

NON-LTC MEMBERS: PART B IF THE DRUG IS BEING ADMINISTERED WITH AN INFUSION PUMP. PART D FOR ALL OTHER ADMINISTRATION TECHNIQUES. LTC MEMBERS - ALWAYS PART D

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

GATTEX (S)

DRUG NAME

GATTEX

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ACTIVE GASTROINTESTINAL MALIGNANCY (GASTROINTESTINAL TRACT, HEPATOBILIARY, PANCREATIC), COLORECTAL CANCER, OR SMALL BOWEL CANCER

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF SHORT BOWEL SYNDROME AND PATIENT IS RECEIVING SPECIALIZED NUTRITIONAL SUPPORT (I.E. PARENTERAL NUTRITION)

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS A REDUCED NEED FOR PARENTERAL SUPPORT (20% REDUCTION) AFTER AT LEAST 6 MONTHS OF THERAPY.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

GILENYA (S)

DRUG NAME

GILENYA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. FIRST CLINICAL EPISODE WITH MRI FEATURES CONSISTENT WITH MULTIPLE SCLEROSIS.

EXCLUSION CRITERIA

RECENT (WITHIN THE LAST 6 MONTHS) OCCURRENCE OF: MYOCARDIAL INFARCTION, UNSTABLE ANGINA, STROKE, TRANSIENT ISCHEMIC ATTACK, DECOMPENSATED HEART FAILURE REQUIRING HOSPITALIZATION, OR CLASS III/IV HEART FAILURE. HISTORY OR PRESENCE OF MOBITZ TYPE II 2ND DEGREE OR 3RD DEGREE AV BLOCK OR SICK SINUS SYNDROME, UNLESS PATIENT HAS A PACEMAKER. BASELINE QTC INTERVAL GREATER THAN OR EQUAL TO 500 MS. RECEIVING CONCURRENT TREATMENT WITH CLASS IA OR CLASS III ANTI-ARRHYTHMIC DRUGS (QUINIDINE, PROCAINAMIDE, AMIODARONE, SOTALOL).

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF A RELAPSING FORM OF MULTIPLE SCLEROSIS OR DIAGNOSIS OF FIRST CLINICAL EPISODE WITH MRI FEATURES CONSISTENT WITH MS AND PATIENT WILL BE OBSERVED FOR SIGNS AND SYMPTOMS OF BRADYCARDIA IN A CONTROLLED SETTING FOR AT LEAST 6 HOURS AFTER THE FIRST DOSE

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL - 6 MONTHS. RENEWAL - 12 MONTHS

OTHER CRITERIA

FOR RENEWAL, THE PATIENT HAS EXPERIENCED NO OR SLOWED DISEASE PROGRESSION.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

GILOTRIF (S)

DRUG NAME

GILOTRIF

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF METASTATIC NON-SMALL CELL LUNG CANCER AND PATIENT HAS KNOWN ACTIVE EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) EXON 19 DELETIONS OF EXON 21 (L858R) SUBSTITUTION MUTATION AS DETECTED BY AN FDA-APPROVED TEST OR CLINICAL LABORATORY IMPROVEMENT AMENDMENTS-APPROVED FACILITY AND THE MEDICATION WILL BE USED FIRST-LINE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

GLEEVEC (S)

DRUG NAME

GLEEVEC | IMATINIB MESYLATE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING IN AN ADULT: A) PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOGENOUS LEUKEMIA (PH+ CML), B) PH+ ACUTE LYMPHOBLASTIC LEUKEMIA (ALL), C) GASTROINTESTINAL TUMOR (GIST) WHERE PATIENT HAS DOCUMENTED C-KIT (CD117) POSITIVE UNRESECTABLE OR METASTATIC MALIGNANT GIST OR PATIENT HAD RESECTION OF C-KIT POSITIVE GIST AND IMATINIB WILL BE USED AS AN ADJUVANT THERAPY, D) DERMATOFIBROSARCOMA PROTUBERANS THAT IS UNRESECTABLE, RECURRENT, OR METASTATIC, E) HYPEREOSINOPHILIC SYNDROME OR CHRONIC EOSINOPHILIC LEUKEMIA, F) MYELOYDYSPLASTIC SYNDROME OR MYELOPROLIFERATIVE DISEASE ASSOCIATED WITH PLATELET-DERIVED GROWTH FACTOR RECEPTOR GENE RE-ARRANGEMENTS, G) AGGRESSIVE SYSTEMIC MASTOCYTOSIS WITHOUT THE D816V C-KIT MUTATION OR WITH C-KIT MUTATION OR WITH C-KIT MUTATIONAL STATUS UNKNOWN. DIAGNOSIS OF ONE OF THE FOLLOWING IN A PEDIATRIC PATIENT: A) PH+ CML THAT IS NEWLY DIAGNOSED IN THE CHRONIC PHASE B) NEWLY DIAGNOSED PH+ ALL

AGE RESTRICTIONS

18 YEARS OF AGE OR YOUNGER - NEWLY DIAGNOSED CML IN THE CHRONIC PHASE OR NEWLY DIAGNOSED PH+ ALL. 18 YEARS OF AGE OR OLDER FOR OTHER INDICATIONS.

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

GRALISE (S)

DRUG NAME

GRALISE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF POST-HERPETIC NEURALGIA AND PATIENT HAS TRIED AND FAILED A DOSE OF AT LEAST 1800 MG OF GENERIC GABAPENTIN OR PATIENT HAS EXPERIENCED INTOLERANCE TO GENERIC GABAPENTIN

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS IMPROVEMENT IN PAIN SEVERITY.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

GRANIX (S)

DRUG NAME

GRANIX

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

FOR USE AS PRIMARY PROPHYLAXIS OF FEBRILE NEUTROPENIA (FN) IN ONE OF THE FOLLOWING PATIENTS: A) PATIENT HAS A 20% OR HIGHER RISK OF FN BASED ON CHEMOTHERAPY REGIMEN OR B) PATIENT HAS 10% TO LESS THAN 20% RISK OF DEVELOPING FN BASED ON CHEMOTHERAPY REGIMEN AND AT LEAST ONE OF THE FOLLOWING RISK FACTORS ARE PRESENT: 65 YEARS OR OLDER, POOR PERFORMANCE STATUS, POOR NUTRITIONAL STATUS, PREVIOUS EPISODES OF FEBRILE NEUTROPENIA, EXTENSIVE PRIOR TREATMENT INCLUDING LARGE RADIATION PORTS, CYTOPENIAS DUE TO BONE MARROW INVOLVEMENT BY TUMOR, ADMINISTRATION OF COMBINED CHEMORADIO THERAPY, PRESENCE OF OPEN WOUNDS OR ACTIVE INFECTIONS, OTHER SERIOUS COMORBIDITIES (INCLUDING RENAL OR LIVER DYSFUNCTION NOTABLY ELEVATED BILIRUBIN), OR C) PATIENT HAS LESS THAN 10% RISK OF DEVELOPING FN BASED ON CHEMOTHERAPY REGIMEN AND THE INTENT OF TREATMENT IS CURATIVE OR ADJUVANT AND PATIENT IS AT RISK FOR SERIOUS MEDICAL CONSEQUENCES OF FN, INCLUDING DEATH AND PATIENT IS RECEIVING MYELOSUPPRESSIVE CHEMOTHERAPY REGIMEN FOR A NON-MYELOID MALIGNANCY, OR D) FOR USE AS SECONDARY PROPHYLAXIS OF FN IN A PATIENT WHO HAD A NEUTROPENIC COMPLICATION FROM A PRIOR CYCLE OF CHEMOTHERAPY (FOR WHICH PRIMARY PROPHYLAXIS WAS NOT RECEIVED) E) FOR USE AS ADJUNCT TREATMENT IN SEVERE FEBRILE NEUTROPENIA IN A PATIENT RECEIVING MYELOSUPPRESSIVE THERAPY FOR A NON-MYELOID MALIGNANCY WITH THE FOLLOWING CRITERIA: PATIENT HAS RECEIVED PROPHYLACTIC CSF, BUT MUST NOT HAVE ALREADY RECEIVED PROPHYLACTIC PEGFILGRASTIM OR PATIENT HAS NOT RECEIVED PROPHYLACTIC CSF THERAPY MUST MEET AT LEAST ONE OF THE FOLLOWING CRITERIA: 65 YEARS OF AGE OR OLDER, PNEUMONIA, HYPOTENSION AND MULTI-ORGAN DYSFUNCTION (SEPSIS SYNDROME), INVASIVE FUNGAL INFECTION OR OTHER CLINICALLY-DOCUMENTED INFECTION, HOSPITALIZATION AT THE TIME

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

OF DEVELOPMENT OF FEVER, PRIOR EPISODE OF FEBRILE NEUTROPENIA, SEVERE (ANC MORE THAN 100/MCL) OR ANTICIPATED PROLONGED (MORE THAN 10 DAYS) NEUTROPENIA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

GROWTH HORMONE (S)

DRUG NAME

GENOTROPIN | HUMATROPE | NORDITROPIN FLEXPRO | NUTROPIN AQ | NUTROPIN AQ NUSPIN | OMNITROPE | SAIZEN | ZOMACTON

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. GROWTH HORMONE DEFICIENCY (GHD). SMALL FOR GESTATIONAL AGE (SGA). CHRONIC RENAL INSUFFICIENCY (CRI). SHORT STATURE HOMEBOX-CONTAINING GENE (SHOX) DEFICIENCY. NOONAN SYNDROME. PRADER-WILLI SYNDROME (PWS). TURNER SYNDROME. ADULT- OR CHILDHOOD-ONSET GHD.

EXCLUSION CRITERIA

CHILD WITH CLOSED EPIPHYSES. ACUTE CRITICAL ILLNESS DUE TO COMPLICATIONS FOLLOWING OPEN HEART OR ABDOMINAL SURGERY, MULTIPLE ACCIDENTAL TRAUMA OR ACUTE RESPIRATORY FAILURE. ACTIVE MALIGNANCY. ACTIVE PROLIFERATIVE OR SEVERE NON-PROLIFERATIVE DIABETIC RETINOPATHY. FOR PWS ONLY: SEVERE OBESITY, HISTORY OF UPPER AIRWAY OBSTRUCTION OR SLEEP APNEA, OR SEVERE RESPIRATORY IMPAIRMENT.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PEDIATRIC INDICATION: A) GHD AND ONE STIM TEST WITH PEAK GH SECRETION BELOW 10 NG/ML OR IGF-1/IGFBP3 LEVEL MORE THAN 2 SDS BELOW MEAN IF CNS PATHOLOGY, H/O IRRADIATION, OR PROVEN GENETIC CAUSE, B) SGA AND BIRTH WT OR LENGTH 2 OR MORE SDS BELOW MEAN FOR GESTATIONAL AGE AND FAILS TO MANIFEST CATCH UP GROWTH BY AGE 2 (HEIGHT [HT] 2 OR MORE SDS BELOW MEAN FOR AGE AND GENDER), C) CRI AND NUTRITIONAL STATUS OPTIMIZED, METABOLIC ABNORMALITIES CORRECTED, AND NOT HAD RENAL TRANSPLANT D) SHOX DEFICIENCY OR NOONAN SYNDROME E) PWS CONFIRMED BY GENETIC TESTING AND HT BELOW 3RD PERCENTILE OR GROWTH VELOCITY (GV) MEASURED OVER 1 YEAR MORE THAN 2 SD BELOW MEAN FOR AGE AND SEX, F) TURNER SYNDROME CONFIRMED BY CHROMOSOME ANALYSIS AND HT BELOW 5TH PERCENTILE FOR AGE AND SEX. FOR GHD, CRI, SHOX DEFICIENCY, AND NOONAN SYNDROME, ONE OF THE FOLLOWING: HT MORE THAN 3 SDS BELOW MEAN FOR AGE AND GENDER, OR HT MORE THAN 2 SDS BELOW MEAN WITH GV MORE THAN 1 SDS BELOW MEAN, OR GV OVER 1 YEAR 2 SDS BELOW MEAN. OR DIAGNOSIS OF ADULT INDICATION: A) CHILDHOOD- OR ADULT-

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

ONSET GHD CONFIRMED BY 2 STANDARD GH STIM TESTS (PROVIDE ASSAY): 1 TEST MUST BE INSULIN TOLERANCE TEST (ITT) WITH BLOOD GLUCOSE NADIR LESS THAN 40 MG/DL (2.2 MMOL/L). IF CONTRAINDICATED, USE A STANDARDIZED STIM TEST (I.E. ARGININE PLUS GH RELEASING HORMONE [PREFERRED], GLUCAGON, ARGININE), B) GHD WITH AT LEAST 1 OTHER PITUITARY HORMONE DEFICIENCY AND FAILED AT LEAST 1 GH STIM TEST (ITT PREFERRED), C) GHD WITH PANHYPOPITUITARISM (3 OR MORE PITUITARY HORMONE DEFICIENCIES), D) GHD WITH IRREVERSIBLE HYPOTHALAMIC-PITUITARY STRUCTURAL LESIONS DUE TO TUMORS, SURGERY OR RADIATION OF PITUITARY OR HYPOTHALAMUS REGION AND A SUBNORMAL IGF-1 (AFTER AT LEAST 1 MONTH OFF GH THERAPY) AND OBJECTIVE EVIDENCE OF GHD COMPLICATIONS, SUCH AS: LOW BONE DENSITY, INCREASED VISCERAL FAT MASS, OR CV COMPLICATIONS AND COMPLETED LINEAR GROWTH (GV LESS THAN 2 CM/YEAR) AND GH HAS BEEN DISCONTINUED FOR AT LEAST 1 MONTH (IF PREVIOUSLY RECEIVING GH).

AGE RESTRICTIONS

SGA MORE THAN 2 YEARS OF AGE

PRESCRIBER RESTRICTIONS

PEDIATRIC ENDOCRINOLOGIST OR PEDIATRIC NEPHROLOGIST FOR PEDIATRIC INDICATIONS. ENDOCRINOLOGIST OR NEPHROLOGIST FOR ADULT INDICATIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL OF PEDIATRIC INDICATIONS, FINAL ADULT HEIGHT HAS NOT BEEN REACHED AS DETERMINED BY THE FIFTH PERCENTILE OF ADULT HEIGHT AND GROWTH VELOCITY IS MORE THAN 2 CM/YEAR. FOR RENEWAL OF ADULT INDICATIONS, PATIENT HAS EXPERIENCED AN IMPROVEMENT OR NORMALIZATION OF IGF-1 LEVELS (NOT A REQUIREMENT IN PATIENTS WITH PANHYPOPITUITARISM).

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HALAVEN (S)

DRUG NAME

HALAVEN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED BY PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF METASTATIC BREAST CANCER AND MEMBER HAS TRIED AND FAILED AN ANTHRACYCLINE AND A TAXANE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HARVONI (S)

DRUG NAME

HARVONI

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

HCV RNA LEVEL.

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

COVERAGE DURATION

DURATION BASED ON FDA APPROVED DOSING SEE OTHER CRITERIA FIELD FOR MORE INFORMATION.

OTHER CRITERIA

GUIDELINE CRITERIA ARE BASED ON AMERICAN ASSOCIATION FOR THE STUDY OF LIVER DISEASES AND INFECTIOUS DISEASE SOCIETY OF AMERICA (AASLD/IDSA) TREATMENT GUIDELINES AND BEST AVAILABLE EVIDENCE. NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). APPROVAL REQUIRES PATIENT HAS EVIDENCE OF HEPATITIS C INFECTION (AT LEAST 2 DETECTABLE HCV RNA LEVELS) OVER THE PAST 6 MONTHS OR PATIENT HAS AT LEAST ONE

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

DETECTABLE HCV RNA LEVEL OVER THE PAST 6 MONTHS AND HAS PREVIOUS EVIDENCE OF INFECTION (E.G., PREVIOUS PRESCRIPTION FOR TREATMENT OF HEPATITIS C). PATIENT IS TREATMENT NAIVE (WITH OR WITHOUT CIRRHOSIS): WILL BE APPROVED FULL 12 WEEKS OF TREATMENT PER PRODUCT LABELING WITHOUT INTERRUPTION (NO RENEWAL). PATIENT WITHOUT CIRRHOSIS WHO HAVE RECEIVED PRIOR TREATMENT (TREATMENT EXPERIENCED PATIENT) SUCH AS PEGINTERFERON AND RIBAVIRIN OR TRIPLE THERAPY WITH HCV PROTEASE INHIBITOR, PEGINTERFERON AND RIBAVIRIN FOR HEPATITIS C: APPROVE 12 WEEKS PER PRODUCT LABELING WITHOUT INTERRUPTION (NO RENEWAL). PATIENT WITH CIRRHOSIS WHO HAS RECEIVED PRIOR TREATMENT (TREATMENT EXPERIENCED PATIENT) SUCH AS PEGINTERFERON AND RIBAVIRIN OR TRIPLE THERAPY WITH HCV PROTEASE INHIBITOR, PEGINTERFERON AND RIBAVIRIN FOR HEPATITIS C: APPROVE 24 WEEKS PER PRODUCT LABELING WITHOUT INTERRUPTION (NO RENEWAL). PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, SIMEPREVIR, SOFOSBUVIR (AS A SINGLE AGENT), STRIBILD (ELVITAGRAVIR/COBICISTAT/EMTRICITABINE /TENOFIVIR), OR TIPRANA VIR/RITONA VIR.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HEPSERA (S)

DRUG NAME

ADEFOVIR DIPIVOXIL | HEPSERA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CHRONIC HEPATITIS B AND PATIENT IS HBSAG-POSITIVE FOR AT LEAST 6 MONTHS AND FOR HBEAG-POSITIVE PATIENTS, SERUM HBV DNA GREATER THAN 20,000 IU/ML (105 COPIES PER ML) AND FOR HBEAG-NEGATIVE PATIENTS, SERUM HBV DNA GREATER THAN 2,000 IU/ML (104 COPIES/ML) AND PATIENT HAS EVIDENCE OF PERSISTENT ELEVATIONS IN SERUM AMINOTRANSFERASE (ALT OR AST) AT LEAST 2 TIMES THE UPPER LIMIT OF NORMAL OR HISTOLOGICALLY ACTIVE DISEASE (I.E. NECROINFLAMMATION ON BIOPSY)

AGE RESTRICTIONS

12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT MUST BE HBEAG NEGATIVE AND HAVE NOT HAD HBSAG CLEARANCE OR HBEAG POSITIVE AND HAVE DETECTABLE HBV DNA AND HAVE NOT BEEN ANTI-HBE FOR AT LEAST 6 MONTHS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HERCEPTIN (S)

DRUG NAME

HERCEPTIN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING: A) HER2 OVEREXPRESSING BREAST CANCER AND PATIENT IS NODE POSITIVE OR NODE NEGATIVE AND EITHER ER/PR NEGATIVE OR ER/PR POSITIVE WITH ONE HIGH RISK FEATURE (I.E. PATHOLOGICAL TUMOR SIZE GREATER THAN 2 CM, GRADE 2-3, OR AGE LESS THAN 35 YEARS) AND MEDICATION IS FOR ADJUVANT TREATMENT AS PART OF A REGIMEN CONSISTING OF: DOXORUBICIN, CYCLOPHOSPHAMIDE, AND EITHER PACLITAXEL OR DOCETAXEL OR WITH DOCETAXEL AND CARBOPLATIN OR AS A SINGLE AGENT FOLLOWING MULTI-MODALITY ANTHRACYCLINE-BASED THERAPY, B) HER2+ METASTATIC BREAST CANCER AND MEDICATION WILL BE USED AS NEOADJUVANT TREATMENT IN A MEMBER WITH LOCALLY ADVANCED, INFLAMMATORY OR EARLY STAGE DISEASE (EITHER GREATER THAN 2 CM IN DIAMETER OR NODE POSITIVE) AND HERCEPTIN IS USED IN COMBINATION WITH PERTUZUMAB AND DOCETAXEL C) HER2-OVEREXPRESSING METASTATIC BREAST CANCER AND MEDICATION WILL BE USED IN COMBINATION WITH PACLITAXEL FOR FIRST-LINE TREATMENT OR AS A SINGLE AGENT IN A PATIENT WHO RECEIVED ONE OR MORE CHEMOTHERAPY REGIMENS FOR METASTATIC DISEASE OR IN COMBINATION WITH PERJETA (PERTUZUMAB) IN A PATIENT WHO HAS NOT RECEIVED PRIOR ANTI-HER2 THERAPY (E.G., TRASTUZUMAB) OR CHEMOTHERAPY FOR METASTATIC DISEASE OR IN COMBINATION WITH TYKERB (LAPATINIB) AS SECOND-LINE TREATMENT OF HER2+ RECURRENT OR METASTATIC DISEASE, D) HER2 OVEREXPRESSING METASTATIC GASTRIC OR GASTROESOPHAGEAL JUNCTION ADENOCARCINOMA AND PATIENT HAS NOT RECEIVED PRIOR TREATMENT FOR METASTATIC DISEASE AND MEDICATION WILL BE USED IN COMBINATION WITH CISPLATIN AND CAPECITABINE OR 5-FLUOROURACIL

AGE RESTRICTIONS

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRESCRIBER HAS ASSESSED THE PATIENT'S CARDIAC FUNCTION/LEFT VENTRICULAR EJECTION FRACTION PRIOR TO INITIATION OF THERAPY. FEMALE PATIENTS OF CHILD-BEARING POTENTIAL HAVE BEEN ADVISED OF THE RISK OF EMBRYO-FETAL DEATH AND BIRTH DEFECTS AND THE NEED FOR EFFECTIVE CONTRACEPTION DURING AND AFTER HERCEPTIN TREATMENT. PREGNANCY STATUS WILL BE VERIFIED PRIOR TO INITIATION OF HERCEPTIN.



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HETLIOZ (S)

DRUG NAME

HETLIOZ

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF NON-24-HOUR-SLEEP-WAKE DISORDER (NON-24) AND PATIENT HAS DOCUMENTED BLINDNESS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS (INITIAL), 12 MONTHS (RENEWAL)

OTHER CRITERIA

FOR RENEWAL, PATIENT EXPERIENCED AN OBJECTIVE IMPROVEMENT (E.G., IMPROVEMENT IN TIMING OF NIGHTTIME SLEEP, IMPROVEMENT IN DURATION OF NIGHTTIME SLEEP, OR REDUCTION IN DAYTIME SLEEP).

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HEXALEN (S)

DRUG NAME

HEXALEN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PERSISTENT OR RECURRENT OVARIAN CANCER AND THE MEDICATION WILL BE USED AS PALLIATIVE TREATMENT AND THE MEDICATION WILL BE USED AS A SINGLE AGENT AND THE MEDICATION WILL BE USED FOLLOWING FIRST-LINE THERAPY WITH A CISPLATIN AND/OR ALKYLATING AGENT-BASED COMBINATION.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HORIZANT (S)

DRUG NAME

HORIZANT

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF MODERATE TO SEVERE PRIMARY RESTLESS LEG SYNDROME AND PATIENT HAS EXPERIENCED TREATMENT FAILURE OR IS INTOLERANT TO ROPINIROLE OR PRAMIPEXOLE OR PATIENT HAS A DIAGNOSIS OF POST-HERPETIC NEURALGIA AND PATIENT TRIED AND FAILED A DOSE OF AT LEAST 1800 MG OF GENERIC GABAPENTIN OR PATIENT HAS EXPERIENCED INTOLERANCE TO GENERIC GABAPENTIN

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAD A MEASURABLE RESPONSE TO THERAPY (E.G. DECREASE IN SYMPTOMS ONSET OR SEVERITY, IMPROVED SLEEP, DECREASE IN SYMPTOM INTENSITY FOR RLS OR DECREASED PAIN SEVERITY FOR PHN)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HRM - ANALGESICS

DRUG NAME

**ASCOMP WITH CODEINE | BUTALB-CAFF-ACETAMINOPH-CODEIN | BUTALBITAL
COMPOUND-CODEINE | DEMEROL | FIORINAL WITH CODEINE #3 | INDOCIN |
INDOMETHACIN | KETOROLAC TROMETHAMINE | MEPERIDINE HCL |
PENTAZOCINE-NALOXONE HCL | TALWIN | TIVORBEX**

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

**THE DRUG IS BEING PRESCRIBED FOR AN FDA-APPROVED INDICATION AND THE
PATIENT HAS TRIED AND FAILED AT LEAST ONE NON-HRM ALTERNATIVE (LISTED
IN OTHER CRITERIA) AND THE PRESCRIBING PHYSICIAN HAS BEEN MADE AWARE
THAT THE REQUESTED DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR
ELDERLY PATIENTS (AGE 65 YEARS AND OLDER) AND WISHES TO PROCEED WITH
THE ORIGINALLY PRESCRIBED MEDICATION .**

AGE RESTRICTIONS

PA APPLIES TO PATIENTS 65 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

**MILD PAIN: ACETAMINOPHEN, CODEINE. MODERATE TO SEVERE PAIN: SHORT-
TERM NSAIDS, TRAMADOL, TRAMADOL/APAP, MORPHINE SULFATE,
HYDROCODONE/APAP, OXYCODONE, OXYCODONE/APAP, FENTANYL. NOT
COVERED FOR MEMBERS ENROLLED IN A MEDICARE APPROVED HOSPICE
PROGRAM**

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HRM - ANTI-ARRHYTHMICS

DRUG NAME

**DIGITEK | DIGOX | DIGOXIN | DISOPYRAMIDE PHOSPHATE | LANOXIN | NORPACE |
NORPACE CR**

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

**THE DRUG IS BEING PRESCRIBED FOR AN FDA-APPROVED INDICATION AND THE
PRESCRIBING PHYSICIAN HAS BEEN MADE AWARE THAT THE REQUESTED DRUG IS
CONSIDERED A HIGH RISK MEDICATION FOR ELDERLY PATIENTS (AGE 65 YEARS
AND OLDER) AND WISHES TO PROCEED WITH THE ORIGINALLY PRESCRIBED
MEDICATION .**

AGE RESTRICTIONS

PA APPLIES TO PATIENTS 65 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HRM - ANTIDEPRESSANTS

DRUG NAME

**AMITRIPTYLINE HCL | ANAFRANIL | CHLORDIAZEPOXIDE-AMITRIPTYLINE |
CLOMIPRAMINE HCL | DOXEPIN HCL | IMIPRAMINE HCL | IMIPRAMINE PAMOATE |
PERPHENAZINE-AMITRIPTYLINE | SURMONTIL | TOFRANIL | TRIMIPRAMINE
MALEATE**

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

**THE DRUG IS BEING PRESCRIBED FOR AN FDA-APPROVED INDICATION AND THE
PATIENT HAS TRIED AND FAILED AT LEAST ONE NON-HRM ALTERNATIVE (LISTED
IN OTHER CRITERIA) AND THE PRESCRIBING PHYSICIAN HAS BEEN MADE AWARE
THAT THE REQUESTED DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR
ELDERLY PATIENTS (AGE 65 YEARS AND OLDER) AND WISHES TO PROCEED WITH
THE ORIGINALLY PRESCRIBED MEDICATION .**

AGE RESTRICTIONS

PA APPLIES TO PATIENTS 65 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

**APPLIES TO NEW STARTS ONLY. DEPRESSION (TRICYCLIC ANTIDEPRESSANTS):
NORTRIPTYLINE, DESIPRAMINE, LOW-DOSE DOXEPIN, TRAZODONE. DEPRESSION
(OTHER): SSRI, SNRI, MIRTAZAPINE, BUPROPION. DULOXETINE, GABAPENTIN.**

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HRM - ANTIEMETIC DRUGS

DRUG NAME

**HYDROXYZINE HCL | HYDROXYZINE PAMOATE | PHENADOZ | PHENERGAN |
PROMETHAZINE HCL | PROMETHEGAN | TIGAN | TRIMETHOBENZAMIDE HCL |
VISTARIL**

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

**THE DRUG IS BEING PRESCRIBED FOR AN FDA-APPROVED INDICATION AND THE
PRESCRIBING PHYSICIAN HAS BEEN MADE AWARE THAT THE REQUESTED DRUG IS
CONSIDERED A HIGH RISK MEDICATION FOR ELDERLY PATIENTS (AGE 65 YEARS
AND OLDER) AND WISHES TO PROCEED WITH THE ORIGINALLY PRESCRIBED
MEDICATION .**

AGE RESTRICTIONS

PA APPLIES TO PATIENTS 65 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

**NOT COVERED FOR MEMBERS ENROLLED IN A MEDICARE APPROVED HOSPICE
PROGRAM.**

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HRM - ANTIHISTAMINES

DRUG NAME

**ARBINOXA | CARBINOXAMINE MALEATE | CLEMASTINE FUMARATE |
CYPROHEPTADINE HCL | KARBINAL ER**

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

**THE DRUG IS BEING PRESCRIBED FOR AN FDA-APPROVED INDICATION AND THE
PRESCRIBING PHYSICIAN HAS BEEN MADE AWARE THAT THE REQUESTED DRUG IS
CONSIDERED A HIGH RISK MEDICATION FOR ELDERLY PATIENTS (AGE 65 YEARS
AND OLDER) AND WISHES TO PROCEED WITH THE ORIGINALLY PRESCRIBED
MEDICATION .**

AGE RESTRICTIONS

PA APPLIES TO PATIENTS 65 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HRM - ANTIHYPERTENSIVE AGENTS

DRUG NAME

**GUANFACINE HCL | METHYLDOPA | METHYLDOPA-HYDROCHLOROTHIAZIDE |
METHYLDOPATE HCL | TENEX**

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

THE DRUG IS BEING PRESCRIBED FOR AN FDA-APPROVED INDICATION AND THE PATIENT HAS TRIED AND FAILED AT LEAST ONE NON-HRM ALTERNATIVE (LISTED IN OTHER CRITERIA) AND THE PRESCRIBING PHYSICIAN HAS BEEN MADE AWARE THAT THE REQUESTED DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR ELDERLY PATIENTS (AGE 65 YEARS AND OLDER) AND WISHES TO PROCEED WITH THE ORIGINALLY PRESCRIBED MEDICATION .

AGE RESTRICTIONS

PA APPLIES TO PATIENTS 65 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

LOW DOSE THIAZIDE OR A SECOND GENERATION CALCIUM CHANNEL BLOCKER OR ACE INHIBITOR, ARB, BETA-BLOCKER OR COMBINATION PRODUCT BASED ON SPECIFIC CHRONIC CONDITIONS. FOR INTUNIV ONLY, ANY FORMULARY METHYLPHENIDATE OR AMPHETAMINE PRODUCT.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HRM - ANTIPARKINSON AGENTS

DRUG NAME

BENZTROPINE MESYLATE | TRIHEXYPHENIDYL HCL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

THE DRUG IS BEING PRESCRIBED FOR AN FDA-APPROVED INDICATION AND THE PRESCRIBING PHYSICIAN HAS BEEN MADE AWARE THAT THE REQUESTED DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR ELDERLY PATIENTS (AGE 65 YEARS AND OLDER) AND WISHES TO PROCEED WITH THE ORIGINALLY PRESCRIBED MEDICATION .

AGE RESTRICTIONS

PA APPLIES TO PATIENTS 65 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HRM - ANTIPSYCHOTICS

DRUG NAME

THIORIDAZINE HCL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

THE DRUG IS BEING PRESCRIBED FOR AN FDA-APPROVED INDICATION AND THE PATIENT HAS TRIED AND FAILED AT LEAST ONE NON-HRM ALTERNATIVE (LISTED IN OTHER CRITERIA) AND THE PRESCRIBING PHYSICIAN HAS BEEN MADE AWARE THAT THE REQUESTED DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR ELDERLY PATIENTS (AGE 65 YEARS AND OLDER) AND WISHES TO PROCEED WITH THE ORIGINALLY PRESCRIBED MEDICATION .

AGE RESTRICTIONS

PA APPLIES TO PATIENTS 65 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

APPLIES TO NEW STARTS ONLY. REQUIRES TRIAL OF AT LEAST ONE NON-HRM ALTERNATIVE: HALOPERIDOL, ATYPICAL ANTIPSYCHOTIC

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HRM - ANXIOLYTICS

DRUG NAME

MEPROBAMATE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

THE DRUG IS BEING PRESCRIBED FOR AN FDA-APPROVED INDICATION AND THE PRESCRIBING PHYSICIAN HAS BEEN MADE AWARE THAT THE REQUESTED DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR ELDERLY PATIENTS (AGE 65 YEARS AND OLDER) AND WISHES TO PROCEED WITH THE ORIGINALLY PRESCRIBED MEDICATION .

AGE RESTRICTIONS

PA APPLIES TO PATIENTS 65 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

NOT COVERED FOR MEMBERS ENROLLED IN A MEDICARE APPROVED HOSPICE PROGRAM.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HRM - CALCIUM CHANNEL BLOCKERS, DIHYDROPYRIDINE

DRUG NAME

NIFEDIPINE | PROCARDIA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

THE DRUG IS BEING PRESCRIBED FOR AN FDA-APPROVED INDICATION AND THE PATIENT HAS TRIED AND FAILED AT LEAST ONE NON-HRM ALTERNATIVE (LISTED IN OTHER CRITERIA) AND THE PRESCRIBING PHYSICIAN HAS BEEN MADE AWARE THAT THE REQUESTED DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR ELDERLY PATIENTS (AGE 65 YEARS AND OLDER) AND WISHES TO PROCEED WITH THE ORIGINALLY PRESCRIBED MEDICATION .

AGE RESTRICTIONS

PA APPLIES TO PATIENTS 65 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

REQUIRES TRIAL OF AT LEAST ONE NON-HRM ALTERNATIVE: EXTENDED-RELEASE NIFEDIPINE, NICARDIPINE, AMLODIPINE

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HRM - DEMENTIA AGENTS

DRUG NAME

ERGOLOID MESYLATES

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

THE DRUG IS BEING PRESCRIBED FOR AN FDA-APPROVED INDICATION AND THE PATIENT HAS TRIED AND FAILED AT LEAST ONE NON-HRM ALTERNATIVE (LISTED IN OTHER CRITERIA) AND THE PRESCRIBING PHYSICIAN HAS BEEN MADE AWARE THAT THE REQUESTED DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR ELDERLY PATIENTS (AGE 65 YEARS AND OLDER) AND WISHES TO PROCEED WITH THE ORIGINALLY PRESCRIBED MEDICATION .

AGE RESTRICTIONS

PA APPLIES TO PATIENTS 65 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

REQUIRES TRIAL OF AT LEAST ONE NON-HRM ALTERNATIVE: DONEPEZIL, GALANTAMINE, RIVASTIGMINE, MEMANTINE

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HRM - ONCOLOGY

DRUG NAME

MEGACE | MEGACE ES | MEGESTROL ACETATE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

THE DRUG IS BEING PRESCRIBED FOR AN FDA-APPROVED INDICATION AND THE PRESCRIBING PHYSICIAN HAS BEEN MADE AWARE THAT THE REQUESTED DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR ELDERLY PATIENTS (AGE 65 YEARS AND OLDER) AND WISHES TO PROCEED WITH THE ORIGINALLY PRESCRIBED MEDICATION .

AGE RESTRICTIONS

PA APPLIES TO PATIENTS 65 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

APPLIES TO NEW STARTS ONLY.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HRM - ORAL AND TRANSDERMAL ESTROGENS AND PROGESTINS

DRUG NAME

ALORA | ANGELIQ | CLIMARA | CLIMARA PRO | ELESTRIN | ESTRACE | ESTRADIOL | ESTROPIPATE | EVAMIST | FEMHRT | JINTELI | MENEST | MENOSTAR | MINIVELLE | NORETHINDRON-ETHINYL ESTRADIOL | PREFEST | PREMARIN | PREMPHASE | PREMPRO | VIVELLE-DOT

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

THE DRUG IS BEING PRESCRIBED FOR AN FDA-APPROVED INDICATION AND THE PRESCRIBING PHYSICIAN HAS BEEN MADE AWARE THAT THE REQUESTED DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR ELDERLY PATIENTS (AGE 65 YEARS AND OLDER) AND WISHES TO PROCEED WITH THE ORIGINALLY PRESCRIBED MEDICATION .

AGE RESTRICTIONS

PA APPLIES TO PATIENTS 65 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HRM - SEDATIVE HYPNOTIC AGENTS

DRUG NAME

AMBIEN | AMBIEN CR | EDLUAR | ESZOPICLONE | INTERMEZZO | LUNESTA | SONATA | ZALEPLON | ZOLPIDEM TARTRATE | ZOLPIDEM TARTRATE ER

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

THE DRUG IS BEING PRESCRIBED FOR AN FDA-APPROVED INDICATION AND THE PRESCRIBING PHYSICIAN HAS BEEN MADE AWARE THAT THE REQUESTED DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR ELDERLY PATIENTS (AGE 65 YEARS AND OLDER) WHEN USED LONGER THAN 90 DAYS AND WISHES TO PROCEED WITH THE ORIGINALLY PRESCRIBED MEDICATION AND INTENDED DURATION OF THERAPY WILL BE VERIFIED.

AGE RESTRICTIONS

PA APPLIES TO PATIENTS 65 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HRM - SKELETAL MUSCLE RELAXANTS

DRUG NAME

AMRIX | CARISOPRODOL | CARISOPRODOL-ASPIRIN | CARISOPRODOL-ASPIRIN-CODEINE | CHLORZOXAZONE | CYCLOBENZAPRINE HCL | FEXMID | LORZONE | METAXALONE | METHOCARBAMOL | ORPHENADRINE CITRATE | SKELAXIN | SOMA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

THE DRUG IS BEING PRESCRIBED FOR AN FDA-APPROVED INDICATION AND THE PRESCRIBING PHYSICIAN HAS BEEN MADE AWARE THAT THE REQUESTED DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR ELDERLY PATIENTS (AGE 65 YEARS AND OLDER) AND WISHES TO PROCEED WITH THE ORIGINALLY PRESCRIBED MEDICATION .

AGE RESTRICTIONS

PA APPLIES TO PATIENTS 65 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HRM - SULFONYLUREAS

DRUG NAME

**CHLORPROPAMIDE | GLUCOVANCE | GLYBURIDE | GLYBURIDE MICRONIZED |
GLYBURIDE-METFORMIN HCL | GLYNASE**

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

THE DRUG IS BEING PRESCRIBED FOR AN FDA-APPROVED INDICATION AND THE PATIENT HAS TRIED AND FAILED AT LEAST ONE NON-HRM ALTERNATIVE (LISTED IN OTHER CRITERIA) AND THE PRESCRIBING PHYSICIAN HAS BEEN MADE AWARE THAT THE REQUESTED DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR ELDERLY PATIENTS (AGE 65 YEARS AND OLDER) AND WISHES TO PROCEED WITH THE ORIGINALLY PRESCRIBED MEDICATION .

AGE RESTRICTIONS

PA APPLIES TO PATIENTS 65 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

GLIMEPIRIDE, GLIPIZIDE

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HRM - VASODILATORS

DRUG NAME

DIPYRIDAMOLE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

THE DRUG IS BEING PRESCRIBED FOR AN FDA-APPROVED INDICATION AND THE PATIENT HAS TRIED AND FAILED AT LEAST ONE NON-HRM ALTERNATIVE (LISTED IN OTHER CRITERIA) AND THE PRESCRIBING PHYSICIAN HAS BEEN MADE AWARE THAT THE REQUESTED DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR ELDERLY PATIENTS (AGE 65 YEARS AND OLDER) AND WISHES TO PROCEED WITH THE ORIGINALLY PRESCRIBED MEDICATION .

AGE RESTRICTIONS

PA APPLIES TO PATIENTS 65 YEARS OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

REQUIRES TRIAL OF AT LEAST ONE NON-HRM ALTERNATIVE: CLOPIDOGREL, AGGRENOX

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

HUMIRA (S)

DRUG NAME

HUMIRA | HUMIRA PEDIATRIC CROHN'S | HUMIRA PEN | HUMIRA PEN CROHN-UC-HS STARTER | HUMIRA PEN PSORIASIS-UVEITIS

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS)

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF 1 OF THE FOLLOWING: A) MODERATE TO SEVERE RHEUMATOID ARTHRITIS AND INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO 1 OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS) (E.G., HYDROXYCHLOROQUINE [HCQ], SULFASALAZINE, METHOTREXATE [MTX], LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE) FOR AT LEAST 3 CONSECUTIVE MONTHS B) MODERATE TO SEVERE POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS AND INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO 1 OR MORE NON-BIOLOGIC DMARDS (E.G., HCQ, SULFASALAZINE, MTX, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE) FOR AT LEAST 3 CONSECUTIVE MONTHS C) PSORIATIC ARTHRITIS AND INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO MTX D) ANKYLOSING SPONDYLITIS AND INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO ONE OR MORE NSAIDS E) MODERATE TO SEVERE CHRONIC PLAQUE PSORIASIS (AFFECTING MORE THAN 5% OF BODY SURFACE AREA OR CRUCIAL BODY AREAS SUCH AS THE HANDS, FEET, FACE, OR GENITALS) AND INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO AT LEAST 1 OF THE FOLLOWING: PHOTOTHERAPY (INCLUDING BUT NOT LIMITED TO ULTRAVIOLET A WITH A PSORALEN [PUVA] AND/OR RETINOIDS [REPUVA] FOR AT LEAST 1 CONTINUOUS MONTH OR 1 OR MORE ORAL SYSTEMIC TREATMENTS (E.G., MTX, CYCLOSPORINE, ACITRETIN, SULFASALAZINE) FOR AT LEAST 3 CONSECUTIVE MONTHS F) MODERATE TO SEVERE CROHN'S DISEASE AND INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO 2 OR MORE OF THE FOLLOWING: CORTICOSTEROIDS (E.G., PREDNISONE, METHYLPREDNISOLONE) OR NON-BIOLOGIC DMARDS (E.G., AZATHIOPRINE, MTX, MERCAPTOPYRINE) G) MODERATE TO SEVERE ULCERATIVE COLITIS AND

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO 2 OR MORE OF THE FOLLOWING: CORTICOSTEROIDS (E.G., PREDNISONE, METHYLPREDNISOLONE), 5-ASA (I.E. MESALAMINE, SULFASALAZINE, BALSALAZIDE, OLSALAZINE) OR NON-BIOLOGIC DMARDS (AZATHIOPRINE, MTX, MERCAPTOPYRINE) H) MODERATE TO SEVERE HIDRADENITIS SUPPURATIVA (HS) I) JUVENILE IDIOPATHIC ARTHRITIS J) NON-INFECTIOUS INTERMEDIATE, POSTERIOR AND PANUVEITIS IN ADULT PATIENTS.

AGE RESTRICTIONS

2 YEARS OF AGE AND OLDER FOR JUVENILE IDIOPATHIC ARTHRITIS AND IN PATIENTS 6 YEARS AND OLDER FOR PEDIATRIC CROHN'S DISEASE. 18 YEARS OF AGE OR OLDER FOR ALL OTHER INDICATIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL - 16 WEEKS (CD), 12 WEEKS (UC), 12 MONTHS (OTHERS). RENEWAL - 12 MONTHS.

OTHER CRITERIA

PATIENT HAS BEEN TESTED FOR TB AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED AS PER GUIDELINES. FOR RENEWAL, PATIENT HAS STABLE DISEASE OR HAS IMPROVED WHILE ON THERAPY (FOR PJIA, REDUCTION IN DISEASE FLARES, IMPROVEMENT IN ACR SCORING. FOR RA, IMPROVEMENT IN TENDER/SWOLLEN JOINT COUNT, IMPROVEMENT IN ACR SCORING. FOR PSA, IMPROVEMENT IN NUMBER OF SWOLLEN/TENDER JOINTS, PAIN, STIFFNESS. FOR AS, IMPROVEMENT IN AS SYMPTOMS, SUCH AS STIFFNESS AND BACK PAIN. FOR CD, SYMPTOMATIC REMISSION. FOR UC, CLINICAL REMISSION, REDUCTION IN STEROID USE.)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ILARIS (S)

DRUG NAME

ILARIS

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CRYOPYRIN-ASSOCIATED PERIOD SYNDROMES (CAPS), INCLUDING FAMILIAL COLD AUTO-INFLAMMATORY SYNDROME (FCAS) AND/OR MUCKLEWELLS SYNDROME (MWS) OR DIAGNOSIS OF ACTIVE SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA) AND PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE, CONTRAINDICATION OR INTOLERANCE TO CORTICOSTEROIDS (E.G., PREDNISONE, METHYLPREDNISOLONE) OR METHOTREXATE

AGE RESTRICTIONS

CAPS - 4 YEARS OF AGE OR OLDER. SJIA - 2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH OR RECOMMENDATION OF, AN IMMUNOLOGIST, ALLERGIST, DERMATOLOGIST, RHEUMATOLOGIST, NEUROLOGIST, OR OTHER MEDICAL SPECIALIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT EXPERIENCED DISEASE STABILITY OR IMPROVEMENT.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

IMBRUVICA (S)

DRUG NAME

IMBRUVICA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

INCRELEX (S)

DRUG NAME

INCRELEX

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

CLOSED EPIPHYSES. ACTIVE OR SUSPECTED MALIGNANCY.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF GROWTH FAILURE IN A CHILD WITH SEVERE PRIMARY IGF-1 DEFICIENCY, DEFINED AS HEIGHT STANDARD DEVIATION SCORE (SDS) LESS THAN OR EQUAL TO -3.0 AND BASAL IGF-1 SDS LESS THAN OR EQUAL TO -3.0 AND NORMAL OR ELEVATED GROWTH HORMONE OR DIAGNOSIS OF GROWTH HORMONE GENE DELETION WITH DEVELOPMENT OF NEUTRALIZING ANTIBODIES TO GROWTH HORMONE AND OTHER CAUSES OF IGF-1 DEFICIENCY (E.G., HYPOTHYROIDISM, NUTRITIONAL DEFICIENCIES, PITUITARY DISORDERS, ETC.) HAVE BEEN RULED OUT OR CORRECTED PRIOR TO INITIATING THERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PEDIATRIC ENDOCRINOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAD A MINIMUM GROWTH RATE OF AT LEAST 2 CM/YEAR.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

INHALED TOBRAMYCIN (S)

DRUG NAME

TOBI PODHALER

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CYSTIC FIBROSIS AND PATIENT HAS EVIDENCE OF P. AERUGINOSA IN THE LUNGS

AGE RESTRICTIONS

6 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT IS BENEFITING FROM TREATMENT (I.E. IMPROVEMENT IN LUNG FUNCTION [FEV1], DECREASED NUMBER OF PULMONARY EXACERBATIONS). FOR INHALATION SOLUTION ONLY (DOES NOT APPLY TO TOBI PODHALER): PART D IF PATIENT IN LONG TERM CARE (DEFINED BY CUSTOMER LOCATION CODE ON CLAIM) OTHERWISE PART B.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

INLYTA (S)

DRUG NAME

INLYTA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ADVANCED RENAL CELL CARCINOMA AND PATIENT FAILED ONE OR MORE SYSTEMIC THERAPIES FOR RENAL CELL CARCINOMA (E.G., SUNITINIB-, BEVACIZUMAB-, TEMSIROLIMUS-, OR CYTOKINE-CONTAINING REGIMENS)

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

INTRON A (S)

DRUG NAME

INTRON A

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

UNCONTROLLED DEPRESSION. SOLID ORGAN TRANSPLANT OTHER THAN LIVER. AUTOIMMUNE HEPATITIS OR OTHER AUTOIMMUNE CONDITION KNOWN TO BE EXACERBATED BY INTERFERON AND RIBAVIRIN.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF HAIRY CELL LEUKEMIA OR DIAGNOSIS OF CONDYLOMATA ACUMINATA OR DIAGNOSIS OF AIDS-RELATED KAPOSI'S SARCOMA OR CLINICALLY AGGRESSIVE FOLLICULAR LYMPHOMA AND THE MEDICATION WILL BE USED CONCURRENTLY WITH ANTHRACYCLINE-CONTAINING CHEMOTHERAPY OR IS NOT A CANDIDATE FOR ANTHRACYCLINE-CONTAINING CHEMOTHERAPY OR MALIGNANT MELANOMA AND THE REQUEST FOR COVERAGE IS WITHIN 56 DAYS OF SURGERY AND THE PATIENT IS AT HIGH RISK OF DISEASE RECURRENCE OR DIAGNOSIS OF CHRONIC HEPATITIS B WITH COMPENSATED LIVER DISEASE AND PATIENT HAS EVIDENCE OF HEPATITIS B VIRAL REPLICATION AND PATIENT HAS BEEN SERUM HEPATITIS B SURFACE ANTIGEN-POSITIVE FOR AT LEAST 6 MONTHS OR DIAGNOSIS OF CHRONIC HEPATITIS C WITH COMPENSATED LIVER DISEASE AND IS RECEIVING COMBINATION THERAPY WITH RIBAVIRIN, UNLESS RIBAVIRIN IS CONTRAINDICATED, AND THE MEDICATION WILL NOT BE USED AS PART OF TRIPLE THERAPY WITH A PROTEASE INHIBITOR AND PATIENT HAS A CLINICAL REASON FOR NOT USING PEGINTERFERON

AGE RESTRICTIONS

1 YEAR OF AGE OR OLDER FOR HBV. 3 YEARS OF AGE OR OLDER FOR HCV. 18 YEARS OF AGE OR OLDER FOR OTHER INDICATIONS.

PRESCRIBER RESTRICTIONS

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

COVERAGE DURATION

**CONDYLOMATA: 3 MOS. HBV E ANTIGEN POS: 16 WKS, E ANTIGEN NEG: 48 WKS. KS:
16 WKS. OTHERS: 12 MOS**

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

INVOKANA (S)

DRUG NAME

INVOKANA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

SEVERE RENAL IMPAIRMENT (ESTIMATED GLOMERULAR FILTRATION RATE [EGFR] LESS THAN 45 ML/MIN/1.73 M2), END STAGE RENAL DISEASE (ESRD), CURRENTLY REQUIRING DIALYSIS, DIABETIC KETOACIDOSIS

REQUIRED MEDICAL INFORMATION

THE MEMBER HAS A DIAGNOSIS OF TYPE 2 DIABETES MELLITUS AND HAS HAD AN INADEQUATE RESPONSE TO DIET AND EXERCISE ALONE AND THE MEMBER HAS TRIED AND HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO METFORMIN.

AGE RESTRICTIONS

18 YEARS OR AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS EXPERIENCED AN IMPROVEMENT IN HEMOGLOBIN A1C (HBA1C) WITH INVOKANA THERAPY. NOTE: MEMBERS WITH AN EGFR OF 45 TO LESS THAN 60 ML/MIN/1.73 M2 WILL BE APPROVED FOR THE 100 MG STRENGTH ONLY ACCORDING TO THE PRESCRIBING INFORMATION.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ISTODAX (S)

DRUG NAME

ISTODAX

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CUTANEOUS T-CELL LYMPHOMA (CTCL) AND THE PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO AT LEAST ONE PRIOR SYSTEMIC THERAPY (E.G., RETINOIDS, TARGRETIN, CORTICOSTEROIDS, RADIATION THERAPY) OR DIAGNOSIS OF PERIPHERAL T-CELL LYMPHOMA (PTCL) AND WHO HAVE TRIED AND HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO AT LEAST ONE PRIOR THERAPY (E.G., RETINOIDS, TARGRETIN, CORTICOSTEROIDS, RADIATION THERAPY).

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

IVIG (S)

DRUG NAME

BIVIGAM | CARIMUNE NF NANOFILTERED | FLEBOGAMMA DIF | GAMMAGARD LIQUID | GAMMAKED | GAMMAPLEX | GAMUNEX-C | PRIVIGEN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

HISTORY OF HYPERSENSITIVITY (INCLUDING ANAPHYLAXIS OR SEVERE SYSTEMIC REACTION) TO IMMUNE GLOBULIN OR ANY COMPONENT OF THE PREPARATION. PRIVIGEN ONLY: HYPERPROLINEMIA.

REQUIRED MEDICAL INFORMATION

MEDICATION WILL BE GIVEN INTRAVENOUSLY AND THE PATIENT HAS ONE OF THE FOLLOWING: A) IDIOPATHIC THROMBOCYTOPENIC PURPURA (ITP) AFTER TRIAL OF CORTICOSTEROIDS UNLESS THE PLATELET COUNT IS LESS THAN 30,000 CELLS/MM3, B) KAWASAKI SYNDROME, C) HYPOGAMMAGLOBULINEMIA (IG LEVEL LESS THAN 500 MG/DL) AND RECURRENT BACTERIAL INFECTION ASSOCIATED WITH B-CELL CHRONIC LYMPHOCYTIC LEUKEMIA, D) CHRONIC INFLAMMATORY DEMYELINATING POLYNEUROPATHY (CIDP), E) MULTIFOCAL MOTOR NEUROPATHY (MMN). OR MEDICATION WILL BE GIVEN BY THE SUBCUTANEOUS ROUTE OR INTRAVENOUS ROUTE AND PATIENT HAS A DIAGNOSIS OF ONE OF THE FOLLOWING TYPES OF PRIMARY IMMUNODEFICIENCY (PI): HYPOGAMMAGLOBULINEMIA, SEVERE COMBINED IMMUNODEFICIENCY, X-LINKED IMMUNODEFICIENCY WITH HYPERIMMUNOGLOBULIN M, CONGENITAL AGAMMAGLOBULINEMIA, COMMON VARIABLE IMMUNODEFICIENCY, WISKOTT-ALDRICH SYNDROME, HYPERIMMUNOGLOBULINEMIA E SYNDROME, SELECTIVE ANTIBODY DEFICIENCY. FOR IV ADMINISTRATION ONLY: PATIENT WILL NOT TAKE THE MEDICATION AT THE MINIMUM CONCENTRATION AVAILABLE AND THE MINIMUM INFUSION RATE PRACTICABLE IF THEY HAVE ONE OF THE FOLLOWING CONDITIONS: PRE-EXISTING RENAL INSUFFICIENCY, DIABETES MELLITUS, VOLUME DEPLETION, SEPSIS, PARAPROTEINEMIA, AGE OVER 65 YEARS, RECEIVING KNOWN NEPHROTOXIC DRUGS.

AGE RESTRICTIONS

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

ITP, KAWASAKI - 3 MONTHS, OTHER - 12 MONTHS.

OTHER CRITERIA

PART B: PATIENT HAS A DIAGNOSIS OF PRIMARY IMMUNE DEFICIENCY AND THE MEDICATION WILL BE PROVIDED IN THE HOME. PART D: MEDICATION WILL BE GIVEN IN THE HOME AND THE PATIENT HAS A DIAGNOSIS OTHER THAN PID OR THE MEDICATION WILL NOT BE GIVEN IN THE HOME.



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

IXEMPRA (S)

DRUG NAME

IXEMPRA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

HISTORY OF SEVERE (CTC GRADE 3/4) HYPERSENSITIVITY REACTION TO AGENTS CONTAINING CREMOPHOR EL OR ITS DERIVATIVES. NEUTROPHILS COUNT LESS THAN 1500 CELLS/MM3 OR A PLATELET COUNT LESS THAN 100,000 CELLS/MM3. AST OR ALT MORE THAN 2.5 TIMES THE UPPER LIMIT OF NORMAL (ULN) OR BILIRUBIN MORE THAN 1 TIME THE ULN WHEN USED IN COMBINATION WITH CAPECITABINE.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF METASTATIC OR LOCALLY ADVANCED BREAST CANCER RESISTANT TO TREATMENT WITH AN ANTHRACYCLINE AND A TAXANE OR WHOSE CANCER IS TAXANE-RESISTANT AND FOR WHOM FURTHER ANTHRACYCLINE THERAPY IS CONTRAINDICATED AND THE MEDICATION WILL BE USED IN COMBINATION WITH CAPECITABINE. DIAGNOSIS OF METASTATIC OR LOCALLY ADVANCED BREAST CANCER IN PATIENTS WHOSE TUMORS ARE RESISTANT OR REFRACTORY TO ANTHRACYCLINES, TAXANES, AND CAPECITABINE AND THE MEDICATION WILL BE USED AS MONOTHERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

JAKAFI (S)

DRUG NAME

JAKAFI

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF MYELOFIBROSIS (PRIMARY, POST-POYCYTHEMIA VERA OR POST-ESSENTIAL THROMBOCYTHEMIA) AND PATIENT HAS TWO OR MORE OF THE FOLLOWING: AGE OLDER THAN 65 YEARS, WHITE BLOOD CELL COUNT GREATER THAN 25 X 10⁹/L, HEMOGLOBIN LESS THAN 10 G/DL, PERIPHERAL BLASTS MORE THAN 1%, CONSTITUTIONAL SYMPTOMS (E.G., NIGHT SWEATS, FEVERS, UNINTENTIONAL WEIGHT LOSS, DEBILITATING FATIGUE)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

FOR RENEWAL, THE PATIENT EXPERIENCED ONE OF THE FOLLOWING: AT LEAST 35% REDUCTION IN SPLEEN VOLUME FROM BASELINE AS MEASURED BY CT OR MRI OR A 50% REDUCTION IN SPLEEN SIZE FROM BASELINE BASED ON PALPATION OR 2 G/DL OR GREATER INCREASE IN HEMOGLOBIN LEVEL (IN TRANSFUSION-INDEPENDENT) OR BECOMING TRANSFUSION INDEPENDENT (FOR TRANSFUSION DEPENDENT) OR IMPROVEMENT IN SYMPTOMS (I.E. ABDOMINAL DISCOMFORT, PAIN UNDER LEFT RIBS, EARLY SATIETY, NIGHT SWEATS, ITCHING, BONE OR MUSCLE PAIN) WITHOUT PROGRESSIVE SPLENOMEGALY OR WORSENING OF ANEMIA (I.E. NEWLY TRANSFUSION DEPENDENT OR HEMOGLOBIN REDUCTION BY 2 G/DL THAT PERSISTS FOR AT LEAST 12 WEEKS), THROMBOCYTOPENIA (MORE THAN 2-GRADE DECLINE BUT ABOVE 25,000 X 10⁹/L) OR NEUTROPENIA (MORE THAN 2-GRADE DECLINE BUT ABOVE 0.5 X 10⁹/L)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

JEVTANA (S)

DRUG NAME

JEVTANA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

HYPERSENSITIVITY TO CABAZITAXEL OR POLYSORBATE 80

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF HORMONE-REFRACTORY (CASTRATION-RESISTANT) METASTATIC PROSTATE CANCER AND PATIENT HAS BEEN PREVIOUSLY TREATED WITH A DOCETAXEL-CONTAINING REGIMEN AND PATIENT IS RECEIVING CONCURRENT PREDNISONE AND PATIENT'S NEUTROPHIL COUNT IS GREATER THAN 1,500/MM³

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

JUXTAPID (S)

DRUG NAME

JUXTAPID

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

MODERATE TO SEVERE LIVER IMPAIRMENT OR ACTIVE LIVER DISEASE INCLUDING UNEXPLAINED PERSISTENT ABNORMAL LIVER FUNCTION TESTS. PREGNANCY. CONCOMITANT USE WITH STRONG OR MODERATE CYP3A4 INHIBITORS.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA AS EVIDENCED BY ONE OF THE FOLLOWING: A) GENETIC CONFIRMATION OF 2 MUTANT ALLELES AT THE LDL RECEPTOR, APOB, PCSK9, OR AUTOSOMAL RECESSIVE HYPERCHOLESTEROLEMIA (ARH) ADAPTOR PROTEIN GENE LOCUS OR B) UNTREATED/PRE-TREATMENT LDL GREATER THAN 500 MG/DL WITH AT LEAST ONE OF THE FOLLOWING: CUTANEOUS OR TENDONOUS XANTHOMA BEFORE AGE 10 YEARS, HISTORY OF EARLY VASCULAR DISEASE (MEN YOUNGER THAN 55 YEARS, WOMEN YOUNGER THAN 60 YEARS) ON BOTH SIDES OF THE FAMILY IF PARENTAL LDL LEVELS ARE UNKNOWN, ELEVATED LDL CHOLESTEROL LEVELS BEFORE LIPID-LOWERING THERAPY CONSISTENT WITH HETEROZYGOUS FH IN BOTH PARENTS WHERE LDL LEVELS ARE KNOWN: LDL CHOLESTEROL MORE THAN 250 MG/DL IN A PATIENT 30 YEARS OF AGE OR OLDER, LDL CHOLESTEROL GREATER THAN 220 MG/DL FOR PATIENTS 20 TO 29 YEARS OF AGE, LDL CHOLESTEROL GREATER THAN 190 MG/DL IN PATIENTS YOUNGER THAN 20 YEARS AND MEDICATION WILL BE USED AS ADJUNCT TO A LOW-FAT DIET AND OTHER LIPID-LOWERING TREATMENTS AND PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE TO THE MAXIMUM TOLERATED DOSE OF A HIGH POTENCY STATIN (E.G., ATORVASTATIN, ROSUVASTATIN), UNLESS ALL STATIN ARE CONTRAINDICATED

AGE RESTRICTIONS

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL - 6 MONTHS. RENEWAL - 12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS RESPONDED TO THERAPY WITH A DECREASE IN LDL LEVELS FROM BASELINE AND PATIENT DOES NOT HAVE CONTRAINDICATIONS TO THERAPY.



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

KADCYLA (S)

DRUG NAME

KADCYLA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PATIENT HAS A DIAGNOSIS OF HER2-POSITIVE METASTATIC BREAST CANCER AND THE MEMBER HAS BEEN PREVIOUSLY TREATED WITH TRASTUZUMAB AND A TAXANE

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PRESCRIBER HAS ASSESSED THE PATIENT'S HEPATIC FUNCTION AND LEFT VENTRICULAR EJECTION FRACTION PRIOR TO INITIATION OF THERAPY. FEMALE PATIENTS OF CHILD-BEARING POTENTIAL HAD PREGNANCY STATUS VERIFIED PRIOR TO THE INITIATION OF KADCYLA AND HAVE BEEN ADVISED OF THE RISK OF EMBRYO-FETAL DEATHS AND BIRTH DEFECTS AND THE NEED FOR EFFECTIVE CONTRACEPTION.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

KALYDECO (S)

DRUG NAME

KALYDECO

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CYSTIC FIBROSIS AND PATIENT HAS ONE OF THE FOLLOWING MUTATIONS: G551D, G1244E, G1349D, G178R, G551S, R117H, S1251N, S1255P, S549N, OR S549R ON AT LEAST ONE ALLELE IN THE CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR GENE DOCUMENTED BY AN FDA-CLEARED CYSTIC FIBROSIS-MUTATION TEST FOLLOWED BY VERIFICATION WITH BI-DIRECTIONAL SEQUENCING WHEN RECOMMENDED BY THE MUTATION TEST INSTRUCTIONS

AGE RESTRICTIONS

2 YEARS AND OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS EXPERIENCED BENEFIT FROM THERAPY (I.E. IMPROVEMENT IN PULMONARY LUNG FUNCTION [FEV1], DECREASED NUMBER OF PULMONARY EXACERBATIONS)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

KEYTRUDA (S)

DRUG NAME

KEYTRUDA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

KINERET (S)

DRUG NAME

KINERET

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS)

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF MODERATE TO SEVERE RHEUMATOID ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS) FOR AT LEAST 3 CONSECUTIVE MONTHS OR DIAGNOSIS OF CRYOPYRIN-ASSOCIATED PERIODIC SYNDROME (CAPS) WITH NEONATAL-ONSET MULTISYSTEM INFLAMMATORY DISEASE (NOMID)

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER FOR RHEUMATOID ARTHRITIS

PRESCRIBER RESTRICTIONS

FOR CAPS, DIAGNOSED BY, OR UPON CONSULTATION WITH OR RECOMMENDATION OF, AN IMMUNOLOGIST, ALLERGIST, DERMATOLOGIST, RHEUMATOLOGIST, NEUROLOGIST OR OTHER MEDICAL SPECIALIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PATIENT HAS BEEN TESTED FOR TB IN THE PAST YEAR AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED PER GUIDELINES. FOR RENEWAL, PATIENT HAS STABLE DISEASE OR IMPROVED ON TREATMENT (FOR RA, IMPROVEMENT IN TENDER/SWOLLEN JOINT COUNT, IMPROVEMENT IN ACR SCORING. FOR CAPS, SYMPTOM IMPROVEMENT, IMPROVEMENT IN SERUM MARKERS OF INFLAMMATION)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

KORLYM (S)

DRUG NAME

KORLYM

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

PREGNANCY. PATIENT REQUIRES CONCOMITANT TREATMENT WITH LONG-TERM CORTICOSTEROIDS (E.G., IMMUNOSUPPRESSION FOR ORGAN TRANSPLANT). HISTORY OF UNEXPLAINED VAGINAL BLEEDING. ENDOMETRIAL HYPERPLASIA WITH ATYPIA OR ENDOMETRIAL CARCINOMA. CONCOMITANTLY TAKING SIMVASTATIN, LOVASTATIN, OR A CYP3A SUBSTRATE WITH A NARROW THERAPEUTIC INDEX (E.G., CYCLOSPORINE, DIHYDROERGOTAMINE, ERGOTAMINE, FENTANYL, PIMOZIDE, QUINIDINE, SIROLIMUS, OR TACROLIMUS)

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ENDOGENOUS CUSHING'S SYNDROME AND DIAGNOSIS OF TYPE 2 DIABETES MELLITUS OR GLUCOSE INTOLERANCE AND PATIENT HAS HYPERGLYCEMIA SECONDARY TO HYPERCORTISOLISM AND PATIENT HAS FAILED OR IS NOT A CANDIDATE FOR SURGERY

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAD A POSITIVE RESPONSE TO THERAPY WITH KORLYM

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

KUVAN (S)

DRUG NAME

KUVAN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PHENYLKETONURIA (PKU) AND PATIENT IS AND WILL BE MAINTAINED ON A PHENYLALANINE-RESTRICTED DIET

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL: 2 MONTHS. RENEWAL: 12 MONTHS.

OTHER CRITERIA

FOR INITIAL APPROVAL, PATIENT WILL HAVE PHENYLALANINE LEVELS MEASURED ONE WEEK AFTER STARTING THERAPY AND PERIODICALLY FOR UP TO TWO MONTHS OF THERAPY TO DETERMINE RESPONSE. FOR RENEWAL, PATIENT HAS BEEN DETERMINED TO BE A RESPONDER TO THERAPY (I.E. PHENYLALANINE LEVELS HAVE DECREASED BY AT LEAST 30% FROM BASELINE) AND PHENYLALANINE LEVELS WILL BE MEASURED PERIODICALLY DURING THERAPY.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

KYNAMRO (S)

DRUG NAME

KYNAMRO

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

MODERATE TO SEVERE LIVER IMPAIRMENT OR ACTIVE LIVER DISEASE INCLUDING UNEXPLAINED PERSISTENT ABNORMAL LIVER FUNCTION TESTS.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA AS EVIDENCED BY ONE OF THE FOLLOWING: A) GENETIC CONFIRMATION OF 2 MUTANT ALLELES AT THE LDL RECEPTOR, APOB, PCSK9, OR AUTOSOMAL RECESSIVE HYPERCHOLESTEROLEMIA (ARH) ADAPTOR PROTEIN GENE LOCUS OR B) UNTREATED/PRE-TREATMENT LDL GREATER THAN 500 MG/DL WITH AT LEAST ONE OF THE FOLLOWING: CUTANEOUS OR TENDONOUS XANTHOMA BEFORE AGE 10 YEARS, HISTORY OF EARLY VASCULAR DISEASE (MEN YOUNGER THAN 55 YEARS, WOMEN YOUNGER THAN 60 YEARS) ON BOTH SIDES OF THE FAMILY IF PARENTERAL LDL LEVELS ARE UNKNOWN, ELEVATED LDL CHOLESTEROL LEVELS BEFORE LIPID-LOWERING THERAPY CONSISTENT WITH HETEROZYGOUS FH IN BOTH PARENTS AND MEDICATION WILL BE USED AS ADJUNCT TO A LOW-FAT DIET AND OTHER LIPID-LOWERING TREATMENTS AND PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE TO THE MAXIMUM TOLERATED DOSE OF A HIGH POTENCY STATIN (E.G., ATORVASTATIN, ROSUVASTATIN), UNLESS ALL STATIN ARE CONTRAINDICATED

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL - 6 MONTHS. RENEWAL - 12 MONTHS

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS RESPONDED TO THERAPY WITH A DECREASE IN LDL LEVELS FROM BASELINE AND PATIENT DOES NOT HAVE CONTRAINDICATIONS TO THERAPY.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

LETAIRIS (S)

DRUG NAME

LETAIRIS

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION WHO GROUP I WITH NEW YORK HEART ASSOCIATION (NYHA) WITH FUNCTIONAL CLASS II OR III THAT WAS CONFIRMED BY RIGHT HEART CATHETERIZATION AND FEMALE PATIENTS HAVE BEEN ENROLLED IN THE LETAIRIS REMS PROGRAM.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL - 6 MONTHS. RENEWAL - 12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

LEUKINE (S)

DRUG NAME

LEUKINE

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

EXCESSIVE LEUKEMIC MYELOID BLASTS (10% OR HIGHER) IN BONE MARROW/PERIPHERAL BLOOD. SIMULTANEOUS USE WITH CYTOTOXIC CHEMOTHERAPY OR RADIOTHERAPY.

REQUIRED MEDICAL INFORMATION

A) MALIGNANT MELANOMA, B) ADJUNCT THERAPY (TX) FOR SEVERE FEBRILE NEUTROPENIA (FN) AND RECEIVING MYELOSUPPRESSIVE TX FOR NON-MYELOID MALIGNANCY AND ONE: RECEIVED PROPHYLACTIC CSF (NOT NEULASTA) OR DID NOT RECEIVE PROPHYLACTIC CSF AND USED AS ADJUNCT TO ANTIBIOTICS IN HIGH-RISK PT WITH ANY ONE: 65 YEARS OR OLDER, PNEUMONIA, HYPOTENSION AND MULTIORGAN DYSFUNCTION (SEPSIS SYNDROME), INVASIVE FUNGAL INFECTION OR CLINICALLY-DOCUMENTED INFECTION, HOSPITALIZED WHEN FEVER DEVELOPED, PRIOR FN, SEVERE (ANC LESS THAN 100/MCL) OR ANTICIPATED PROLONGED (MORE THAN 10 DAYS) NEUTROPENIA, C) AUTOLOGOUS PERIPHERAL-BLOOD PROGENITOR CELL TRANSPLANT FOR COLLECTION BY LEUKAPHERESIS, D) MYELOABLATIVE CHEMOTX FOR NON-MYELOID MALIGNANCY FOLLOWED BY BMT, E) ACUTE MYELOID LEUKEMIA AFTER COMPLETING INDUCTION/CONSOLIDATION CHEMOTX, F) ACUTE LYMPHOBLASTIC LEUKEMIA AFTER COMPLETING FIRST FEW DAYS OF CHEMOTX OF INITIAL INDUCTION OR FIRST POST-REMISSION COURSE, G) MYELOYDYSPLASTIC SYNDROME WITH SEVERE NEUTROPENIA AND RECURRENT INFECTION, H) RECEIVING RADIATION TX, NOT CHEMOTX, AND EXPECT PROLONGED TX DELAYS DUE TO NEUTROPENIA, I) NEUTROPENIA DUE TO HIV INFECTION AND ANTIRETROVIRAL TX, J) APLASTIC ANEMIA, K) PRIMARY PROPHYLAXIS OF FN AND ONE: AT LEAST 20% FN RISK BASED ON CHEMOTX OR 10% UP TO 20% RISK WITH ONE OF THE FOLLOWING: 65 YEARS OR OLDER, POOR PERFORMANCE STATUS, POOR NUTRITIONAL STATUS, PREVIOUS FN, EXTENSIVE PRIOR TX WITH LARGE RADIATION PORTS, CYTOPENIAS DUE TO BONE MARROW INVOLVEMENT BY TUMOR, RECEIVING COMBINED

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

CHEMORADIOTX, OPEN WOUNDS OR ACTIVE INFECTIONS, OTHER SERIOUS COMORBIDITY (E.G., RENAL OR LIVER DYSFUNCTION) OR LESS THAN 10% RISK AND INTENT IS CURATIVE OR ADJUVANT AND AT RISK FOR SERIOUS MEDICAL CONSEQUENCES, INCLUDING DEATH L) MYELOSUPPRESSIVE CHEMOTX FOR NON-MYELOID MALIGNANCY. M) SECONDARY PROPHYLAXIS OF FN IN PT WITH NEUTROPENIC COMPLICATION FROM PRIOR CHEMOTX CYCLE (WHERE PRIMARY PROPHYLAXIS WAS NOT GIVEN) N) ALLOGENEIC OR AUTOLOGOUS BONE MARROW TRANSPLANT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

LEUPROLIDE (S)

DRUG NAME

LEUPROLIDE ACETATE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CENTRAL PRECOCIOUS PUBERTY.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING: A) ADVANCED OR METASTATIC PROSTATE CANCER, B) DIAGNOSIS OF CENTRAL PRECOCIOUS PUBERTY AND PATIENT HAD EARLY ONSET OF SECONDARY SEXUAL CHARACTERISTICS (MALE: EARLIER THAN 9 YEARS OF AGE. FEMALE: EARLIER THAN 8 YEARS OF AGE) AND ADVANCED BONE AGE OF AT LEAST ONE YEAR COMPARED WITH CHRONOLOGICAL AGE AND HAS UNDERGONE GONADOTROPIN-RELEASING HORMONE AGONIST (GNRHA) TESTING WITH PEAK LUTEINIZING HORMONE (LH) LEVEL ABOVE PRE-PUBERTAL RANGE OR RANDOM LH LEVEL IN PUBERTAL RANGE AND PATIENT HAD THE FOLLOWING DIAGNOSTIC EVALUATIONS TO RULE OUT TUMORS, WHEN SUSPECTED: DIAGNOSTIC IMAGING OF THE BRAIN (MRI OR CT SCAN), PELVIC/TESTICULAR/ADRENAL ULTRASOUND (IF STEROID LEVELS SUGGEST SUSPICION), HUMAN CHORIONIC GONADOTROPIN LEVELS (IN ALL BOYS), ADRENAL STEROIDS TO RULE OUT CONGENITAL ADRENAL HYPERPLASIA OR C) THE MEDICATION WILL BE USED FOR STIMULATION TESTING TO CONFIRM THE DIAGNOSIS OF CENTRAL PRECOCIOUS PUBERTY

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

CPP - PRESCRIBED BY OR IN CONSULTATION WITH A PEDIATRIC ENDOCRINOLOGIST

COVERAGE DURATION

12 MONTHS. CPP TESTING: ONE TIME DOSE.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

OTHER CRITERIA

FOR RENEWAL OF CPP, LH LEVELS HAVE BEEN SUPPRESSED TO PRE-PUBERTAL LEVELS AND CONSIDERATION FOR DISCONTINUATION OF THERAPY WHEN THE PATIENT IS 11 YEARS OF AGE FOR GIRLS AND 12 YEARS OF AGE FOR BOYS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

LIDODERM (S)

DRUG NAME

LIDOCAINE | LIDODERM

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF POST-HERPETIC NEURALGIA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS IMPROVEMENT IN PAIN SEVERITY.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

LINZESS (S)

DRUG NAME

LINZESS

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

MECHANICAL GASTROINTESTINAL OBSTRUCTION.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF IRRITABLE BOWEL SYNDROME-CONSTIPATION FOR AT LEAST 12 NON-CONSECUTIVE WEEKS AND PATIENT HAS TRIED AND FAILED INCREASING FLUID AND FIBER INTAKE AND PATIENT HAS TRIED AND FAILED OR HAS AN INTOLERANCE TO OSMOTIC LAXATIVES, STIMULANT LAXATIVES OR PROBIOTICS OR DIAGNOSIS OF CHRONIC IDIOPATHIC CONSTIPATION FOR AT LEAST 3 MONTHS AND PATIENT HAS TRIED AND FAILED INCREASING FLUID AND FIBER INTAKE AND PATIENT HAS TRIED AND FAILED OR HAS AN INTOLERANCE TO OSMOTIC LAXATIVES, STIMULANT LAXATIVES OR STOOL SOFTENERS.

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL - 4 MONTHS. RENEWAL - 12 MONTHS

OTHER CRITERIA

FOR RENEWAL, THE PATIENT HAS EXPERIENCED AN INCREASE IN THE NUMBER OF BOWEL MOVEMENTS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

LUMIZYME (S)

DRUG NAME

LUMIZYME

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF POMPE DISEASE (ACID A-GLUCOSIDASE (GAA) DEFICIENCY)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

LUPANETA (S)

DRUG NAME

LUPANETA PACK

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

UNDIAGNOSED ABNORMAL UTERINE BLEEDING. BREASTFEEDING. KNOWN, SUSPECTED OR HISTORY OF BREAST CANCER OR OTHER HORMONE-SENSITIVE CANCER. THROMBOTIC OR THROMBOEMBOLIC DISORDERS. LIVER TUMORS OR LIVER DISEASE.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ENDOMETRIOSIS AND PATIENT IS UNDERGOING AN INITIAL TREATMENT COURSE AND HAS HAD AN INADEQUATE PAIN CONTROL RESPONSE, INTOLERANCE OR CONTRAINDICATION TO ONE OF THE FOLLOWING: DANAZOL, COMBINATION [ESTROGEN/PROGESTERONE] ORAL CONTRACEPTIVES, PROGESTINS OR PATIENT IS UNDERGOING A RECURRENT TREATMENT COURSE AND IS EXPERIENCING A REAPPEARANCE OF SYMPTOMS AFTER AN INITIAL COURSE OF LEUPROLIDE THERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

IN PATIENTS OF CHILD-BEARING POTENTIAL, PREGNANCY HAS BEEN EXCLUDED AND PATIENT WILL USE NON-HORMONAL CONTRACEPTION DURING AND FOR 12 WEEKS AFER THERAPY.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

LUPRON DEPOT (S)

DRUG NAME

LUPRON DEPOT

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

PREGNANCY IN PATIENTS WITH CHILD-BEARING POTENTIAL. BREASTFEEDING. UNDIAGNOSED ABNORMAL VAGINAL BLEEDING.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING: A) ADVANCED OR METASTATIC PROSTATE CANCER (7.5 MG 1-MONTH, 22.5 MG 3-MONTH, 30 MG 4-MONTH, & 45 MG 6-MONTH DEPOTS ONLY), B) ENDOMETRIOSIS (3.75 MG 1-MONTH & 11.25 MG 3-MONTH DEPOTS ONLY) AND FOR INITIAL, PATIENT HAS HAD AN INADEQUATE PAIN CONTROL RESPONSE OR PATIENT HAS AN INTOLERANCE OR CONTRAINDICATION TO ONE OF THE FOLLOWING: DANAZOL OR COMBINATION [ESTROGEN/PROGESTERONE] ORAL CONTRACEPTIVES OR PROGESTINS AND FOR RETREATMENT COURSE, PATIENT IS EXPERIENCING RECURRENCE OF SYMPTOMS AFTER AN INITIAL COURSE OF THERAPY WITH LEUPROLIDE ACETATE AND NORETHINDRONE ACETATE 5 MG DAILY WILL BE CO-ADMINISTERED, OR C) ANEMIA DUE TO UTERINE LEIOMYOMATA (FIBROIDS) (3.75 MG 1-MONTH & 11.25 MG 3-MONTH DEPOTS ONLY) AND PATIENT IS PREOPERATIVE AND PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE TO MONOTHERAPY WITH IRON AND PATIENT WILL BE RECEIVING CONCOMITANT IRON THERAPY WHILE ON LEUPROLIDE.

AGE RESTRICTIONS

UTERINE FIBROIDS - 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

ENDOMETRIOSIS - 6 MONTHS, UTERINE FIBROIDS - 3 MONTHS, PROSTATE CANCER - 12 MONTHS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

OTHER CRITERIA

**FOR ENDOMETRIOSIS AND UTERINE FIBROIDS, PATIENT WILL BE USING
NONHORMONAL CONTRACEPTION DURING AND FOR 12 WEEKS AFTER THERAPY.**

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

LUPRON DEPOT- PED (S)

DRUG NAME

LUPRON DEPOT-PED

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CENTRAL PRECOCIOUS PUBERTY AND PATIENT HAD EARLY ONSET OF SECONDARY SEXUAL CHARACTERISTICS (MALE: EARLIER THAN 9 YEARS OF AGE. FEMALE: EARLIER THAN 8 YEARS OF AGE) AND ADVANCED BONE AGE OF AT LEAST ONE YEAR COMPARED WITH CHRONOLOGICAL AGE AND HAS UNDERGONE GONADOTROPIN-RELEASING HORMONE AGONIST (GNRHA) TESTING WITH PEAK LUTEINIZING HORMONE (LH) LEVEL ABOVE PRE-PUBERTAL RANGE OR RANDOM LH LEVEL IN PUBERTAL RANGE AND PATIENT HAD THE FOLLOWING DIAGNOSTIC EVALUATIONS TO RULE OUT TUMORS, WHEN SUSPECTED: DIAGNOSTIC IMAGING OF THE BRAIN (MRI OR CT SCAN), PELVIC/TESTICULAR/ADRENAL ULTRASOUND (IF STEROID LEVELS SUGGEST SUSPICION), HUMAN CHORIONIC GONADOTROPIN LEVELS (IN ALL BOYS), ADRENAL STEROIDS TO RULE OUT CONGENITAL ADRENAL HYPERPLASIA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A PEDIATRIC ENDOCRINOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL OF CPP, LH LEVELS HAVE BEEN SUPPRESSED TO PRE-PUBERTAL LEVELS AND CONSIDERATION FOR DISCONTINUATION OF THERAPY WHEN THE PATIENT IS 11 YEARS OF AGE FOR GIRLS AND 12 YEARS OF AGE FOR BOYS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

MEKINIST (S)

DRUG NAME

MEKINIST

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF UNRESECTABLE OR METASTATIC MELANOMA AND MEDICATION IS USED AS A SINGLE AGENT AND PATIENT HAS A POSITIVE BRAF V600E OR V600K MUTATION AS DETECTED BY AN FDA-APPROVED TEST (THXID-BRAF KIT) OR CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)-APPROVED FACILITY, AND THE PATIENT HAS NOT RECEIVED PRIOR BRAF-INHIBITOR THERAPY OR MEDICATION WILL BE USED IN COMBINATION WITH TAFINLAR IN A PATIENT WITH BRAF V600E OR V600K MUTATIONS, AS DETECTED BY AN FDA-APPROVED TEST (THXID-BRAF KIT) OR CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)-APPROVED FACILITY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

MODAFINIL (S)

DRUG NAME

MODAFINIL | PROVIGIL

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING: A) EXCESSIVE SLEEPINESS ASSOCIATED WITH OBSTRUCTIVE SLEEP APNEA (OSA)/HYPOPNEA SYNDROME CONFIRMED BY SLEEP LAB EVALUATION (E.G., MULTIPLE SLEEP LATENCY TEST, POLYSOMNOGRAPHY) AND DOCUMENTATION OF RESIDUAL EXCESSIVE SLEEPINESS B) EXCESSIVE SLEEPINESS ASSOCIATED WITH NARCOLEPSY CONFIRMED BY SLEEP LAB EVALUATION (E.G., MULTIPLE SLEEP LATENCY TEST, POLYSOMNOGRAPHY) AND PATIENT HAS TRIED AND FAILED, IS UNABLE TO TOLERATE, OR HAS CONTRAINDICATION(S) TO AT LEAST ONE OTHER CENTRAL NERVOUS SYSTEM STIMULANT (E.G., METHYLPHENIDATE, MIXED AMPHETAMINE SALTS, DEXTROAMPHETAMINE) OR DIAGNOSIS OF EXCESSIVE SLEEPINESS ASSOCIATED WITH SHIFT WORK DISORDER CONFIRMED BY SLEEP LAB EVALUATION (E.G., MULTIPLE SLEEP LATENCY TEST, POLYSOMNOGRAPHY) AND SLEEP DISTURBANCE CAUSES MEASURABLE FUNCTIONAL IMPAIRMENT IN SOCIAL, OCCUPATIONAL, OR OTHER IMPORTANT AREAS OF FUNCTIONING THAT HAS PERSISTED FOR AT LEAST THREE MONTHS.

AGE RESTRICTIONS

16 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OSA/HYPONNEA SYNDROME - 6 MONTHS (INITIAL), 12 MONTHS (RENEWAL). OTHER DIAGNOSES - 12 MONTHS.

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

MOZOBIL (S)

DRUG NAME

MOZOBIL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PATIENT IS TO UNDERGO AUTOLOGOUS STEM CELL TRANSPLANTATION FOR THE TREATMENT OF NON-HODGKIN'S LYMPHOMA OR MULTIPLE MYELOMA AND PATIENT WILL CONCOMITANTLY RECEIVE A DAILY DOSE OF A GRANULOCYTE COLONY-STIMULATING FACTOR (G-CSF) FOR 4 DAYS PRIOR TO THE FIRST EVENING DOSE OF MOZOBIL AND ON EACH DAY PRIOR TO APHERESIS WHILE USING MOZOBIL.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

4 DAYS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

MYALEPT (S)

DRUG NAME

MYALEPT

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PATIENT HAS A DIAGNOSIS OF CONGENITAL OR ACQUIRED GENERALIZED LIPODYSTROPHY AND PATIENT HAS ONE OR MORE OF THE FOLLOWING METABOLIC ABNORMALITIES: INSULIN RESISTANCE (DEFINED AS REQUIRING MORE THAN 200 UNITS PER DAY), HYPERTRIGLYCERIDEMIA, OR DIABETES AND PATIENT IS REFRACTORY TO CURRENT STANDARDS OF CARE FOR LIPID AND DIABETIC MANAGEMENT AND THE PRESCRIBER IS REGISTERED IN THE MYALEPT REMS PROGRAM

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, THE PATIENT HAS MET ONE OF THE FOLLOWING: SUSTAINED REDUCTION IN HEMOGLOBIN A1C LEVEL FROM BASELINE OR SUSTAINED REDUCTION IN TRIGLYCERIDE LEVELS FROM BASELINE.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

NAGLAZYME (S)

DRUG NAME

NAGLAZYME

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF MUCOPOLYSACCHARIDOSIS VI (MPS VI OR MAROTEAUX-LAMY SYNDROME).

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

NEULASTA (S)

DRUG NAME

NEULASTA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

FOR USE AS PRIMARY PROPHYLAXIS OF FEBRILE NEUTROPENIA (FN) IN ONE OF THE FOLLOWING PATIENTS: A) PATIENT HAS A 20% OR HIGHER RISK OF FN BASED ON CHEMOTHERAPY REGIMEN OR B) PATIENT HAS 10% TO LESS THAN 20% RISK OF DEVELOPING FN BASED ON CHEMOTHERAPY REGIMEN AND AT LEAST ONE OF THE FOLLOWING RISK FACTORS ARE PRESENT: 65 YEARS OR OLDER, POOR PERFORMANCE STATUS, POOR NUTRITIONAL STATUS, PREVIOUS EPISODES OF FEBRILE NEUTROPENIA, EXTENSIVE PRIOR TREATMENT INCLUDING LARGE RADIATION PORTS, CYTOPENIAS DUE TO BONE MARROW INVOLVEMENT BY TUMOR, ADMINISTRATION OF COMBINED CHEMORADIO THERAPY, PRESENCE OF OPEN WOUNDS OR ACTIVE INFECTIONS, OTHER SERIOUS COMORBIDITIES (INCLUDING RENAL OR LIVER DYSFUNCTION NOTABLY ELEVATED BILIRUBIN), OR C) PATIENT HAS LESS THAN 10% RISK OF DEVELOPING FN BASED ON CHEMOTHERAPY REGIMEN AND THE INTENT OF TREATMENT IS CURATIVE OR ADJUVANT AND PATIENT IS AT RISK FOR SERIOUS MEDICAL CONSEQUENCES OF FN, INCLUDING DEATH AND PATIENT IS RECEIVING MYELOSUPPRESSIVE CHEMOTHERAPY REGIMEN FOR A NON-MYELOID MALIGNANCY, OR D) FOR USE AS SECONDARY PROPHYLAXIS OF FN IN A PATIENT WHO HAD A NEUTROPENIC COMPLICATION FROM A PRIOR CYCLE OF CHEMOTHERAPY (FOR WHICH PRIMARY PROPHYLAXIS WAS NOT RECEIVED).

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

NEUPOGEN (S)

DRUG NAME

NEUPOGEN | ZARXIO

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

A) CONGENITAL, CYCLIC, OR IDIOPATHIC NEUTROPENIA, B) ADJUNCT THERAPY (TX) FOR SEVERE FEBRILE NEUTROPENIA (FN) AND RECEIVING MYELOSUPPRESSIVE TX FOR NON-MYELOID MALIGNANCY WITH ANY ONE: RECEIVED PROPHYLACTIC CSF (NOT NEULASTA) OR DID NOT RECEIVE PROPHYLACTIC CSF AND USE AS ADJUNCT TO ANTIBIOTICS IN HIGH-RISK PT AND ANY ONE: 65 YEARS OR OLDER, PNEUMONIA, HYPOTENSION AND MULTIORGAN DYSFUNCTION (SEPSIS SYNDROME), INVASIVE FUNGAL INFECTION OR CLINICALLY-DOCUMENTED INFECTION, HOSPITALIZED WHEN DEVELOPED FEVER, PRIOR FN, SEVERE (ANC LESS THAN 100/MCL) OR ANTICIPATED PROLONGED (MORE THAN 10 DAYS) NEUTROPENIA, C) AUTOLOGOUS PERIPHERAL-BLOOD PROGENITOR CELL TRANSPLANT FOR COLLECTION BY LEUKAPHERESIS, D) MYELOABLATIVE CHEMOTX FOR NON-MYELOID MALIGNANCY FOLLOWED BY BMT, E) ACUTE MYELOID LEUKEMIA AFTER COMPLETING INDUCTION/CONSOLIDATION CHEMOTX, F) ACUTE LYMPHOBLASTIC LEUKEMIA AFTER COMPLETING FIRST FEW DAYS OF CHEMOTX OF INITIAL INDUCTION OR FIRST POST-REMISSION COURSE, G) MYELOYDYSPLASTIC SYNDROME WITH SEVERE NEUTROPENIA AND RECURRENT INFECTION, H) RECEIVING RADIATION TX, NOT CHEMOTX, AND EXPECT PROLONGED TX DELAYS DUE TO NEUTROPENIA, I) NEUTROPENIA DUE TO HIV INFECTION AND ANTIRETROVIRAL TX, J) APLASTIC ANEMIA, K) PRIMARY PROPHYLAXIS OF FN IN ONE OF THE FOLLOWING: AT LEAST 20% FN RISK BASED ON CHEMOTX OR 10% UP TO 20% RISK WITH ONE OF THE FOLLOWING: 65 YEARS OR OLDER, POOR PERFORMANCE STATUS, POOR NUTRITIONAL STATUS, PREVIOUS FN, EXTENSIVE PRIOR TX WITH LARGE RADIATION PORTS, CYTOPENIAS DUE TO BONE MARROW INVOLVEMENT BY TUMOR, COMBINED CHEMORADIOTX, OPEN WOUNDS OR ACTIVE INFECTIONS, OTHER SERIOUS COMORBIDITIES (E.G., RENAL OR LIVER DYSFUNCTION) OR LESS THAN 10% RISK AND INTENT IS CURATIVE OR

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

ADJUVANT AND RISK FOR SERIOUS MEDICAL CONSEQUENCES, INCLUDING DEATH
L) RECEIVING MYELOSUPPRESSIVE CHEMOTX FOR NON-MYELOID MALIGNANCY
M) SECONDARY PROPHYLAXIS OF FN IN PT WITH NEUTROPENIC COMPLICATION
FROM PRIOR CHEMOTX CYCLE (WHERE PRIMARY PROPHYLAXIS WAS NOT
RECEIVED)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

NEXAVAR (S)

DRUG NAME

NEXAVAR

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

SQUAMOUS CELL LUNG CANCER BEING TREATED WITH CARBOPLATIN AND PACLITAXEL.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING: A) UNRESECTABLE HEPATOCELLULAR CARCINOMA, B) ADVANCED RENAL CELL CARCINOMA C) LOCALLY RECURRENT OR METASTATIC, PROGRESSIVE, DIFFERENTIATED THYROID CARCINOMA REFRACTORY TO RADIOACTIVE IODINE TREATMENT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

NORTHERA (S)

DRUG NAME

NORTHERA

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

3 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

NOXAFIL (S)

DRUG NAME

NOXAFIL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

CONCOMITANT TREATMENT WITH SIROLIMUS, CYP 3A4 SUBSTRATES (PIMOZIDE, QUINIDINE), HMG-COA REDUCTASE INHIBITORS PRIMARILY METABOLIZED THROUGH CYP 3A4, OR ERGOT ALKALOIDS

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF OROPHARYNGEAL CANDIDIASIS AND PATIENT TRIED AND FAILED ITRACONAZOLE AND/OR FLUCONAZOLE OR MEDICATION WILL BE USED AS PROPHYLAXIS OF INVASIVE ASPERGILLUS AND CANDIDA INFECTIONS AND THE PATIENT IS AT HIGH RISK OF DEVELOPING THESE INFECTIONS DUE TO BEING SEVERELY IMMUNOCOMPROMISED, SUCH AS HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT) RECIPIENTS WITH GRAFT-VERSUS-HOST DISEASE (GVHD) OR THOSE WITH HEMATOLOGIC MALIGNANCIES WITH PROLONGED NEUTROPENIA FROM CHEMOTHERAPY.

AGE RESTRICTIONS

13 YEARS OF AGE OR OLDER FOR PROPHYLAXIS OF INVASIVE ASPERGILLUS OR CANDIDATE INFECTION

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 WEEKS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

NULOJIX (S)

DRUG NAME

NULOJIX

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

MEDICATION WILL BE USED FOR THE PREVENTION OF KIDNEY TRANSPLANT ORGAN REJECTION AND THE PATIENT IS IMMUNE TO THE EPSTEIN-BARR VIRUS (EBV SEROPOSITIVE) AND THE PATIENT IS PRESCRIBED CONCURRENT THERAPY WITH MYCOPHENOLATE AND CORTICOSTEROIDS.

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

PRESCRIBER IS EXPERIENCED IN IMMUNOSUPPRESSIVE THERAPY AND MANAGEMENT OF TRANSPLANT PATIENTS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PART B IF TRANSPLANT COVERED BY MEDICARE. OTHERWISE PART D

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

NUVIGIL (S)

DRUG NAME

ARMODAFINIL | NUVIGIL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING: A) EXCESSIVE SLEEPINESS ASSOCIATED WITH OBSTRUCTIVE SLEEP APNEA (OSA)/HYPOPNEA SYNDROME CONFIRMED BY SLEEP LAB EVALUATION (E.G., MULTIPLE SLEEP LATENCY TEST, POLYSOMNOGRAPHY) AND DOCUMENTATION OF RESIDUAL EXCESSIVE SLEEPINESS B) EXCESSIVE SLEEPINESS ASSOCIATED WITH NARCOLEPSY CONFIRMED BY SLEEP LAB EVALUATION (E.G., MULTIPLE SLEEP LATENCY TEST, POLYSOMNOGRAPHY) AND PATIENT HAS TRIED AND FAILED, IS UNABLE TO TOLERATE, OR HAS CONTRAINDICATION(S) TO AT LEAST ONE OTHER CENTRAL NERVOUS SYSTEM STIMULANT (E.G., METHYLPHENIDATE, MIXED AMPHETAMINE SALTS, DEXTROAMPHETAMINE) OR DIAGNOSIS OF EXCESSIVE SLEEPINESS ASSOCIATED WITH SHIFT WORK DISORDER CONFIRMED BY SLEEP LAB EVALUATION (E.G., MULTIPLE SLEEP LATENCY TEST, POLYSOMNOGRAPHY) AND SLEEP DISTURBANCE CAUSES MEASURABLE FUNCTIONAL IMPAIRMENT IN SOCIAL, OCCUPATIONAL, OR OTHER IMPORTANT AREAS OF FUNCTIONING THAT HAS PERSISTED FOR AT LEAST THREE MONTHS

AGE RESTRICTIONS

17 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OSA/HYPONNEA SYNDROME - 6 MONTHS (INITIAL), 12 MONTHS (RENEWAL). OTHER DIAGNOSES - 12 MONTHS.

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

OFEV (S)

DRUG NAME

OFEV

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

NOT APPROVED FOR PATIENTS WITH OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, AND CANCER. NOT APPROVED IF PATIENT HAS NOT OBTAINED LIVER FUNCTION TESTS

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

OLYSIO (S)

DRUG NAME

OLYSIO

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PATIENT HAS NOT PREVIOUSLY FAILED A TREATMENT REGIMEN WITH A HEPATITIS C PROTEASE INHIBITOR AND DIAGNOSIS OF CHRONIC HEPATITIS C GENOTYPE 1 VIRUS INFECTION WITH COMPENSATED LIVER DISEASE AND A) MEDICATION WILL BE USED WITH SOFOSBUVIR WITH OR WITHOUT RIBVARIN IN PATIENTS WITH NO CIRRHOSIS FOR 12 WEEKS OR FOR 24 WEEKS IN PATIENTS WITH CIRRHOSIS AND WITHOUT Q80K POLYMORPHISM B) PATIENTS WHO ARE EITHER TREATMENT NAIVE OR TREATMENT EXPERIENCED WHO HAVE FAILED PEG-IFN AND RBV GENOTYPE 1 ARE ELIGIBLE FOR SIMEPREVIR + SOFOSBUVIR.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 OR 24 WEEKS DEPENDING ON PAST MEDICAL HISTORY, CIRRHOSIS HISTORY, AND GENOTYPE

OTHER CRITERIA

NONE

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ONMEL (S)

DRUG NAME

ONMEL

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

VENTRICULAR DYSFUNCTION. CONGESTIVE HEART FAILURE (CHF). HISTORY OF CHF. PREGNANCY OR INTENT TO BECOME PREGNANT. CONCURRENT THERAPY WITH CERTAIN DRUGS METABOLIZED BY CYP3A4 (E.G., CISAPRIDE, LOVASTATIN, METHADONE, ETC.)

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONYCHOMYCOSIS CONFIRMED BY ONE OF THE FOLLOWING: POSITIVE POTASSIUM HYDROXIDE (KOH) PREPARATION, CULTURE, OR HISTOLOGY AND THE PATIENT HAS EXTENSIVE NAIL INVOLVEMENT CAUSING SIGNIFICANT PAIN AND/OR DEBILITATION AND PATIENT HAS TRIED AND FAILED OR HAD A CONTRAINDICATION OR INTOLERANCE TO ORAL TERBINAFINE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

FINGERNAILS - 1 MONTH. TOENAILS OR BOTH - 3 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

OPDIVO (S)

DRUG NAME

OPDIVO

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

OPSUMIT (S)

DRUG NAME

OPSUMIT

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

PREGNANCY.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION WHO GROUP I WITH NEW YORK HEART ASSOCIATION FUNCTIONAL CLASS II OR III AND DIAGNOSIS WAS CONFIRMED BY RIGHT HEART CATHETERIZATION AND FEMALE PATIENTS ARE ENROLLED IN THE OPSUMIT REMS PROGRAM

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS - INITIAL. 12 MONTHS - RENEWAL

OTHER CRITERIA

FOR RENEWAL, MEDICATION WAS EFFECTIVE (I.E. IMPROVED 6 MINUTE WALK DISTANCE, OXYGEN SATURATION, ETC.)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ORENCIA (S)

DRUG NAME

ORENCIA | ORENCIA CLICKJECT

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS)

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING: A) MODERATE TO SEVERE RHEUMATOID ARTHRITIS AND B.)PATIENT HAD AN INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)FOR AT LEAST 3 CONSECUTIVE MONTHS C.) MODERATE TO SEVERE POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS AND D.) PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DMARDS FOR AT LEAST 3 CONSECUTIVE MONTHS AND PATIENT HAD AN INADEQUATE RESPONSE TO ONE OR MORE TUMOR NECROSIS FACTOR INHIBITORS (ADALIMUMAB, CERTOLIZUMAB PEGOL, ETANERCEPT)

AGE RESTRICTIONS

6 YEARS OF AGE OR OLDER FOR JIA. 18 YEARS OF AGE OR OLDER FOR RHEUMATOID ARTHRITIS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PATIENT HAS BEEN TESTED FOR TB AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED. FOR RENEWAL, PATIENT HAS STABLE DISEASE OR HAS

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

IMPROVED WHILE ON THERAPY (E.G., FOR PJIA, REDUCTION IN DISEASE FLARES, IMPROVEMENT IN ACR SCORING. FOR RA, IMPROVEMENT IN TENDER/SWOLLEN JOINT COUNT, IMPROVEMENT IN ACR SCORING.)



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ORENITRAM (S)

DRUG NAME

ORENITRAM ER

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

SEVERE HEPATIC IMPAIRMENT (CHILD PUGH CLASS C)

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION WHO GROUP I WITH NEW YORK HEART ASSOCIATION (NYHA) FUNCTIONAL CLASS III OR III THAT WAS CONFIRMED BY RIGHT HEART CATHETERIZATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS - INITIAL. 12 MONTHS - RENEWAL

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

OTEZLA (S)

DRUG NAME

OTEZLA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PATIENT HAS A DIAGNOSIS OF PSORIATIC ARTHRITIS AND PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE, CONTRAINDICATION, OR INTOLERANCE TO METHOTREXATE

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS STABLE DISEASE OR HAS IMPROVED ON THERAPY, SUCH AS IMPROVEMENT IN NUMBER OF SWOLLEN/TENDER JOINTS, PAIN, OR STIFFNESS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

OXANDRIN (S)

DRUG NAME

OXANDROLONE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

BREAST OR PROSTATE CANCER IN MEN. BREAST CANCER IN WOMEN WITH HYPERCALCEMIA. PREGNANCY. NEPHROSIS OR NEPHROTIC PHASE OF NEPHRITIS. HYPERCALCEMIA.

REQUIRED MEDICAL INFORMATION

PATIENT IS RECEIVING TREATMENT AS AN ADJUNCT THERAPY TO PROMOTE WEIGHT GAIN AND HAS ONE OF THE FOLLOWING: EXTENSIVE SURGERY, CHRONIC INFECTIONS, SEVERE TRAUMA, FAILURE TO GAIN OR MAINTAIN AT LEAST 90% OF IDEAL BODY WEIGHT WITHOUT DEFINITE PATHOPHYSIOLOGIC REASONS AND PATIENT HAS HAD AN INADEQUATE RESPONSE, INTOLERANCE, OR CONTRAINDICATION TO NUTRITIONAL SUPPLEMENTS AND A NUTRITIONAL CONSULT WAS PERFORMED OR OXANDRIN (OXANDROLONE) WILL BE USED TO COUNTERBALANCE PROTEIN CATABOLISM ASSOCIATED WITH CHRONIC CORTICOSTEROID ADMINISTRATION OR PATIENT HAS BONE PAIN ASSOCIATED WITH OSTEOPOROSIS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

OSTEOPOROSIS BONE PAIN: 1 MONTH. OTHER DIAGNOSES: 3 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS EXPERIENCED AN OBJECTIVE IMPROVEMENT (I.E. WEIGHT GAIN, INCREASE IN LEAD BODY MASS, OR REDUCTION IN MUSCLE PAIN/WEAKNESS)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

PEGASYS (S)

DRUG NAME

PEGASYS | PEGASYS PROCLICK

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

UNCONTROLLED DEPRESSION. AUTOIMMUNE HEPATITIS OR OTHER AUTOIMMUNE CONDITION KNOWN TO BE EXACERBATED BY INTERFERON AND RIBAVIRIN.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF HEPATITIS C WITH COMPENSATED LIVER DISEASE AND PATIENT WILL BE RECEIVING ONE OF THE FOLLOWING: A) COMBINATION THERAPY WITH SOFOSBUVIR AND RIBAVIRIN FOR INITIAL TREATMENT OF GENOTYPES 3, 4, 5 OR 6 AND RETREATMENT OF GENOTYPES 2, 3, 4, 5 OR 6 FOR 12 WEEKS OR B.) DIAGNOSIS OF CHRONIC HEPATITIS B AND EVIDENCE OF HEPATITIS B VIRAL REPLICATION AND PATIENT HAS BEEN SERUM HEPATITIS B SURFACE ANTIGEN (HBSAG)- POSITIVE FOR AT LEAST 6 MONTHS.

AGE RESTRICTIONS

TREATMENT OF ADULTS 18 YEARS OR OLDER WITH CHRONIC HEPATITIS C WITH COMPENSATED LIVER DISEASE AS PART OF A COMBINATION REGIMEN WITH OTHER HEPATITIS C VIRUS (HCV) ANTIVIRAL DRUGS. TREATMENT OF PEDIATRIC PATIENTS 5 YEARS AND OLDER WITH CHRONIC HEPATITIS C AND COMPENSATED LIVER DISEASE IN COMBINATION WITH RIBAVIRIN

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

HBV: 12 MOS. HCV: SOVALDI, OLYSIO- 12 WKS. OTHERS-16 WKS (INITIAL) RENEWAL-BASED ON FDA LABEL.

OTHER CRITERIA

FOR RENEWAL OF HCV, APPROVAL IS BASED ON THE REQUIREMENTS OUTLINED IN THE FDA-APPROVED LABELING, INCLUDING VIRAL LOAD, PRESENCE OF CIRRHOSIS , AND RESPONSE TO PRIOR THERAPY.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

PEGINTRON (S)

DRUG NAME

PEGINTRON | PEGINTRON REDIPEN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

UNCONTROLLED DEPRESSION. AUTOIMMUNE HEPATITIS OR OTHER AUTOIMMUNE CONDITION KNOWN TO BE EXACERBATED BY INTERFERON AND RIBAVIRIN.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF HEPATITIS C WITH COMPENSATED LIVER DISEASE AND PATIENT WILL BE RECEIVING ONE OF THE FOLLOWING: A) COMBINATION THERAPY WITH SOFOSBUVIR AND RIBAVIRIN FOR INITIAL TREATMENT OF GENOTYPES 3, 4, 5 OR 6 AND RETREATMENT OF GENOTYPES 2, 3, 4, 5 OR 6 FOR 12 WEEKS.

AGE RESTRICTIONS

3 YEARS OLD OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

SOVALDI, OLYSIO- 12 WKS. OTHERS-16 WKS (INITIAL) RENEWAL- BASED ON FDA LABEL.

OTHER CRITERIA

FOR RENEWAL, APPROVAL IS BASED ON THE REQUIREMENTS OUTLINED IN THE FDA-APPROVED LABELING, INCLUDING VIRAL LOAD, COMBINATION THERAPY, AND RESPONSE TO PRIOR THERAPY.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

PERJETA (S)

DRUG NAME

PERJETA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING: A) HER2-POSITIVE METASTATIC BREAST CANCER AND MEDICATION IS BEING USED IN COMBINATION WITH TRASTUZUMAB AND A TAXANE (PACLITAXEL OR DOCETAXEL) AND PATIENT HAS NOT RECEIVED PRIOR ANTI-HER2 THERAPY (E.G., TRASTUZUMAB) OR CHEMOTHERAPY FOR METASTATIC DISEASE B) HER2-POSITIVE BREAST CANCER AND MEDICATION WILL BE USED AS NEOADJUVANT THERAPY AND PATIENT HAS LOCALLY ADVANCED, INFLAMMATORY, OR EARLY STAGE DISEASE (EITHER GREATER THAN 2 CM IN DIAMETER OR NODE POSITIVE) AND MEDICATION WILL BE USED IN COMBINATION WITH TRASTUZUMAB AND DOCETAXEL

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PREGNANCY STATUS WILL BE VERIFIED PRIOR TO INITIATION OF THERAPY AND FEMALES OF REPRODUCTIVE POTENTIAL WILL BE ADVISED OF THE RISKS OF EMBRYO-FETAL DEATH AND BIRTH DEFECTS, AND THE NEED FOR EFFECTIVE CONTRACEPTION DURING AND AFTER PERTUZUMAB TREATMENT. LEFT VENTRICULAR FUNCTION WILL BE EVALUATED PRIOR TO AND DURING TREATMENT WITH PERJETA. IF THERE IS A CONFIRMED CLINICALLY SIGNIFICANT DECREASE IN LVEF, PERJETA WILL BE DISCONTINUED.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

PLEGRIDY (S)

DRUG NAME

PLEGRIDY | PLEGRIDY PEN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF RELAPSING FORM OF MULTIPLE SCLEROSIS OR DIAGNOSIS OF FIRST CLINICAL EPISODE AND MRI FEATURES CONSISTENT WITH MULTIPLE SCLEROSIS

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, DISEASE HAS NOT PROGRESSED AND HAS RESPONDED TO THERAPY.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

POMALYST (S)

DRUG NAME

POMALYST

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PATIENT HAS A DIAGNOSIS OF MULTIPLE MYELOMA AND THE PATIENT HAS RECEIVED TWO PRIOR THERAPIES, INCLUDING REVLIMID AND VELCADE UNLESS THE PATIENT HAS A CONTRAINDICATION OR INTOLERANCE TO REVLIMID OR VELCADE AND THE PATIENT HAS DEMONSTRATED DISEASE PROGRESSION ON OR WITHIN 60 DAYS OF COMPLETION OF LAST THERAPY AND THE PRESCRIBER IS REGISTERED, AND PATIENT IS ENROLLED IN THE POMALYST REMS PROGRAM

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTH

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

PROLIA (S)

DRUG NAME

PROLIA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PATIENT IS AT HIGH RISK FOR FRACTURE DEFINED AS ONE OF THE FOLLOWING: HISTORY OF OSTEOPOROTIC FRACTURE OR MULTIPLE RISK FACTORS FOR FRACTURE: OLDER AGE (POSTMENOPAUSAL WOMEN AND MEN GREATER THAN 50 YEARS OF AGE, FEMALE GENDER, LOW BMI (LESS THAN 19 KG/M²), RHEUMATOID ARTHRITIS, SMOKER, ALCOHOL INTAKE MORE THAN 3 DRINKS/DAY, PARENTAL HISTORY OF HIP FRACTURE, ORAL GLUCOCORTICOID THERAPY (5 MG OR HIGHER PREDNISONE OR EQUIVALENT FOR 3 MONTHS OR LONGER) AND DIAGNOSIS OF ONE OF THE FOLLOWING: PATIENT IS FEMALE AND IS RECEIVING ADJUVANT AROMATASE INHIBITOR THERAPY FOR BREAST CANCER, PATIENT IS MALE AND IS RECEIVING ANDROGEN DEPRIVATION THERAPY FOR NON-METASTATIC PROSTATE CANCER, PATIENT IS A MALE OR POSTMENOPAUSAL FEMALE WITH A DIAGNOSIS OF OSTEOPOROSIS AND PATIENT HAS A DOCUMENTED TRIAL AND FAILURE WITH A BISPHOSPHONATE (FAILURE IS DEFINED AS NEW FRACTURES IN COMPLIANT PATIENTS) OR CONTRAINDICATION OR INTOLERANCE TO BISPHOSPHONATE THERAPY OR IS UNABLE TO COMPLY WITH APPROPRIATE ADMINISTRATION RECOMMENDATIONS FOR ORAL OR INJECTABLE BISPHOSPHONATE THERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS IMPROVED OR STABILIZED BMD, NO NEW FRACTURES, OR IMPROVED BIOCHEMICAL MARKERS, ETC.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

PROMACTA (S)

DRUG NAME

PROMACTA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING: A) RELAPSED/REFRACTORY CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIC PURPURA (ITP) FOR GREATER THAN 6 MONTHS AND BASELINE PLATELET COUNT IS LESS THAN 50,000/MCL AND DEGREE OF THROMBOCYTOPENIA AND CLINICAL CONDITION INCREASE THE RISK OF BLEEDING AND PATIENT HAD AN INSUFFICIENT RESPONSE, INTOLERANCE, CONTRAINDICATION TO CORTICOSTEROIDS OR IMMUNE GLOBULIN OR INADEQUATE RESPONSE OR CONTRAINDICATION TO SPLENECTOMY, B) CHRONIC HEPATITIS C AND PATIENT HAS THROMBOCYTOPENIA DEFINED AS PLATELETS LESS THAN 90,000/MCL FOR INITIATION (PRE-TREATMENT) OF INTERFERON THERAPY

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

ITP - 12 MONTHS. HEP C - 9 WEEKS (INITIAL), 24 WEEKS (RENEWAL)

OTHER CRITERIA

FOR RENEWAL OF ITP, AFTER AT LEAST 4 WEEKS OF THERAPY AT THE MAXIMUM WEEKLY DOSE (10 MCG/KG) THE PLATELET COUNT INCREASED TO A SUFFICIENT LEVEL TO AVOID CLINICALLY IMPORTANT BLEEDING. FOR RENEWAL OF HEPATITIS C, PLATELETS LESS THAN 75,000/MCL FOR MAINTENANCE OF OPTIMAL INTERFERON-BASED THERAPY.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

PULMOZYME (S)

DRUG NAME

PULMOZYME

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CYSTIC FIBROSIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT IS BENEFITING FROM TREATMENT (I.E. IMPROVEMENT IN LUNG FUNCTION [FEV1], DECREASED NUMBER OF PULMONARY EXACERBATIONS). PART D IF PATIENT IN LONG TERM CARE (DEFINED BY CUSTOMER LOCATION CODE ON CLAIM) OTHERWISE PART B.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

QUININE SULFATE (S)

DRUG NAME

QUALAQUIN | QUININE SULFATE

COVERED USES

**ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
PLASMODIUM VIVAX MALARIA. BABESIOSIS.**

EXCLUSION CRITERIA

**PROLONGATION OF QT INTERVAL. GLUCOSE-6-PHOSPHATE DEHYDROGENASE
DEFICIENCY. MYASTHENIA GRAVIS. KNOWN HYPERSENSITIVITY TO MEFLOROQUINE
OR QUINIDINE. OPTIC NEURITIS.**

REQUIRED MEDICAL INFORMATION

**PATIENT HAS A DIAGNOSIS OF ONE OF THE FOLLOWING: A) UNCOMPLICATED
PLASMODIUM FALCIPARUM MALARIA B) UNCOMPLICATED PLASMODIUM VIVAX
MALARIA C) BABESIOSIS**

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

ONE MONTH

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

RANEXA (S)

DRUG NAME

RANEXA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

HEPATIC CIRRHOSIS. PRE-EXISTING QT PROLONGATION. CONCURRENT THERAPY WITH A STRONG CYP3A4 INHIBITOR. CONCURRENT THERAPY WITH A CYP3A4 INDUCER.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

RAVICTI (S)

DRUG NAME

RAVICTI

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ACUTE HYPERAMMONEMIA. N-ACETYLGLUTAMATE SYNTHASE (NAGS) DEFICIENCY

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF UREA CYCLE DISORDER INVOLVING DEFICIENCIES OF CARBAMOYL PHOSPHATE SYNTHETASE (CPS), ORNITHINE TRANSCARBAMOYLASE (OTC), OR ARGININOSUCCINIC ACID SYNTHETASE (AAS) CONFIRMED VIA ENZYMATIC, BIOCHEMICAL, OR GENETIC TESTING AND PROTEIN-RESTRICTED DIET ALONE OR AMINO ACID SUPPLEMENTS ALONE HAS BEEN INEFFECTIVE AND PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE, IS INTOLERANT, OR HAS A CONTRAINDICATION TO BUPHENYL AND PATIENT WILL MAINTAIN A PROTEIN-RESTRICTED DIET WHILE ON THERAPY.

AGE RESTRICTIONS

2 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

REBIF (S)

DRUG NAME

REBIF | REBIF REBIDOSE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. FIRST CLINICAL EPISODE WITH MRI FEATURES CONSISTENT WITH MULTIPLE SCLEROSIS.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF RELAPSING FORM OF MULTIPLE SCLEROSIS OR DIAGNOSIS OF FIRST CLINICAL EPISODE AND MRI FEATURES CONSISTENT WITH MULTIPLE SCLEROSIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS EXPERIENCED AN OBJECTIVE RESPONSE TO THERAPY (I.E. NO OR SLOWED PROGRESSION OF DISEASE)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

RECLAST (S)

DRUG NAME

RECLAST | ZOLEDRONIC ACID

COVERED USES

ALL FDA-APPROVED INDICATION NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

CREATININE CLEARANCE LESS THAN 35 ML/MIN OR EVIDENCE OF ACUTE RENAL IMPAIRMENT. HYPOCALCEMIA (CORRECTED CALCIUM LEVEL LESS THAN 8.0 MG/DL). PATIENT IS CURRENTLY RECEIVING ZOMETA.

REQUIRED MEDICAL INFORMATION

A) POSTMENOPAUSAL FEMALE WITH OSTEOPOROSIS DIAGNOSED BY BMD (T-SCORE -2.5 OR BELOW) OR HISTORY OF FRACTURE, B) PREVENTION OF OSTEOPOROSIS IN POSTMENOPAUSAL FEMALE WITH ONE RISK FACTOR: LOW BMD (T-SCORE -1.5 OR BELOW), LOW BMI (LESS THAN 19 KG/M²), RHEUMATOID ARTHRITIS, SMOKING, ALCOHOL USE (MORE THAN 3 DRINKS/DAY), PARENTAL HISTORY OF HIP FRACTURE, EQUIVALENT DOSE OF 5 MG PREDNISONE OR MORE/DAY FOR AT LEAST 3 MONTHS, C) GLUCOCORTICOID-INDUCED OSTEOPOROSIS AND ONE OF FOLLOWING: POSTMENOPAUSAL FEMALE OR MALE 50 YEARS OF AGE OR OLDER AT HIGH-RISK FOR FRACTURE (DEFINED AS HISTORY OF OSTEOPOROTIC FRACTURE OR MULTIPLE RISK FACTORS FOR FRACTURE SUCH AS: LOW BMI (LESS THAN 19 KG/M²), FEMALE GENDER, RHEUMATOID ARTHRITIS, SMOKER, ALCOHOL INTAKE MORE THAN 3 DRINKS/DAY, PARENTAL HISTORY OF HIP FRACTURE, OR ORAL GLUCOCORTICOID THERAPY (5 MG OR MORE PREDNISONE DAILY OR EQUIVALENT FOR AT LEAST 3 MONTHS) OR POSTMENOPAUSAL FEMALE, MALE 50 YEARS OF AGE OR OLDER AT MEDIUM OR LOW RISK FOR FRACTURE, OR YOUNGER PATIENT WITH HISTORY OF OSTEOPOROTIC FRACTURE AND EXPECTED TO BE ON 7.5 MG OR HIGHER DAILY DOSE OF PREDNISONE OR EQUIVALENT FOR AT LEAST 3 MONTHS OR PREMENOPAUSAL FEMALE OR MALE 50 YEARS OF AGE OR OLDER WITHOUT HISTORY OF FRACTURE AND EXPECTED TO BE ON 7.5 MG OF PREDNISONE DAILY DOSE OR EQUIVALENT FOR AT LEAST 12 MONTHS. G) PAGET'S DISEASE OF BONE WITH ONE OF THE FOLLOWING: SERUM ALKALINE PHOSPHATASE TWO TIMES OR MORE HIGHER THAN THE UPPER LIMIT OF THE AGE-SPECIFIC NORMAL REFERENCE RANGE, SYMPTOMATIC DISEASE (I.E. BONE PAIN, HEADACHE WITH

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

SKULL INVOLVEMENT, BACK PAIN DUE TO RADICULOPATHY OR ARTHROPATHY, FISSURE FRACTURES), AT RISK FOR COMPLICATIONS FROM THE DISEASE (E.G., THOSE WITH ACTIVE DISEASE NEAR NEUROVASCULAR STRUCTURES OR MAJOR JOINTS) AND FOR OSTEOPOROSIS INDICATIONS, INADEQUATE RESPONSE TO ORAL BISPHOSPHONATES, UNLESS CONTRAINDICATION/INTOLERANCE OR IS UNABLE TO COMPLY WITH APPROPRIATE ADMINISTRATION RECOMMENDATIONS FOR ORAL BISPHOSPHONATE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RETREATMENT OF PAGET'S DISEASE, PATIENT HAS RELAPSED, BASED ON INCREASES IN SERUM ALKALINE PHOSPHATASE, OR IN THOSE WHO FAILED TO ACHIEVE NORMALIZATION OF THEIR SERUM ALKALINE PHOSPHATASE, OR IN THOSE PATIENTS WITH SYMPTOMS. FOR RENEWAL OF GLUCOCORTICOID-INDUCED OSTEOPOROSIS, PATIENT IS CONTINUING TO RECEIVE CORTICOSTEROIDS AND IS BENEFITTING FROM THERAPY (E.G., IMPROVED OR STABILIZED BMD, NO NEW FRACTURES, OR IMPROVED BIOCHEMICAL MARKERS). FOR RENEWAL OF OTHER INDICATIONS, PATIENT IS BENEFITTING FROM THERAPY (E.G., IMPROVED OR STABILIZED BMD, NO NEW FRACTURES, OR IMPROVED BIOCHEMICAL MARKERS).

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

RELISTOR (S)

DRUG NAME

RELISTOR

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

KNOWN OR SUSPECTED MECHANICAL GASTROINTESTINAL OBSTRUCTION. ON RENEWAL, PATIENT DOES NOT HAVE SEVERE OR PERSISTENT DIARRHEA.

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

4 MONTHS

OTHER CRITERIA

FOR RENEWAL, THE PATIENT HAS RESPONDED TO THERAPY (I.E. INCREASE IN BOWEL MOVEMENTS)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

REMICADE (S)

DRUG NAME

REMICADE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS). MODERATE TO SEVERE HEART FAILURE IN PATIENTS RECEIVING DOSES GREATER THAN 5 MG/KG.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING: A) MODERATE TO SEVERE RHEUMATOID ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS) FOR AT LEAST 3 CONSECUTIVE MONTHS AND PATIENT WILL BE ON CONCOMITANT METHOTREXATE B) ANKYLOSING SPONDYLITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO ONE OR MORE NSAIDS C) SEVERE CHRONIC PLAQUE PSORIASIS (AFFECTING MORE THAN 10% OF BODY SURFACE AREA OR AFFECTING CRUCIAL BODY AREAS SUCH AS THE HANDS, FEET, FACE, OR GENITALS) AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO CONVENTIONAL THERAPY WITH AT LEAST ONE OF THE FOLLOWING: PHOTOTHERAPY (INCLUDING BUT NOT LIMITED TO ULTRAVIOLET A WITH A PSORALEN [PUVA] AND/OR RETINOIDS [REPUVA] FOR AT LEAST ONE CONTINUOUS MONTH OR ONE OR MORE ORAL SYSTEMIC TREATMENTS FOR AT LEAST 3 CONSECUTIVE MONTHS D) MODERATE TO SEVERE CROHN'S DISEASE AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE, OR CONTRAINDICATION TO CONVENTIONAL THERAPY WITH TWO OR MORE OF THE FOLLOWING: CORTICOSTEROIDS OR NON-BIOLOGIC DMARDS E) FISTULIZING CROHN'S DISEASE F) MODERATE TO SEVERE ULCERATIVE COLITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO CONVENTIONAL THERAPY WITH TWO OR MORE OF THE FOLLOWING: CORTICOSTEROIDS, 5-ASA (I.E. MESALAMINE, SULFASALAZINE, BALSALAZIDE, OLSALAZINE) OR NON-BIOLOGIC DMARDS G) PSORIATIC ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO METHOTREXATE.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

AGE RESTRICTIONS

6 YEARS OF AGE OR OLDER FOR UC OR CROHN'S DISEASE (NON-FISTULIZING). 18 YEARS OF AGE OR OLDER FOR ALL OTHER INDICATIONS, INCLUDING FISTULIZING CROHN'S DISEASE

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL: 18 WEEKS (CD), 12 MONTHS (OTHERS). RENEWAL 12 MONTHS

OTHER CRITERIA

PATIENT HAS BEEN TESTED FOR TB AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED. FOR RENEWAL, PATIENT HAS STABLE DISEASE OR HAS IMPROVED WHILE ON THERAPY (FOR RA, IMPROVEMENT IN TENDER/SWOLLEN JOINT COUNT, IMPROVEMENT IN ACR SCORING. FOR PSA, IMPROVEMENT IN NUMBER OF SWOLLEN/TENDER JOINTS, PAIN, STIFFNESS. FOR AS, IMPROVEMENT IN AS SYMPTOMS, SUCH AS STIFFNESS AND BACK PAIN. FOR CD, SYMPTOMATIC REMISSION. FOR UC, CLINICAL REMISSION, REDUCTION IN STEROID USE.)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

REMODULIN (S)

DRUG NAME

REMODULIN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION WHO GROUP I WITH NEW YORK HEART ASSOCIATION (NYHA) FUNCTIONAL CLASS II-IV THAT WAS CONFIRMED BY RIGHT HEART CATHETERIZATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS - INITIAL. 12 MONTHS - RENEWAL

OTHER CRITERIA

PART D IF PATIENT IN LONG TERM CARE (DEFINED BY CUSTOMER LOCATION CODE ON CLAIM) OTHERWISE PART B.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

REVATIO (S)

DRUG NAME

REVATIO | SILDENAFIL | SILDENAFIL CITRATE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

RECEIVING NITRATE THERAPY (INCLUDES INTERMITTENT USE)

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION WHO GROUP I WITH NEW YORK HEART ASSOCIATION (NYHA) FUNCTIONAL CLASS II OR III THAT WAS CONFIRMED BY RIGHT HEART CATHETERIZATION

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS - INITIAL. 12 MONTHS - RENEWAL

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

REVLIMID (S)

DRUG NAME

REVLIMID

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF MULTIPLE MYELOMA AND PATIENT HAS RECEIVED AT LEAST ONE PRIOR THERAPY AND MEDICATION WILL BE USED IN COMBINATION WITH DEXAMETHASONE OR DIAGNOSIS OF TRANSFUSION-DEPENDENT ANEMIA DUE TO LOW- OR INTERMEDIATE-1-RISK MYELODYSPLASTIC SYNDROMES ASSOCIATED WITH A DELETION 5Q CYTOGENETIC ABNORMALITY WITH OR WITHOUT ADDITIONAL CYTOGENETIC ABNORMALITIES OR DIAGNOSIS OF MANTLE CELL LYMPHOMA AND PATIENT'S DISEASE HAS RELAPSED OR PROGRESSED AFTER TRYING AT LEAST TWO PRIOR THERAPIES INCLUDING VELCADE AND PATIENT IS ENROLLED IN THE REVLIMID REMS PROGRAM AND PATIENT IS NOT USING THE MEDICATION FOR THE TREATMENT OF CHRONIC LYMPHOCYTIC LEUKEMIA

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

RILUTEK (S)

DRUG NAME

RILUTEK | RILUZOLE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF AMYOTROPHIC LATERAL SCLEROSIS (ALS)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

RITUXAN (S)

DRUG NAME

RITUXAN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

SEVERE, ACTIVE INFECTION.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING: A) NON-HODGKIN'S LYMPHOMA B) CHRONIC LYMPHOCYTIC LEUKEMIA C) GRANULOMATOSIS WITH POLYANGIITIS (GPA, WEGENER'S GRANULOMATOSIS) AND IS RECEIVING CONCURRENT GLUCOCORTICOID THERAPY D) MICROSCOPIC POLYANGIITIS AND IS RECEIVING CONCURRENT GLUCOCORTICOID THERAPY E) MODERATE TO SEVERE RHEUMATOID ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS FOR AT LEAST 3 CONSECUTIVE MONTHS AND PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO BOTH HUMIRA AND ENBREL.

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PATIENT HAS BEEN SCREENED FOR HEPATITIS B VIRUS INFECTION AND DOES NOT HAVE HBV REACTIVATION. FOR RENEWAL OF RA, PATIENT HAS STABLE DISEASE OR HAS IMPROVED WHILE ON THERAPY (E.G., IMPROVEMENT IN TENDER/SWOLLEN JOINT COUNT, IMPROVEMENT IN ACR SCORING) AND IT HAS BEEN 16 WEEKS SINCE THE LAST COURSE OF TREATMENT.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SANDOSTATIN (S)

DRUG NAME

OCTREOTIDE ACETATE | SANDOSTATIN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ACROMEGALY AND PATIENT HAD AN INADEQUATE RESPONSE OR CANNOT BE TREATED WITH SURGICAL RESECTION, PITUITARY IRRADIATION, AND/OR BROMOCRIPTINE MESYLATE AT MAXIMALLY TOLERATED DOSES OR DIAGNOSIS OF METASTATIC CARCINOID TUMOR REQUIRING SYMPTOMATIC TREATMENT OF SEVERE DIARRHEA AND FLUSHING EPISODES OR DIAGNOSIS OF VASOACTIVE INTESTINAL PEPTIDE TUMOR REQUIRING TREATMENT OF PROFUSE WATERY DIARRHEA.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL OF ACROMEGALY, IGF-1 LEVEL HAS NORMALIZED OR IMPROVED. FOR RENEWAL OF METASTATIC CARCINOID TUMOR, PATIENT HAS IMPROVEMENT IN DIARRHEA AND FLUSHING EPISODES. FOR RENEWAL OF VASOACTIVE INTESTINAL PEPTIDE TUMOR, IMPROVEMENT IN DIARRHEA EPISODES.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SANDOSTATIN LAR (S)

DRUG NAME

SANDOSTATIN LAR

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ACROMEGALY AND PATIENT HAD AN INADEQUATE RESPONSE OR CANNOT BE TREATED WITH SURGICAL RESECTION, PITUITARY IRRADIATION, AND/OR BROMOCRIPTINE MESYLATE AT MAXIMALLY TOLERATED DOSES OR DIAGNOSIS OF METASTATIC CARCINOID TUMOR REQUIRING SYMPTOMATIC TREATMENT OF SEVERE DIARRHEA AND FLUSHING EPISODES OR DIAGNOSIS OF VASOACTIVE INTESTINAL PEPTIDE TUMOR REQUIRING TREATMENT OF PROFUSE WATERY DIARRHEA AND PATIENT RECEIVED AT LEAST TWO WEEKS OF SANDOSTATIN INJECTION AND HAS TOLERATE THERAPY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL OF ACROMEGALY, IGF-1 LEVEL HAS NORMALIZED OR IMPROVED. FOR RENEWAL OF METASTATIC CARCINOID TUMOR, PATIENT HAS IMPROVEMENT IN DIARRHEA AND FLUSHING EPISODES. FOR RENEWAL OF VASOACTIVE INTESTINAL PEPTIDE TUMOR, IMPROVEMENT IN DIARRHEA EPISODES.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SAVELLA (S)

DRUG NAME

SAVELLA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

**USE OF MONOAMINE OXIDASE INHIBITORS CONCOMITANTLY OR WITHIN 14 DAYS.
UNCONTROLLED NARROW-ANGLE GLAUCOMA.**

REQUIRED MEDICAL INFORMATION

**DIAGNOSIS OF FIBROMYALGIA AND PATIENT HAD A PREVIOUS TRIAL (OF AT
LEAST 30 DAYS) WITH OR HAS A CONTRAINDICATION, INTOLERANCE, OR ALLERGY
TO ONE OF THE FOLLOWING AGENTS USED FOR THE TREATMENT OF
FIBROMYALGIA: TRICYCLIC ANTIDEPRESSANT, SNRI, SSRI, OR GABAPENTIN.**

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

**FOR RENEWAL PATIENT HAD AN IMPROVEMENT IN PAIN, PHYSICAL FUNCTIONING,
ETC.**

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SEROSTIM (S)

DRUG NAME

SEROSTIM

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ACUTE CRITICAL ILLNESS DUE TO COMPLICATIONS FOLLOWING OPEN HEART OR ABDOMINAL SURGERY, MULTIPLE ACCIDENTAL TRAUMA OR ACUTE RESPIRATORY FAILURE. ACTIVE MALIGNANCY. ACTIVE PROLIFERATIVE OR SEVERE NON-PROLIFERATIVE DIABETIC RETINOPATHY.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF AIDS-WASTING SYNDROME OR CACHEXIA (DEFINED AS UNINTENTIONAL WEIGHT LOSS OF AT LEAST 10% OF BASELINE WEIGHT) AND TREATMENT FAILURE WITH OR INTOLERANCE TO DRONABINOL AND PATIENT IS CURRENTLY RECEIVING TREATMENT WITH ANTIRETROVIRALS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 WEEKS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS EXPERIENCED AN INCREASE IN BODY WEIGHT AND/OR IMPROVEMENT IN LEAD BODY MASS AND WASTING IS STILL EVIDENT

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SIGNIFOR (S)

DRUG NAME

SIGNIFOR

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF (PITUITARY) CUSHING'S DISEASE AND PITUITARY SURGERY IS NOT AN OPTION OR HAS NOT BEEN CURATIVE

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAD A CLINICALLY MEANINGFUL REDUCTION IN 24-HOUR URINARY FREE CORTISOL LEVELS AND/OR IMPROVEMENT IN SIGNS OR SYMPTOMS OF THE DISEASE

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SIMPONI (S)

DRUG NAME

SIMPONI

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS)

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING: A) MODERATE TO SEVERE RHEUMATOID ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS) FOR AT LEAST 3 CONSECUTIVE MONTHS AND PATIENT WILL BE ON CONCOMITANT METHOTREXATE B) PSORIATIC ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE, OR CONTRAINDICATION TO METHOTREXATE C) ANKYLOSING SPONDYLITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO ONE OR MORE NSAIDS D) MODERATELY TO SEVERELY ACTIVE ULCERATIVE COLITIS AND PATIENT HAS HAD INADEQUATE RESPONSES TO, IS INTOLERANT TO, OR IS CONTRAINDICATED TO CONVENTIONAL THERAPY WITH TWO OR MORE OF THE FOLLOWING: CORTICOSTEROIDS (I.E. PREDNISONE, METHYLPREDNISOLONE), 5-ASAS (I.E. MESALAMINE, SULFASALAZINE, BALSALAZIDE, OLSALAZINE), OR NON-BIOLOGIC DMARDS (I.E. AZATHIOPRINE, METHOTREXATE, MERCAPTOPYRINE)

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

RA /PSA/AS: 4 MONTHS. UC: 12 MONTHS RENEWAL: 12 MONTHS FOR ALL DIAGNOSES.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

OTHER CRITERIA

PATIENT HAS BEEN TESTED FOR TB AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED. FOR RENEWAL, PATIENT HAS STABLE DISEASE OR HAS IMPROVED WHILE ON THERAPY (E.G., FOR RA, IMPROVEMENT IN TENDER/SWOLLEN JOINT COUNT, IMPROVEMENT IN ACR SCORING. FOR PSA, IMPROVEMENT IN NUMBER OF SWOLLEN/TENDER JOINTS, PAIN, STIFFNESS. FOR AS, IMPROVEMENT IN AS SYMPTOMS, SUCH AS STIFFNESS AND BACK PAIN. FOR UC, CLINICAL REMISSION, REDUCTION IN STEROID USE.)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SIMPONI ARIA (S)

DRUG NAME

SIMPONI ARIA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS)

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF MODERATE TO SEVERE RHEUMATOID ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS) FOR AT LEAST 3 CONSECUTIVE MONTHS AND PATIENT WILL BE ON CONCOMITANT METHOTREXATE

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS.

OTHER CRITERIA

PATIENT HAS BEEN TESTED FOR TB AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED. FOR RENEWAL, PATIENT HAS STABLE DISEASE OR HAS IMPROVED WHILE ON THERAPY (E.G., FOR RA, IMPROVEMENT IN TENDER/SWOLLEN JOINT COUNT, IMPROVEMENT IN ACR SCORING.)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SIMVASTATIN (S)

DRUG NAME

SIMVASTATIN | VYTORIN | ZOCOR

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ACTIVE LIVER DISEASE. PREGNANCY. NURSING. PATIENT IS TAKING OR INITIATING THERAPY WITH ANY OF THE FOLLOWING: VERAPAMIL, DILTIAZEM, AMIODARONE, DRONEDARONE, AMLODIPINE, RANOLAZINE, STRONG CYP3A4 INHIBITORS (I.E., ITRACONAZOLE, KETOCONAZOLE, POSACONAZOLE, PROTEASE INHIBITORS, ERYTHROMYCIN, CLARITHROMYCIN, TELITHROMYCIN, AND NEFAZODONE), GEMFIBROZIL, CYCLOSPORINE, AND DANAZOL.

REQUIRED MEDICAL INFORMATION

PATIENT HAS BEEN TAKING SIMVASTATIN 80 MG CHRONICALLY (12 MONTHS OR MORE) WITHOUT EVIDENCE OF MUSCLE TOXICITY AND, IF PATIENT IS OF CHINESE DESCENT, THEY ARE NOT CONCURRENTLY RECEIVING LIPID-MODIFYING DOSES (AT LEAST 1 GRAM/DAY) OF NIACIN-CONTAINING PRODUCTS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SOMAVERT (S)

DRUG NAME

SOMAVERT

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ACROMEGALY AND INADEQUATE RESPONSE TO SURGERY AND/OR RADIATION THERAPY AND/OR OTHER MEDICAL THERAPIES (SUCH AS DOPAMINE AGONISTS) AND PATIENT HAD AN INADEQUATE RESPONSE OR INTOLERANCE TO GENERIC OCTREOTIDE OR PATIENT IS NOT A CANDIDATE FOR ANY OF THOSE TREATMENT OPTIONS.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS EXPERIENCED A DECREASE OR NORMALIZATION OF INSULIN-LIKE GROWTH FACTOR-1 (IGF-1) LEVELS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SOVALDI (S)

DRUG NAME

SOVALDI

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CHRONIC HEPATITIS C WITH HCV GENOTYPE 1A, 1B, 2, 3, 4, 5, AND 6

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

UPDATE TO 12-48 WEEKS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SPORANOX (S)

DRUG NAME

ITRACONAZOLE | SPORANOX

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

VENTRICULAR DYSFUNCTION. CONGESTIVE HEART FAILURE (CHF). HISTORY OF CHF. PREGNANCY OR INTENT TO BECOME PREGNANT. CONCURRENT THERAPY WITH CERTAIN DRUGS METABOLIZED BY CYP3A4 (E.G., CISAPRIDE, LOVASTATIN, METHADONE, ETC.)

REQUIRED MEDICAL INFORMATION

PATIENT MEETS ONE OF THE FOLLOWING CONDITIONS: A) DIAGNOSIS OF SYSTEMIC FUNGAL INFECTION (E.G., ASPERGILLOSIS, HISTOPLASMOSIS, BLASTOMYCOSIS) OR B) DIAGNOSIS OF ONYCHOMYCOSIS CONFIRMED BY ONE OF THE FOLLOWING: POSITIVE POTASSIUM HYDROXIDE (KOH) PREPARATION, CULTURE, OR HISTOLOGY AND THE PATIENT HAS EXTENSIVE NAIL INVOLVEMENT CAUSING SIGNIFICANT PAIN AND/OR DEBILITATION AND PATIENT HAS TRIED AND FAILED ORAL TERBINAFINE OR C) DIAGNOSIS OF ONE OF THE FOLLOWING: TINEA CORPORIS (RINGWORM), TINEA CRURIS (JOCK ITCH), TINEA PEDIS (ATHLETE'S FOOT), TINEA CAPITIS (SCALP RINGWORM), PITYRIASIS VERSICOLOR AND THE PATIENT IS RESISTANT TO TOPICAL TREATMENT OR THE PATIENT HAS A DIAGNOSIS OF CANDIDIASIS (ESOPHAGEAL OR OROPHARYNGEAL) THAT IS REFRACTORY TO FLUCONAZOLE (ORAL SOLUTION ONLY)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

**ONYCHOMYCOSIS 5 WEEKS (FINGER) , 3 MONTHS (TOE) OR OTHER USE.
CANDIDIASIS - 4 WEEKS**

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SPRYCEL (S)

DRUG NAME

SPRYCEL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. GIST.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOGENOUS LEUKEMIA (PH+ CML) IN THE CHRONIC PHASE AND PATIENT IS FOUND TO BE PH+ OR BCR-ABL POSITIVE AS DETECTED BY BONE MARROW CYTOGENETICS OR FISH OR PH+ CML WITH RESISTANCE, RELAPSE OR INADEQUATE RESPONSE TO PRIOR TKI THERAPY (E.G., GLEEVEC, TASIGNA, ICLUSIG, BOSULIF) AND IF PATIENT HAS MUTATION TESTING, PATIENT DOES NOT HAVE T315I MUTATION OR PH+ CML WITH INTOLERANCE TO PRIOR THERAPY OR DIAGNOSIS OF PH+ ACUTE LYMPHOBLASTIC LEUKEMIA OR GASTROINTESTINAL STROMAL TUMORS (GIST) AFTER DISEASE PROGRESSION ON GLEEVEC (IMATINIB) OR SUTENT (SUNITINIB)

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

STELARA (S)

DRUG NAME

STELARA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS [TB])

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING: A) MODERATE TO SEVERE PLAQUE PSORIASIS (AFFECTING MORE THAN 5% OF THE BODY SURFACE AREA OR AFFECTING CRUCIAL BODY AREAS SUCH AS THE HANDS, FEET, FACE, OR GENITALS) AND PATIENT TRIED AND HAD AN INADEQUATE RESPONSE, IS INTOLERANT OF, OR IS CONTRAINDICATED TO CONVENTIONAL THERAPY WITH AT LEAST ONE OF THE FOLLOWING: PHOTOTHERAPY (INCLUDING BUT NOT LIMITED TO, PSORALEN WITH ULTRAVIOLET-A [PUVA] AND/OR RETINOIDS [REPUVA]) FOR AT LEAST ONE CONTINUOUS MONTH OR ORAL SYSTEMIC TREATMENT (E.G., METHOTREXATE, CYCLOSPORINE, ACITRETIN) FOR AT LEAST 3 CONSECUTIVE MONTHS B) PSORIATIC ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE, OR CONTRAINDICATION TO METHOTREXATE

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PATIENT HAS BEEN TESTED FOR LATENT TB INFECTION AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED PER GUIDELINES. FOR RENEWAL, PATIENT HAS STABLE DISEASE OR HAS IMPROVED WHILE ON THERAPY (E.G., FOR PSA, IMPROVEMENT IN NUMBER OF SWOLLEN/TENDER JOINTS, PAIN, STIFFNESS).

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

STIVARGA (S)

DRUG NAME

STIVARGA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF: A) METASTATIC COLON OR RECTAL CANCER AND PATIENT HAS PREVIOUSLY TREATED WITH FLUOROPYRIMIDINE-, OXALIPLATIN-, AND IRINOTECAN-BASED THERAPY, AN ANTI-VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) THERAPY, AND, IF KRAS WILD TYPE, AN ANTI-EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) THERAPY OR B) GASTROINTESTINAL STROMAL TUMORS THAT IS LOCALLY ADVANCED, UNRESECTABLE OR METASTATIC AND PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE, CONTRAINDICATION OR INTOLERANCE TO GLEEVEC OR SUTENT.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

IF PATIENT HAS ELEVATED LIVER FUNCTION TESTS OF HEPATOCELLULAR NECROSIS, THERAPY WILL BE INTERRUPTED AND THEN REDUCED OR DISCONTINUED.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SUBUTEX (S)

DRUG NAME

BUPRENORPHINE HCL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PATIENT HAS A DIAGNOSIS OF OPIOID DEPENDENCE AND PRESCRIPTION IS A PART OF AN OVERALL TREATMENT PROGRAM (E.G., SELF-HELP GROUPS, COUNSELING, PROVIDE ONGOING CARE, VOCATIONAL TRAINING) AND PATIENT IS NOT RECEIVING ANY OTHER OPIOIDS SINCE STARTING THERAPY

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBER IS CERTIFIED THROUGH SAMHSA (SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION) TO PRESCRIBE SUBOXONE AND PROVIDE REGISTRATION NUMBER

COVERAGE DURATION

INITIAL - 3 MONTHS (PREGNANT) OR 1 MONTH (NOT PREGNANT). RENEWAL - 9 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT MEETS ALL INITIAL CRITERIA AND PRESCRIBER IS EVALUATING RANDOM URINE DRUG SCREENS AND ASSESSING THE PATIENT'S PROGRESS (E.G., RELAPSE, PROGRESS/ACCOMPLISHMENT OF TREATMENT GOALS)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SUTENT (S)

DRUG NAME

SUTENT

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ADVANCED/METASTATIC RENAL CELL CARCINOMA OR DIAGNOSIS OF GASTROINTESTINAL STROMAL TUMORS AFTER DISEASE PROGRESSION ON OR INTOLERANCE TO GLEEVEC OR DIAGNOSIS OF PROGRESSIVE, WELL-DIFFERENTIATED PANCREATIC NEUROENDOCRINE TUMORS IN A PATIENT WITH UNRESECTABLE LOCALLY ADVANCED OR METASTATIC DISEASE.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SYLATRON (S)

DRUG NAME

SYLATRON

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

AUTOIMMUNE HEPATITIS. HEPATIC DECOMPENSATION (CHILD-PUGH SCORE GREATER THAN 6 [CLASS B OR C])

REQUIRED MEDICAL INFORMATION

PATIENT IS BEING TREATED ADJUVANTLY FOR MELANOMA WITH MICROSCOPIC OR GROSS NODAL INVOLVEMENT WITHIN 84 DAYS OF DEFINITIVE SURGICAL RESECTION INCLUDING COMPLETE LYMPHADENECTOMY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SYLVANT (S)

DRUG NAME

SYLVANT

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PATIENT HAS A DIAGNOSIS OF MULTICENTRIC CASTLEMAN'S DISEASE AND PATIENT IS HIV NEGATIVE AND PATIENT IS HUMAN HERPES VIRUS-8 (HHV-8) NEGATIVE

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS NOT EXPERIENCED TREATMENT FAILURE DEFINED AS DISEASE PROGRESSION BASED ON INCREASE IN SYMPTOMS, RADIOLOGIC PROGRESSION, OR DETERIORATION IN PERFORMANCE STATUS

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SYMLIN (S)

DRUG NAME

SYMLINPEN 120 | SYMLINPEN 60

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

CONFIRMED DIAGNOSIS OF GASTROPARESIS. CONCURRENT USE OF DRUGS THAT STIMULATE GASTROINTESTINAL MOTILITY. RECURRENT SEVERE HYPOGLYCEMIA REQUIRING ASSISTANCE DURING THE PAST 6 MONTHS. PRESENCE OF HYPOGLYCEMIA UNAWARENESS. POOR COMPLIANCE WITH CURRENT INSULIN REGIMEN. POOR COMPLIANCE WITH PRESCRIBED SELF-BLOOD GLUCOSE MONITORING. HEMOGLOBIN A1C LEVEL HIGHER THAN 9%.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF TYPE 1 OR TYPE 2 DIABETES MELLITUS AND PATIENT HAS FAILED TO ACHIEVE DESIRED GLUCOSE CONTROL DESPITE OPTIMAL INSULIN THERAPY AND PATIENT IS TAKING CONCURRENT MEALTIME INSULIN THERAPY (E.G., HUMULIN, HUMALOG, NOVOLIN, NOVOLOG) AND PATIENT IS RECEIVING ONGOING CARE AND GUIDANCE FOR THEIR DIABETES

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS AN IMPROVEMENT IN HEMOGLOBIN A1C FROM BASELINE.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SYNAGIS (S)

DRUG NAME

SYNAGIS

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

PATIENT WILL USE PALIVIZUMAB FOR IMMUNOPROPHYLAXIS OF RESPIRATORY SYNCYTIAL VIRUS (RSV) DURING THE PEAK MONTHS OF INFECTION IN THE PATIENT'S GEOGRAPHIC REGION AND PATIENT MEETS ONE OF THE FOLLOWING CRITERIA: A) INFANTS BORN AT 28 WEEKS, SIX DAYS GESTATION OR EARLIER AND WHO ARE YOUNGER THAN 12 MONTHS OF AGE AT THE START OF THE RSV SEASON OR B) INFANTS BORN AT 29 TO 31 WEEKS, SIX DAYS GESTATION AND WHO ARE YOUNGER THAN SIX MONTHS OF AGE AT THE START OF THE RSV SEASON OR C) INFANTS BORN AT 32 TO 34 WEEKS, SIX DAYS GESTATION AND WHO ARE YOUNGER THAN THREE MONTHS OF AGE AT THE START OF RSV SEASON WITH AT LEAST ONE OF THE FOLLOWING RISK FACTORS MAY BE DOSED UNTIL 90 DAYS OF AGE: CHILD CARE ATTENDANCE OR SIBLING YOUNGER THAN FIVE YEARS OF AGE LIVING IN THE SAME HOUSEHOLD (WHO IS NOT A MULTIPLE BIRTH YOUNGER THAN ONE YEAR OF AGE) OR D) INFANTS AND CHILDREN YOUNGER THAN ONE YEAR OF AGE AT THE START OF RSV SEASON WITH EITHER CONGENITAL ABNORMALITIES OF THE AIRWAY OR NEUROMUSCULAR DISEASE THAT COMPROMISES HANDLING OF RESPIRATORY SECRETIONS OR E) INFANTS AND CHILDREN YOUNGER THAN TWO YEARS OF AGE WITH HEMODYNAMICALLY SIGNIFICANT CONGENITAL HEART DISEASE AND WHO HAVE AT LEAST ONE OF THE FOLLOWING CRITERIA: RECEIVING MEDICATION TO CONTROL CONGESTIVE HEART FAILURE, HAS MODERATE TO SEVERE PULMONARY HYPERTENSION, OR HAS CYANOTIC HEART DISEASE OR F) INFANTS AND CHILDREN YOUNGER THAN TWO YEARS OF AGE WHO HAVE RECEIVED MEDICAL THERAPY (OXYGEN, BRONCHODILATOR, DIURETIC, OR CORTICOSTEROID THERAPY) FOR CHRONIC LUNG DISEASE WITHIN SIX MONTHS OF THE START OF THE RSV SEASON

AGE RESTRICTIONS

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

APPROVE 5 DOSES BASED ON PATIENT BODY WEIGHT.



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

SYNRIBO (S)

DRUG NAME

SYNRIBO

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CHRONIC MYELOGENOUS LEUKEMIA AND PATIENT HAS TRIED AND FAILED OR HAS A CONTRAINDICATION OR INTOLERANCE TO 2 TYROSINE KINASE INHIBITORS

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TACLONEX (S)

DRUG NAME

CALCIPOTRIENE-BETAMETHASONE DP | TACLONEX

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF STABLE PSORIASIS VULGARIS (PLAQUE PSORIASIS) AND PATIENT TRIED ADEQUATE THERAPY (AT LEAST TWO WEEKS) WITH AT LEAST ONE OF THE FOLLOWING AGENTS: MEDIUM TO HIGH POTENCY TOPICAL STEROID (UNLESS CONTRAINDICATED/INTOLERANT WITHOUT CONCURRENT VITAMIN D ANALOG USE) OR VITAMIN D ANALOGS (UNLESS CONTRAINDICATED/INTOLERANT WITHOUT CONCURRENT STEROID USE) OR TAZAROTENE (UNLESS CONTRAINDICATED/INTOLERANT TO ITS USE)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, HAS THE PATIENT'S SYMPTOMS HAVE IMPROVED

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TAFINLAR (S)

DRUG NAME

TAFINLAR

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF UNRESECTABLE OR METASTATIC MELANOMA AND MEDICATION WILL BE USED AS A SINGLE AGENT IN A PATIENT WITH A POSITIVE BRAF V600E MUTATION AS DETECTED BY AN FDA-APPROVED TEST (THXID-BRAF KIT) OR CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)-APPROVED FACILITY OR MEDICATION WILL BE USED IN COMBINATION WITH MEKINIST IN A PATIENT WITH BRAF V600E OR V600K MUTATION, AS DETECTED BY AN FDA-APPROVED TEST (THXID-BRAF KIT) OR CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)-APPROVED FACILITY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TARCEVA (S)

DRUG NAME

TARCEVA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF LOCALLY ADVANCED, UNRESECTABLE, OR METASTATIC PANCREATIC CANCER AND TARCEVA WILL BE USED IN COMBINATION WITH GEMCITABINE OR DIAGNOSIS OF LOCALLY ADVANCED OR METASTATIC (STAGE III OR IV) NON-SMALL CELL LUNG CANCER WITH ONE OF THE FOLLOWING: A) FAILURE WITH AT LEAST ONE PRIOR CHEMOTHERAPY REGIMEN AND TARCEVA WILL BE USED AS MONOTHERAPY, OR B) NO EVIDENCE OF DISEASE PROGRESSION AFTER FOUR CYCLES OF FIRST-LINE PLATINUM-BASED CHEMOTHERAPY AND TARCEVA WILL BE USED AS MAINTENANCE TREATMENT AND TARCEVA WILL BE USED AS MONOTHERAPY, OR C) PATIENT HAS KNOWN ACTIVE EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) EXON 19 DELETIONS OR EXON 21 (L858R) SUBSTITUTION MUTATION AS DETECTED BY AN FDA-APPROVED TEST OR CLINICAL LABORATORY IMPROVEMENT AMENDMENTS-APPROVED FACILITY

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TARGRETIN (S)

DRUG NAME

BEXAROTENE | TARGRETIN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CUTANEOUS T-CELL LYMPHOMA (CTCL) AND PATIENT IS NOT A CANDIDATE FOR OR HAD AN INADEQUATE RESPONSE, IS INTOLERANT TO, OR HAS A CONTRAINDICATION TO AT LEAST ONE PRIOR SYSTEMIC THERAPY (E.G., CORTICOSTEROIDS) FOR CUTANEOUS MANIFESTATIONS OF CTCL

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FEMALE PATIENTS OF CHILD-BEARING POTENTIAL HAVE A DOCUMENTED NEGATIVE PREGNANCY TEST ONE WEEK PRIOR TO THE INITIATION OF THERAPY. FOR RENEWAL, PATIENT HAS NOT HAD DISEASE PROGRESSION WHILE ON THERAPY AND FEMALE PATIENTS OF CHILD-BEARING POTENTIAL ARE NOT PREGNANT AND ARE CONTINUING TO USE ADEQUATE BIRTH-CONTROL MEASURES DURING THERAPY.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TASIGNA (S)

DRUG NAME

TASIGNA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. GIST.

EXCLUSION CRITERIA

LONG QT SYNDROME. UNCORRECTED HYPOKALEMIA. UNCORRECTED HYPOMAGNESEMIA. CONCOMITANT USE WITH A DRUG KNOWN TO PROLONG THE QT INTERVAL OR STRONG CYTOCHROME P450 3A4 INHIBITORS

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING: A) NEWLY DIAGNOSED PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOGENOUS LEUKEMIA (PH+ CML) IN THE CHRONIC PHASE AND PATIENT IS FOUND TO BE PH+ OR BCR-ABL POSITIVE AS DETECTED BY BONE MARROW CYTOGENETICS OR FISH OR DIAGNOSIS OF PH+ CML WITH RESISTANCE, RELAPSE OR INADEQUATE RESPONSE TO PRIOR THERAPY AND IF THE PATIENT HAD MUTATION TESTING, PATIENT DOES NOT HAVE THE T315I MUTATION OR PH+ CML WITH INTOLERANCE TO PRIOR THERAPY B) GASTROINTESTINAL STROMAL TUMORS AFTER DISEASE PROGRESSION ON GLEEVEC OR SUTENT

AGE RESTRICTIONS

18 YEARS OF AGE

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TAZORAC (S)

DRUG NAME

TAZORAC

COVERED USES

ALL FDA-APPROVED INDICATION NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ACNE VULGARIS AND PATIENT HAS TRIED AN ADEQUATE TRIAL (AT LEAST TWO WEEKS) WITH AT LEAST ONE OTHER TOPICAL ACNE PRODUCT (E.G., BENZOYL PEROXIDE, SALICYLIC ACID, CLINDAMYCIN, ERYTHROMYCIN, ADAPALENE, AZELAIC ACID, AND/OR TRETINOIN) OR DIAGNOSIS OF STABLE MODERATE TO SEVERE PLAQUE PSORIASIS AND 20% OR LESS BODY SURFACE AREA INVOLVEMENT AND PATIENT HAS A CONTRAINDICATION OR TRIED ADEQUATE TRIAL (AT LEAST 2 WEEKS) WITH AT LEAST ONE OTHER TOPICAL PSORIASIS PRODUCT (E.G., MEDIUM TO HIGH POTENCY CORTICOSTEROID AND/OR VITAMIN D ANALOGS) AND FEMALES OF CHILD-BEARING POTENTIAL ARE USING ADEQUATE BIRTH CONTROL MEASURES DURING THERAPY.

AGE RESTRICTIONS

12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TECFIDERA (S)

DRUG NAME

TECFIDERA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF RELAPSING FORMS OF MULTIPLE SCLEROSIS (RELAPSING-REMITTING MS OR PROGRESSIVE-RELAPSING MS, OR SECONDARY-PROGRESSIVE MS) OR PATIENT HAS EXPERIENCED A FIRST CLINICAL EPISODE AND HAS MRI FEATURES CONSISTENT WITH MULTIPLE SCLEROSIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAD AN OBJECTIVE RESPONSE TO THERAPY (IE NO OR SLOWED PROGRESSION OF DISEASE)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TESTOSTERONE (S)

DRUG NAME

**ANDRODERM | ANDROGEL | AXIRON | FORTESTA | STRIANT | TESTIM |
TESTOSTERONE | VOGELXO**

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

**CARCINOMA OF THE BREAST. KNOWN OR SUSPECTED CARCINOMA OF THE
PROSTATE.**

REQUIRED MEDICAL INFORMATION

**DIAGNOSIS OF SYMPTOMATIC HYPOGONADISM (PRIMARY OR
HYPOGONADOTROPIC) AND PATIENT IS MALE AND PATIENT'S SERUM
TESTOSTERONE (TOTAL OR FREE) VALUE AND THE LABORATORY REFERENCE
VALUE RANGE REPORTED BY LABORATORY SERVICE AND DIAGNOSIS HAS BEEN
CONFIRMED BY A LOW-FOR-AGE SERUM TESTOSTERONE (TOTAL OR FREE) LEVEL
DEFINED BY THE NORMAL LABORATORY REFERENCE VALUE**

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

**FOR RENEWAL, SERUM TESTOSTERONE LEVELS HAVE NORMALIZED TO WITHIN
THE LABORATORY REFERENCE RANGE AND PATIENT HAS EXPERIENCED
IMPROVEMENT IN SYMPTOMS OF ANDROGEN DEFICIENCY.**

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

THALOMID (S)

DRUG NAME

THALOMID

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF MULTIPLE MYELOMA THAT IS NEWLY DIAGNOSED AND IS RECEIVING CONCURRENT DEXAMETHASONE OR DIAGNOSIS OF SEVERE ERYTHEMA NODOSUM LEPROSUM WITH CUTANEOUS MANIFESTATIONS AND THE MEDICATION WILL NOT BE USED AS MONOTHERAPY IF THE MEMBER HAS MODERATE TO SEVERE NEURITIS

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

PRESCRIBER IS REGISTERED AND THE MEMBER IS ENROLLED IN THE THALOMID REMS PROGRAM

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TOPICAL RETINOIDS (S)

DRUG NAME

**ATRALIN | AVITA | RETIN-A | RETIN-A MICRO | RETIN-A MICRO PUMP | TRETIN-X |
TRETINOIN | TRETINOIN MICROSPHERE**

COVERED USES

**ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM
PART D**

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PA APPLIES TO PATIENTS OLDER THAN 26 YEARS OF AGE

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

**FOR RENEWAL, MEDICATION HAS BEEN EFFECTIVE IN TREATING THE PATIENT'S
CONDITION.**

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TORISEL (S)

DRUG NAME

TORISEL

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

BILIRUBIN MORE THAN 1.5 TIMES THE UPPER LIMIT OF NORMAL

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ADVANCED RENAL CELL CARCINOMA.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TRACLEER (S)

DRUG NAME

TRACLEER

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

RECEIVING CONCOMITANT CYCLOSPORINE A OR GLYBURIDE THERAPY.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION WHO GROUP I WITH NEW YORK HEART ASSOCIATION (NYHA) FUNCTIONAL CLASS II-IV THAT WAS CONFIRMED BY RIGHT HEART CATHETERIZATION AND PATIENT HAS BEEN ENROLLED INTO THE TAP RESTRICTED DISTRIBUTION PROGRAM

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS - INITIAL. 12 MONTHS - RENEWAL

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TRELSTAR (S)

DRUG NAME

TRELSTAR

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ADVANCED OR METASTATIC PROSTATE CANCER

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TYKERB (S)

DRUG NAME

TYKERB

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF BREAST CANCER WITH TUMORS THAT OVEREXPRESS HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 (HER2) AND A) THE MEDICATION WILL BE USED IN COMBINATION WITH XELODA IN A PATIENT WITH ADVANCED OR METASTATIC DISEASE AND THE PATIENT HAS RECEIVED PRIOR THERAPY INCLUDING AN ANTHRACYCLINE, A TAXANE, AND TRASTUZUMAB OR B) THE MEDICATION WILL BE USED IN COMBINATION WITH FEMARA FOR THE TREATMENT OF A POSTMENOPAUSAL WOMAN WITH HORMONE RECEPTOR-POSITIVE METASTATIC DISEASE FOR WHOM HORMONAL THERAPY IS INDICATED.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PATIENT'S HEPATIC FUNCTION HAS BEEN ASSESSED PRIOR TO STARTING THERAPY.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TYSABRI (S)

DRUG NAME

TYSABRI

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

HISTORY OF PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF RELAPSING FORM OF MULTIPLE SCLEROSIS AND MEDICATION WILL BE USED AS MONOTHERAPY AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE, OR CONTRAINDICATION TO ONE OF THE FOLLOWING: AN INTERFERON BETA PRODUCT, COPAXONE, GILENYA, AUBAGIO, OR TECFIDERA OR DIAGNOSIS OF MODERATE TO SEVERE ACTIVE CROHN'S DISEASE AND MEDICATION WILL NOT BE USED IN COMBINATION WITH IMMUNOSUPPRESSANTS OR INHIBITORS OF TUMOR NECROSIS FACTOR-ALFA AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE, OR CONTRAINDICATION TO ANY OF THE FOLLOWING: HUMIRA, REMICADE, OR CIMZIA.

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PATIENT AND PHYSICIAN ARE REGISTERED IN THE TOUCH PRESCRIBING PROGRAM.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TYVASO (S)

DRUG NAME

TYVASO

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION WHO GROUP I WITH NEW YORK HEART ASSOCIATION (NYHA) FUNCTIONAL CLASS III THAT WAS CONFIRMED BY RIGHT HEART CATHETERIZATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

6 MONTHS - INITIAL. 12 MONTHS - RENEWAL

OTHER CRITERIA

PART D IF PATIENT IN LONG TERM CARE (DEFINED BY CUSTOMER LOCATION CODE ON CLAIM) OTHERWISE PART B.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

TYZEKA (S)

DRUG NAME

TYZEKA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

CO-ADMINISTRATION WITH PEGYLATED INTERFERON ALFA-2A

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CHRONIC HEPATITIS B AND PATIENT IS HBSAG-POSITIVE FOR AT LEAST 6 MONTHS AND FOR HBEAG-POSITIVE PATIENTS, SERUM HBV DNA GREATER THAN 20,000 IU/ML (105 COPIES PER ML) AND FOR HBEAG-NEGATIVE PATIENTS, SERUM HBV DNA GREATER THAN 2,000 IU/ML (104 COPIES/ML) AND PATIENT HAS EVIDENCE OF PERSISTENT ELEVATIONS IN SERUM AMINOTRANSFERASE (ALT OR AST) AT LEAST 2 TIMES THE UPPER LIMIT OF NORMAL OR HISTOLOGICALLY ACTIVE DISEASE (I.E. NECROINFLAMMATION ON BIOPSY)

AGE RESTRICTIONS

16 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT MUST BE HBEAG NEGATIVE AND HAVE NOT HAD HBSAG CLEARANCE OR HBEAG POSITIVE AND HAVE DETECTABLE HBV DNA AND HAVE NOT BEEN ANTI-HBE FOR AT LEAST 6 MONTHS.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

VECTIBIX (S)

DRUG NAME

VECTIBIX

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

VELCADE (S)

DRUG NAME

VELCADE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

HYPERSENSITIVITY TO BORTEZOMIB, BORON, OR MANNITOL. MEDICATION WILL BE GIVEN INTRATHECALLY

REQUIRED MEDICAL INFORMATION

PATIENT HAS A DIAGNOSIS OF: A) MULTIPLE MYELOMA, OR B) MANTLE CELL LYMPHOMA AND THE PATIENT HAS RECEIVED AT LEAST ONE PRIOR THERAPY

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

VENTAVIS (S)

DRUG NAME

VENTAVIS

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION WHO GROUP I WITH NEW YORK HEART ASSOCIATION (NYHA) FUNCTIONAL CLASS III OF IV THAT WAS CONFIRMED BY RIGHT HEART CATHETERIZATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

INITIAL - 6 MONTHS. RENEWAL - 12 MONTHS

OTHER CRITERIA

PART D IF PATIENT IN LONG TERM CARE (DEFINED BY CUSTOMER LOCATION CODE ON CLAIM) OTHERWISE PART B.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

VIDAZA (S)

DRUG NAME

AZACITIDINE | VIDAZA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ADVANCED MALIGNANT HEPATIC TUMOR.

REQUIRED MEDICAL INFORMATION

PATIENT HAS A DIAGNOSIS OF MYELODYSPLASTIC SYNDROME

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

VIEKIRA (S)

DRUG NAME

VIEKIRA PAK

COVERED USES

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

DECOMPENSATED CIRRHOSIS, SEVERE LIVER IMPAIRMENT (CHILD-PUGH C).

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

18 YEARS OF AGE AND OLDER.

PRESCRIBER RESTRICTIONS

GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.

COVERAGE DURATION

DURATION BASED ON FDA APPROVED DOSING SEE OTHER CRITERIA FIELD FOR MORE INFORMATION.

OTHER CRITERIA

GUIDELINE CRITERIA ARE BASED ON AMERICAN ASSOCIATION FOR THE STUDY OF LIVER DISEASES AND INFECTIOUS DISEASE SOCIETY OF AMERICA (AASLD/IDSA) TREATMENT GUIDELINES AND BEST AVAILABLE EVIDENCE. NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). APPROVAL REQUIRES PATIENT HAS EVIDENCE OF HEPATITIS C INFECTION (AT LEAST 2 DETECTABLE HCV RNA LEVELS) OVER THE PAST 6 MONTHS OR PATIENT HAS AT LEAST ONE

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

DETECTABLE HCV RNA LEVEL OVER THE PAST 6 MONTHS AND HAS PREVIOUS EVIDENCE OF INFECTION (E.G., PREVIOUS PRESCRIPTION FOR TREATMENT OF HEPATITIS C). APPROVAL REQUIRES PATIENT HAS INABILITY TO TOLERATE HARVONI. RIBAVIRIN COMBINATION THERAPY REQUIRED FOR GENOTYPE 1A WITHOUT CIRRHOSIS, GENOTYPE 1A WITH CIRRHOSIS, AND FOR USE IN LIVER TRANSPLANT PATIENTS. RIBAVIRIN NOT REQUIRED FOR GENOTYPE 1B PATIENTS . PATIENTS WITH GENOTYPE 1B WITH OR WITHOUT CIRRHOSIS (TREATMENT NAIVE AND TREATMENT EXPERIENCED): APPROVAL FOR FULL 12 WEEKS. PATIENTS WITH GENOTYPE 1A WHO DO NOT HAVE CIRRHOSIS (TREATMENT NAIVE AND TREATMENT EXPERIENCED): APPROVAL FOR FULL 12 WEEKS. PATIENTS WITH GENOTYPE 1A WITH CIRRHOSIS (TREATMENT NAIVE AND TREATMENT EXPERIENCED): APPROVAL FOR FULL 24 WEEKS. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: ALFUZOSIN, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, GEMFIBROZIL, RIFAMPIN, ERGOTAMINE DIHYDROERGOTAMINE, ERGONOVINE, METHYLERGONOVINE, ETHINYL ESTRADIOL CONTAINING MEDICATIONS (SUCH AS COMBINED ORAL CONTRACEPTIVES, NUVARING, ORTHO EVRA OR XULANE TRANSDERMAL PATCH SYSTEM), ST. JOHN S WORT, LOVASTATIN, SIMVASTATIN, PIMOZIDE, EFAVIRENZ, REVATIO, TRIAZOLAM, ORAL MIDAZOLAM, DARUNAVIR/RITONAVIR, LOPINAVIR/RITONAVIR, RILVIRIPINE, SALMETEROL.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

VOTRIENT (S)

DRUG NAME

VOTRIENT

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ADVANCED/METASTATIC RENAL CELL CARCINOMA OR DIAGNOSIS OF ADVANCED SOFT TISSUE SARCOMA AND PATIENT RECEIVED AT LEAST ONE PRIOR CHEMOTHERAPY (E.G., IFOSFAMIDE, DOXORUBICIN, CISPLATIN, DACARBAZINE, DOCETAXEL, OXALIPLATIN, ETC.)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

XALKORI (S)

DRUG NAME

XALKORI

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF LOCALLY ADVANCED OR METASTATIC (STAGE III OR IV) NON-SMALL CELL LUNG CANCER AND PATIENT HAS ALKALINE PHOSPHATASE (ALK)-POSITIVE DISEASE AS DETECTED WITH AN FDA-APPROVED TEST OR CLINICAL LABORATORY IMPROVEMENT AMENDMENTS-APPROVED FACILITY

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

XELJANZ (S)

DRUG NAME

XELJANZ | XELJANZ XR

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS). COMBINED USE WITH A BIOLOGIC DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS OR POTENT IMMUNOSUPPRESSANT (E.G., AZATHIOPRINE OR CYCLOSPORINE)

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE RHEUMATOID ARTHRITIS AND PATIENT TRIED AND HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO METHOTREXATE OR OTHER NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS FOR AT LEAST 3 CONSECUTIVE MONTHS AND PATIENT HAS A DOCUMENTED INADEQUATE RESPONSE TO, OR CONTRAINDICATION TO, A BIOLOGIC MEDICATION (E.G., HUMIRA, ENBREL, ACTEMRA, CIMZIA, ORENCIA, REMICADE, SIMPONI), UNLESS THERE IS A CLINICAL REASON TO NOT USE AN INJECTED PRODUCT (E.G., FEAR OF NEEDLES), PATIENT HAS BEEN TESTED FOR TUBERCULOSIS (TB) INFECTION IN THE PAST YEAR AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED PER GUIDELINES.

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS STABLE DISEASE OR HAS IMPROVED WHILE ON THERAPY (E.G., IMPROVEMENT IN TENDER/SWOLLEN JOINT COUNT, IMPROVEMENT IN ACR SCORING)

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

XENAZINE (S)

DRUG NAME

TETRABENAZINE | XENAZINE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. TOURETTE'S SYNDROME.

EXCLUSION CRITERIA

ACTIVELY SUICIDAL. UNTREATED OR INADEQUATELY TREATED DEPRESSION. IMPAIRED HEPATIC FUNCTION. CONCOMITANT USE OF MONOAMINE OXIDASE INHIBITORS OR WITHIN A MINIMUM OF 14 DAYS AFTER DISCONTINUING A MAOI. CONCOMITANT USE OF RESERPINE OR WITHIN 20 DAYS OF DISCONTINUING RESERPINE.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CHOREA ASSOCIATED WITH HUNTINGTON'S DISEASE OR TARDIVE DYSKINESIA WITH FAILURE OF AT LEAST ONE PREVIOUS THERAPY (E.G., AMANTADINE, BENZODIAZEPINES, HALOPERIDOL, ATYPICAL ANTIPSYCHOTICS, ETC.) OR GILLES DE LA TOURETTE'S SYNDROME WITH FAILURE OR LEAST ONE PREVIOUS THERAPY (E.G., ANTIPSYCHOTIC AGENTS, CLONIDINE) AND ANY MEDICATION POSSIBLY CONTRIBUTING TO THE UNDERLYING SYMPTOMS OF CHOREA AND/OR TARDIVE DYSKINESIA HAS BEEN DISCONTINUED (E.G., ANTICONVULSANTS, ANTIPSYCHOTICS, METOCLOPRAMIDE, AMPHETAMINES, ETC.) UNLESS CESSATION WOULD BE DETRIMENTAL TO THE UNDERLYING CONDITION AND PATIENTS WHO REQUIRE DOSES GREATER THAN 50 MG/DAY WILL BE GENOTYPED FOR CYP2D6 TO DETERMINE WHETHER THE PATIENT IS A POOR, INTERMEDIATE OR EXTENSIVE METABOLIZER.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

OTHER CRITERIA

FOR RENEWAL, PATIENT HAD LACK OF PROGRESSION OF DISEASE OR IMPROVEMENT IN ABNORMAL MOVEMENTS.



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

XEOMIN (S)

DRUG NAME

XEOMIN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

HYPERSENSITIVITY TO HUMAN ALBUMIN OR SUCROSE. PRESENCE OF INFECTION AT THE PROPOSED INJECTION SITE(S).

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF BLEPHAROSPASM AND PATIENT HAS BEEN PREVIOUSLY TREATED WITH BOTOX OR CERVICAL DYSTONIA (SPASMODIC TORTICOLLIS) AND XEOMIN WILL NOT BE USED FOR COSMETIC USES (E.G., WRINKLES)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL OF CERVICAL DYSTONIA, PATIENT EXPERIENCED IMPROVEMENT IN AT LEAST ONE OF THE FOLLOWING: PAIN, SEVERITY OF ABNORMAL HEAD POSITION, OR EFFECTS ON THE PATIENT'S DAILY ACTIVITIES. FOR RENEWAL OF BLEPHAROSPASM, PATIENT EXPERIENCED AN IMPROVEMENT IN SYMPTOMS (E.G., ABILITY TO OPEN EYES, IMPROVEMENT IN BLINKING/SPASMS OF THE EYE).

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

XGEVA (S)

DRUG NAME

XGEVA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

HYPOCALCEMIA (CALCIUM LESS THAN 8.0 MG/DL).

REQUIRED MEDICAL INFORMATION

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

RENEWAL OF GIANT CELL TUMOR OF BONE, TUMOR SIZE IS REDUCED. FOR RENEWAL OF BONE METASTASES FROM SOLID TUMORS, SKELETAL-RELATED EVENTS SUCH AS FRACTURES HAVE DECREASED OR STABILIZED.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

XIFAXAN (S)

DRUG NAME

XIFAXAN

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ALLERGY TO RIFAMYCIN AGENTS

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF TRAVELER'S DIARRHEA AND PATIENT DOES NOT HAVE FEVER OR BLOOD IN THE STOOL OR DIAGNOSIS OF HEPATIC ENCEPHALOPATHY AND TRIED AND FAILED LACTULOSE THERAPY

AGE RESTRICTIONS

TRAVELER'S DIARRHEA - 12 YEARS OF AGE OR OLDER. HEPATIC ENCEPHALOPATHY - 18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

TRAVELER'S DIARRHEA - 3 DAYS. HEPATIC ENCEPHALOPATHY - 6 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

XOLAIR (S)

DRUG NAME

XOLAIR

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF MODERATE TO SEVERE PERSISTENT ALLERGIC ASTHMA AND EVIDENCE OF SPECIFIC ALLERGIC SENSITIVITY CONFIRMED BY POSITIVE SKIN TEST (I.E. PRICK/PUNCTURE TEST) OR BLOOD TEST (I.E. RADIOALLERGOSORBENT TEST) FOR A SPECIFIC IGE OR IN VITRO REACTIVITY TO A PERENNIAL AEROALLERGEN AND PRETREATMENT SERUM IGE LEVELS GREATER THAN OR EQUAL TO 30 AND LESS THAN OR EQUAL TO 700 IU/ML AND SYMPTOMS ARE NOT ADEQUATELY CONTROLLED WITH HIGH-DOSE INHALED CORTICOSTEROID (ICS) PLUS LONG-ACTING BETA2-AGONIST (LABA) FOR AT LEAST 3 MONTHS AND PATIENT HAS BEEN ADHERENT WITHIN A 12 MONTH PERIOD, AND IS CURRENTLY ADHERENT, WITH ASTHMA THERAPY.

AGE RESTRICTIONS

12 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

ASTHMA SPECIALIST (I.E., ALLERGIIST, IMMUNOLOGIST, OR PULMONOLOGIST)

COVERAGE DURATION

6 MONTHS

OTHER CRITERIA

FOR RENEWAL, PATIENT HAS EXPERIENCED AN OBJECTIVE RESPONSE TO THERAPY, DEFINED AS ONE OR MORE OF THE FOLLOWING: REDUCTION IN NUMBER OF ASTHMA EXACERBATIONS FROM BASELINE (I.E. ASTHMA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EXACERBATION REQUIRING TREATMENT WITH SYSTEMIC CORTICOSTEROIDS OR DOUBLING OF ICS DOSE FROM BASELINE), IMPROVEMENT IN FORCED EXPIRATORY VOLUME IN 1 SECOND (FEV1) FROM BASELINE, DECREASED USE OF RESCUE MEDICATIONS FROM BASELINE.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

XTANDI (S)

DRUG NAME

XTANDI

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF METASTATIC CASTRATION-RESISTANT PROSTATE CANCER AND PATIENT HAD PRIOR CHEMOTHERAPY THAT INCLUDED DOCETAXEL AND THE PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE, CONTRAINDICATION OR INTOLERANCE TO ZYTIGA.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

XYREM (S)

DRUG NAME

XYREM

COVERED USES

ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

CONCOMITANT TREATMENT WITH SEDATIVE HYPNOTIC AGENTS. SUCCINIC SEMIALDEHYDE DEHYDROGENASE DEFICIENCY.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF ONE OF THE FOLLOWING: A) NARCOLEPSY WITH EXCESSIVE DAYTIME SLEEPINESS, CATAPLEXY OR BOTH CONFIRMED BY SLEEP LAB EVALUATION (E.G., MULTIPLE SLEEP LATENCY TEST, POLYSOMNOGRAPHY) AND FOR PATIENTS WITH EXCESSIVE DAYTIME SLEEPINESS, PATIENT HAS HAD A PREVIOUS TRIAL WITH OR HAS A CONTRAINDICATION, INTOLERANCE, OR ALLERGY TO MODAFINIL, ARMODAFINIL, METHYLPHENIDATE, DEXTROAMPHETAMINE, OR MIXED AMPHETAMINE SALTS B) FIBROMYALGIA SYNDROME AND PATIENT HAD A PREVIOUS TRIAL (OF AT LEAST 30 DAYS) WITH, OR HAS A CONTRAINDICATION, INTOLERANCE, OR ALLERGY TO TWO OF THE FOLLOWING: DULOXETINE, MILNACIPRAN, OR PREGABALIN.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

FOR RENEWAL, THE PATIENT HAD A POSITIVE RESPONSE TO THE MEDICATION (INCREASED SLEEP QUALITY FOR PATIENTS WITH NARCOLEPSY). PATIENT AND PHYSICIAN ARE ENROLLED IN THE XYREM SUCCESS PROGRAM.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

YERVOY (S)

DRUG NAME

YERVOY

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF UNRESECTABLE OR METASTATIC MELANOMA AND IF THE REQUEST IS FOR RE-INDUCTION, THE PATIENT HAD NO SIGNIFICANT TOXICITY WITH THE PRIOR COURSE OF YERVOY AND THE PATIENT EXPERIENCED PROGRESSION AFTER HAVING STABLE DISEASE FOR LONGER THAN THREE MONTHS OR RELAPSE AFTER HAVING A CLINICAL RESPONSE TO THERAPY AND THE PRESCRIBER IS AWARE OF THE YERVOY REMS PROGRAM.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

16 WEEKS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ZAKADIA (S)

DRUG NAME

ZYKADIA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF METASTATIC NON-SMALL CELL LUNG CANCER AND PATIENT HAS ANAPLASTIC LYMPHOMA KINASE (ALK)-POSITIVE DISEASE AS DETECTED BY AN FDA-APPROVED OR CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)-APPROVED FACILITY AND PATIENT HAD AN INADEQUATE RESPONSE, PROGRESSED ON, OR HAD AN INTOLERANCE OR CONTRAINDICATION TO XALKORI

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA



Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ZALTRAP (S)

DRUG NAME

ZALTRAP

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

SEVERE HEMORRHAGE, DEVELOPMENT OF GASTROINTESTINAL PERFORATION, COMPROMISED WOUND HEALING

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF METASTATIC COLON OR RECTAL CANCER AND WILL BE USED IN COMBINATION WITH IRINOTECAN OR 5-FLUOROURACIL, LEUCOVORIN, AND IRINOTECAN (FOLFIRI) AND DISEASE IS RESISTANT TO OR HAS PROGRESSED FOLLOWING AN OXALIPLATIN-CONTAINING REGIMEN (E.G. 5-FLUOROURACIL, LEUCOVORIN, AND OXALIPLATIN [FOLFOX])

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PATIENT WILL BE MONITORED FOR SIGNS AND SYMPTOMS OF GASTROINTESTINAL BLEEDING AND OTHER SEVERE BLEEDING. THERAPY WILL BE SUSPENDED FOR AT LEAST 4 WEEKS PRIOR TO ELECTIVE SURGERY AND NOT RESUMED FOR AT LEAST 4 WEEKS FOLLOWING MAJOR SURGERY AND UNTIL THE WOUND IS FULLY HEALED.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ZAVESCA (S)

DRUG NAME

ZAVESCA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF MILD TO MODERATE TYPE 1 GAUCHER DISEASE AND PATIENT IS NOT A CANDIDATE FOR ENZYME REPLACEMENT THERAPY.

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PATIENTS HAVE BEEN ADVISED OF THE RISK OF FETAL HARM AND THE NEED FOR EFFECTIVE CONTRACEPTION DURING TREATMENT.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ZELBORAF (S)

DRUG NAME

ZELBORAF

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF UNRESECTABLE OR METASTATIC MELANOMA AND PATIENT HAS POSITIVE BRAF-V600E MUTATION DOCUMENTED BY AN FDA-APPROVED TEST OR CLINICAL LABORATORY IMPROVEMENT AMENDMENTS-APPROVED FACILITY.

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ZOHYDRO (S)

DRUG NAME

ZOHYDRO ER

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA

SIGNIFICANT RESPIRATORY DEPRESSION. ACUTE OR SEVERE BRONCHIAL ASTHMA OR HYPERCARBIA. KNOWN OR SUSPECTED PARALYTIC ILEUS.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF SEVERE PAIN REQUIRING CONTINUOUS, AROUND-THE-CLOCK OPIOID ANALGESIC FOR AN EXTENDED PERIOD OF TIME AND PATIENT HAS TRIED AND FAILED OR UNABLE TO TOLERATE AT LEAST TWO GENERIC EXTENDED-RELEASE OPIOID PRODUCTS, SUCH AS: OXYMORPHONE ER, MORPHINE ER, FENTANYL, TRAMADOL ER

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

NOT COVERED FOR MEMBERS ENROLLED IN A MEDICARE APPROVED HOSPICE PROGRAM

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ZOLINZA (S)

DRUG NAME

ZOLINZA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF CUTANEOUS T-CELL LYMPHOMA AND PROGRESSIVE, PERSISTENT OR RECURRENT DISEASE OR PATIENT IS NOT A CANDIDATES FOR OR FOLLOWING 2 SYSTEMIC THERAPIES (E.G., BEXAROTENE, ROMIDEPSIN, ETC.)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ZOMETA (S)

DRUG NAME

ZOLEDRONIC ACID | ZOMETA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. OSTEOPENIA DUE TO HORMONE THERAPY OR ANDROGEN DEPRIVATION THERAPY. OSTEOPENIA OR OSTEOPOROSIS DUE TO MONOCLONAL GAMMOPATHY OF UNCERTAIN SIGNIFICANCE.

EXCLUSION CRITERIA

CURRENT TREATMENT WITH RECLAST.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF HYPERCALCEMIA OF MALIGNANCY AND HAS A CORRECTED CALCIUM GREATER THAN OR EQUAL TO 12 MG/DL OR DIAGNOSIS OF MULTIPLE MYELOMA AND ASSOCIATED BONE DISEASE (E.G., OSTEOLYTIC BONE LESIONS, BONE METASTASES, OSTEOPENIA, ETC.) OR DIAGNOSIS OF A SOLID TUMOR (E.G., BREAST CANCER, PROSTATE CANCER THAT HAS PROGRESSED AFTER AT LEAST ONE HORMONAL THERAPY (I.E. ANTIANDROGEN [BICALUTAMIDE, FLUTAMIDE, NILUTAMIDE], LHRH AGONIST [LEUPROLIDE, GOSERELIN], LHRH ANTAGONISTS [DEGARELIX]), KIDNEY CANCER, NON-SMALL CELL LUNG CANCER, OR THYROID CANCER) AND PATIENT HAS BONE METASTASES AND MEDICATION WILL BE USED IN CONJUNCTION WITH STANDARD ANTINEOPLASTIC THERAPY AND MEDICATION IS USED FOR THE PREVENTION OF SKELETAL-RELATED EVENTS (E.G. FRACTURE, SPINAL CORD COMPRESSION, HYPERCALCEMIA, BONE PAIN OR LESIONS REQUIRING RADIATION OR SURGERY) AND PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE OR HAS A CONTRAINDICATION/INTOLERANCE TO PAMIDRONATE OR PATIENT HAS ONE OF THE FOLLOWING: OSTEOPENIA (T-SCORE -1.0 TO -2.5) SECONDARY TO ANDROGEN DEPRIVATION THERAPY AND PATIENT HAS A DIAGNOSIS OF PROSTATE CANCER, OSTEOPENIA DUE TO HORMONE THERAPY AND PATIENT HAS A DIAGNOSIS OF BREAST CANCER, OR OSTEOPENIA OR OSTEOPOROSIS AND PATIENT HAS A DIAGNOSIS OF MONOCLONAL GAMMOPATHY OF UNCERTAIN SIGNIFICANT (MGUS)

AGE RESTRICTIONS

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

HYPERCALCEMIA OF MALIGNANCY - 1 MONTH. OTHERS - 12 MONTHS

OTHER CRITERIA

RETREATMENT FOR HYPERCALCEMIA OF MALIGNANCY WILL BE CONSIDERED A MINIMUM OF 7 DAYS AFTER INITIAL TREATMENT, IF SERUM CALCIUM DOES NOT RETURN TO NORMAL OR DOES NOT REMAIN NORMAL AFTER INITIAL TREATMENT. FOR RENEWAL OF THERAPY FOR PATIENTS WITH BONE METASTASES, SKELETAL-RELATED EVENTS SUCH AS FRACTURES HAVE DECREASED OR STABILIZED. FOR RENEWAL OF THERAPY FOR OSTEOPOROSIS OR OSTEOPENIA, IMPROVED OR STABILIZED BMD, NO NEW FRACTURES, ETC.

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ZORBTIVE (S)

DRUG NAME

ZORBTIVE

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

ACUTE CRITICAL ILLNESS DUE TO COMPLICATIONS FOLLOWING OPEN HEART OR ABDOMINAL SURGERY, MULTIPLE ACCIDENTAL TRAUMA OR ACUTE RESPIRATORY FAILURE. ACTIVE MALIGNANCY. ACTIVE PROLIFERATIVE OR SEVERE NON-PROLIFERATIVE DIABETIC RETINOPATHY.

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF SHORT BOWEL SYNDROME AND PATIENT IS RECEIVING SPECIALIZED NUTRITIONAL SUPPORT (I.E. PARENTERAL NUTRITION)

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

4 WEEKS

OTHER CRITERIA

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ZORTRESS (S)

DRUG NAME

ZORTRESS

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

MEDICATION IS BEING USED FOR: A) PREVENTION OF KIDNEY TRANSPLANT ORGAN REJECTION AND PATIENT IS AT LOW-TO-MODERATE IMMUNOLOGIC RISK AND MEMBER IS PRESCRIBED CONCURRENT THERAPY WITH REDUCED DOSES OF CYCLOSPORINE AND CORTICOSTEROIDS, OR B) PREVENTION OF LIVER TRANSPLANT ORGAN REJECTION AND 30 OR MORE DAYS HAVE PASSED SINCE THE TRANSPLANT PROCEDURE AND THE MEMBER IS PRESCRIBED CONCURRENT THERAPY WITH REDUCED DOSES OF TACROLIMUS AND CORTICOSTEROIDS

AGE RESTRICTIONS

18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTIONS

PRESCRIBER IS EXPERIENCED IN IMMUNOSUPPRESSIVE THERAPY AND MANAGEMENT OF TRANSPLANT PATIENTS.

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA

PART B IF TRANSPLANT COVERED BY MEDICARE. OTHERWISE PART D

Missouri Dept. of Highway Transportation

Prior Authorization Requirements

EFFECTIVE DATE: 11/01/2016

PRIOR AUTHORIZATION GROUP DESCRIPTION

ZYTIGA (S)

DRUG NAME

ZYTIGA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

DIAGNOSIS OF METASTATIC CASTRATION-RESISTANT PROSTATE CANCER AND ZYTIGA WILL BE USED IN COMBINATION WITH PREDNISONE

AGE RESTRICTIONS

PRESCRIBER RESTRICTIONS

COVERAGE DURATION

12 MONTHS

OTHER CRITERIA
