

2010 True Blue HMO Prior Authorization Formulary Criteria

Prior Authorization_Group Desc		Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Actimmune	0	All medically accepted indications not otherwise excluded from Part D.					1 year	
Actiq	0	All medically accepted indications not otherwise excluded from Part D.			Patient is 16 years of age or older		1 year	Patient is already receiving opioid therapy and TOLERANT to opioid therapy as defined as receiving: At least 60mg morphine per day, OR At least 25mcg/hr transdermal fentanyl/hour, OR At least 30mg of oxycodone daily, OR At least 8mg of oral hydromorphone daily, OR An equianalgesic dose of another opioid for a week or longer.
Ambien CR, Sonata	1	All medically accepted indications not otherwise excluded from Part D.					1 year	Patient has tried and failed zolpidem (immediate release) in the previous 180 days.

2010 True Blue HMO Prior Authorization Formulary Criteria

Amevive	1	All medically accepted indications not otherwise excluded from Part D.	Currently receiving other immunosuppressive therapy or phototherapy. Patient is HIV positive. CD4+ T lymphocyte count less than 250 cells per microliter. History of recurrent infection, or current chronic infection or clinically important infection, or positive tuberculin skin test or a positive CDC-recommended equivalent test, History of systemic malignancy within last 5 years, Concurrent administration of live or live-attenuated vaccines with Amevive.	Greater than 10% of body surface area with plaque psoriasis or Less than or equal to 10% body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia)	Patient is 18 years of age or older		12 wks. 2nd 12 wk if CD4+ T counts and normal and if at least 12 wks since previous tx	Failure of phototherapy or other systemic therapies to achieve an adequate clinical response, or a medical contraindication to the use of phototherapy or other systemic therapies (e.g. methotrexate). Disease is not controlled with topical therapy. Re-treatment with a second 12 week course may be initiated if CD4+ T lymphocyte counts are normal and at least 12 weeks has passed since the previous course of treatment.
---------	---	--	---	--	-------------------------------------	--	--	--

2010 True Blue HMO Prior Authorization Formulary Criteria

Aranesp	1	All medically accepted indications not otherwise excluded from Part D.	<p>due to other factors such as iron deficiency, folate deficiency or B12 deficiency, hemolysis, gastrointestinal bleeding, other active or occult bleeding, or underlying hematologic diseases (such as sickle cell anemia, thalassemia, and porphyria). Sudden loss of response with severe anemia and low reticulocyte count. Increase in dosage at intervals more frequently than once a month. Treatment of anemia in patients with cancer not treated by chemotherapy known to produce anemia. Treatment of anemia of prematurity. Anemia in cancer patients receiving myelosuppressive chemotherapy when</p>	<p>levels are less than 10 g/dL, prior to initiation of therapy (unless otherwise specified) AND the patient's iron status, including transferrin saturation or serum ferritin or bone marrow, is evaluated and transferrin saturation at least 20% and ferritin at least 80 ng/mL or evidence of bone marrow demonstrates adequate iron stores AND For patients with uncontrolled hypertension, blood pressure is adequately controlled before initiation of therapy and closely monitored and controlled during therapy. For anemia associated with Chronic Renal Failure (CRF), including both patients on dialysis [endstage renal</p>			8 weeks	<p>Darbepoetin Alfa is to achieve and maintain hemoglobin levels within the range of 10 to 12 g/dL including both patients on dialysis (end-stage renal-disease) and not on dialysis. For treatment of anemia due to the effect of concomitantly administered chemotherapy known to produce anemia, chemotherapy is planned for a minimum of 2 months and the diagnosis is non-myeloid cancer and the anticipated outcome is not cure. In the absence of response, use of Darbepoetin Alfa is considered not medically necessary beyond 8 weeks for anemia in myelodysplastic syndrome and 12 weeks for anemia</p>
---------	---	--	---	--	--	--	---------	--

2010 True Blue HMO Prior Authorization Formulary Criteria

Botox/ Myobloc	1	All medically accepted indications not otherwise excluded from Part D.	<p>considered cosmetic as a treatment of skin wrinkles or other cosmetic indications and is not approvable. Botulinum toxin may not be approved for the treatment of any other conditions including, but not limited to, the following: Headache, including but not limited to tension, migraine or chronic daily headaches, Anismus, Chronic motortic disorder, Fibromyalgia/fibromyositis, Gastroparesis, Low back pain, Myofascial pain syndrome, Neck pain not related to conditions mentioned above, Parkinson's disease, Tics associated with Tourette's Syndrome, Tourette's Syndrome, Tremors, Urinary and</p>	<p>For Cervical Dystonia (spasmodic torticollis) of moderate or greater severity when all of the following criteria are met: History of recurrent clonic and/or tonic involuntary contractions of one or more of the following muscles: sternocleidomastoid, splenius, trapezius and/or posterior cervical muscles, and Sustained head tilt and/or abnormal posturing with limited range of motion in the neck, and The duration of the condition is greater than 6 months.</p>			1 year	<p>Treatment of hyperhidrosis will be approved. Treatment of significant drooling in patients who are unable to tolerate scopolamine. Treatment of incontinence related detrusor overreactivity and incontinence of neurogenic origin (i.e., spinal cord injury, multiple sclerosis) that is inadequately controlled with anticholinergic therapy. Treatment of bladder detrusor spincter dyssynergia of neurogenic origin.</p>
Celebrex	0	All medically accepted indications not otherwise excluded from Part D.					1 year	<p>for any diagnosis except FAP, patient had treatment failure two (2) prescription Non-Steroidal Anti-Inflammatory Drugs (NSAID) or salicylates within the previous 180 days. FAP approved without requiring another product to be tried first</p>

2010 True Blue HMO Prior Authorization Formulary Criteria

Cimzia	1	All medically accepted indications not otherwise excluded from Part D.	Individuals with CHF who develop new symptoms or worsening symptoms of pre-existing CHF, Tuberculosis or other active serious infections, including chronic or localized infections, Individuals who have not had a tuberculin skin test or Center for Disease Control recommended equivalent to rule out latent tuberculosis, Multiple sclerosis or other demyelinating neurological disease, Concurrent administration of live (including attenuated) vaccines with certolizumab pegol (Cimzia), Currently receiving other TNF antagonists or anakinra (Kineret).		Member is 18 years of age or older		1 year	For Crohn's Disease, member has had an inadequate response or is unable to tolerate ONE conventional therapy [sulfasalazine, mesalamine products, corticosteroids, or immunosuppressants (6-mercaptopurine, azathioprine, cyclosporine, or methotrexate)], AND Member has had an inadequate response or is intolerant to Remicade (infliximab), or Humira. For Rheumatoid Arthritis, Patient has had an inadequate response to ONE of the disease modifying anti-rheumatic agents (DMARDs) AND Patient has tried and failed Humira, Remicade or Enbrel in the previous 180 days.
--------	---	--	---	--	------------------------------------	--	--------	--

2010 True Blue HMO Prior Authorization Formulary Criteria

Colony Stimulating Factors	1	All medically accepted indications not otherwise excluded from Part D.	chemotherapy regimens as prophylaxis. Receipt of chemotherapy with a risk of febrile neutropenia less than 20% and no significant high risk for complications. Neutropenic patients who are afebrile not meeting criteria. Use as adjunctive therapy to antibiotics in patients with uncomplicated febrile neutropenia, as defined as: fever less than 10 days duration, no evidence of pneumonia, cellulitis, abscess, sinusitis, hypotension, multi-organ dysfunction, or invasive fungal infection, and no uncontrolled malignancies. Administration prior to or concurrent with chemotherapy for	Prognostic factors predictive of clinical deterioration: Expected prolonged (greater than 10 day) and profound (less than 0.1 x 10 ⁹ /L) neutropenia, Age greater than 65 years, Uncontrolled primary disease, Pneumonia, Hypotension and multi organ dysfunction (sepsis syndrome), Invasive fungal infection, Hospitalized at the time of the development of fever.			1 year	patients who have a risk of FN of 20% or greater when there are no equally effective regimens not requiring CSFs available. Prevention of FN when the risk of developing FN is less than 20% in patients who have other risk factors for FN including any of the following: Patient age greater than 65 years, Poor performance status, Previous episodes of FN, history of previous chemotherapy or radiation, After completion of combined chemoradiotherapy, Bone marrow involvement by tumor producing cytopenias, Poor nutritional status, poor renal function, liver dysfunction, The presence of open
----------------------------	---	--	--	--	--	--	--------	--

2010 True Blue HMO Prior Authorization Formulary Criteria

Copaxone	1	All medically accepted indications not otherwise excluded from Part D.	Patients with primary progressive MS. Patients with secondary progressive MS without relapsing disease. Use in patients with secondary progressive MS, or those with an initial demyelinating event. Treatment of MS with INF-B agents or glatiramer acetate at dosages greater than approved by the U.S. FDA. Treatment of MS with combination therapy of any IFN-B agent, glatiramer acetate, or in combination with natalizumab.				1 year	
Elidel, Protopic	0	All medically accepted indications not otherwise excluded from Part D.		diagnosis of chronic mild to moderate atopic dermatitis	Member is equal to or greater than 2 years of age		1 year	A trial of one topical prescription corticosteroid within the previous 120 days

2010 True Blue HMO Prior Authorization Formulary Criteria

Enbrel	1	All medically accepted indications not otherwise excluded from Part D.	Tuberculosis or other active serious infection, or a history of recurrent infection. Patients who have not had a tuberculin skin test or a CDC-recommended equivalent to rule out latent tuberculosis. Using Enbrel in combination with cyclophosphamide, or other TNF agents or Kineret. Current administration of live vaccines with etanercept (Enbrel).	Moderately to severely active rheumatoid arthritis. OR a Diagnosis of moderate to severe plaque psoriasis with either of the following: Patient has greater than 10% of body surface area with plaque psoriasis OR Less than or equal to 10% of body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia). OR a Diagnosis of Psoriatic Arthritis is Patient has active arthritis, with at least 3 swollen joints and 3 tender joints AND Patient has arthritis in any ONE of the following distributions: Distal interphalangeal joint	Patient is 18 years of age or older, except for the diagnosis of JIA. For JIA patient is 2 years of age or older.		1 year	Spondylitis, Patient has failed or had an inadequate response or is not indicated for treatment with ONE of the following conventional therapies: sulfasalazine, methotrexate, or non-steroidal anti-inflammatory drugs. For Moderate to severe Chronic Plaque Psoriasis that was not controlled with topical therapy and had a failure to achieve an adequate clinical response or medical contraindication to phototherapy OR ONE other systemic therapies (e.g. methotrexate, acitretin, or cyclosporine). For Moderately to severely active Rheumatoid Arthritis or Moderate to severe
--------	---	--	---	--	---	--	--------	--

2010 True Blue HMO Prior Authorization Formulary Criteria

Epogen and Procrit	1	All medically accepted indications not otherwise excluded from Part D.	<p>due to other factors such as iron deficiency, folate deficiency or B12 deficiency, hemolysis, gastrointestinal bleeding, other active or occult bleeding, or underlying hematologic diseases (such as sickle cell anemia, thalassemia, and porphyria). Sudden loss of response with severe anemia and low reticulocyte count. Increase in dosage at intervals more frequently than once a month. Treatment of anemia in patients with cancer not treated by chemotherapy known to produce anemia. Treatment of anemia of prematurity. Anemia in cancer patients receiving myelosuppressive chemotherapy when</p>	<p>levels are less than 10 g/dL, prior to initiation of therapy (unless otherwise specified) AND the patient's iron status, including transferrin saturation or serum ferritin or bone marrow, is evaluated and transferrin saturation at least 20% and ferritin at least 80 ng/mL or evidence of bone marrow demonstrates adequate iron stores AND For patients with uncontrolled hypertension, blood pressure is adequately controlled before initiation of therapy and closely monitored and controlled during therapy. For myelodysplastic syndrome, endogenous erythropoietin level is less than 500</p>			8 weeks	<p>achieve and maintain hemoglobin levels within the range of 10 to 12 g/dL including both patients on dialysis (end-stage renal-disease) and not on dialysis. For treatment of anemia due to the effect of concomitantly administered chemotherapy know to produce anemia, chemotherapy is planned for a minimum of 2 months and the diagnosis is non-myeloid cancer and the anticipated outcome is not cure or diagnosis is chronic inflammatory disease. In the absence of response, use of Epoetin Alfa is considered not medically necessary beyond 8 weeks for anemia in myelodysplastic syndrome and 12</p>
--------------------	---	--	---	---	--	--	---------	--

2010 True Blue HMO Prior Authorization Formulary Criteria

Erbix	1	All medically accepted indications not otherwise excluded from Part D.	Patient has received prior treatment with panitumumab (Vectibix). Erbitux is used in combination with other monoclonal antibodies. Erbitux is not being used for only one line of therapy.	Metastatic colorectal carcinoma OR Metastatic anal adenocarcinoma documented by KRAS gene mutation testing and the tumor is determined to be KRAS wild-type.			6 months	colorectal carcinoma OR Metastatic anal adenocarcinoma documented by KRAS gene mutation testing, Erbitux is used as a single agent after failure of both irinotecan- and oxaliplatin-based regimens OR Erbitux is used as a single agent for patients who are intolerant to irinotecan-based regimens OR Erbitux is used in combination with irinotecan for patients who are refractory to irinotecan-based chemotherapy. For Head and/or Neck cancer, Erbitux is used in combination with radiation therapy, for the treatment of locally or regionally advanced squamous cell carcinoma of the head and neck Or as a single agent for the
-------	---	--	--	--	--	--	----------	---

2010 True Blue HMO Prior Authorization Formulary Criteria

Fentora	0	All medically accepted indications not otherwise excluded from Part D.			Patient is 18 years of age or older		1 year	Patient is already receiving opioid therapy and TOLERANT to opioid therapy as defined as receiving: At least 60mg morphine per day, OR At least 25mcg/hr transdermal fentanyl/hour, OR At least 30mg of oxycodone daily, OR At least 8mg of oral hydromorphone daily, OR An equianalgesic dose of another opioid for a week or longer. Physician has discussed the appropriate disposal of unused medication with the patient.
---------	---	--	--	--	-------------------------------------	--	--------	--

2010 True Blue HMO Prior Authorization Formulary Criteria

Forteo	0	All medically accepted indications not otherwise excluded from Part D.		bone mineral density (-3 or below). Patient has sustained a fragility fracture or compression fracture due to osteoporosis despite treatment with antiresorptive therapy. A Bone Mineral Density (BMD) must be provided with all requests. Osteoporosis is defined as a BMD T-Score of less than or equal to -2.5 as compared to young normal adults. BMD T-Scores greater than -2.5 (closer to 0 or positive) are not considered osteoporotic. Request site of fragility or compression fractures. The following are not considered as strongly associated with the progression of osteoporosis: Feet,			2 years. Requests to continue therapy beyond 24 months (2 years) should not be approved.	Intolerant or has a contraindication to other osteoporosis therapy. Intolerance or contraindications to bisphosphonates are defined as having at least one of the following: Allergy to both Actonel and Fosamax, Inability to sit or stand upright for at least 30 minutes, Pre-existing gastrointestinal disorders (Barrett's esophagus, hypersecretory disorders, etc.).
Gleevec	0	All medically accepted indications not otherwise excluded from Part D.					1 year	

2010 True Blue HMO Prior Authorization Formulary Criteria

GnRH Prostate	1	All medically accepted indications not otherwise excluded from Part D.		For Prostate cancer: Palliative treatment of advanced or metastatic prostate cancer. Neoadjuvant or adjuvant therapy with radiation therapy in the management of localized prostate cancer in men with a high risk or very high risk of recurrence (Stage T3a or greater if staging is available or If stage is undetermined, a Gleason score of 8-10 or a PSA level greater than 20 ng/ml).			1 year	
---------------	---	--	--	--	--	--	--------	--

2010 True Blue HMO Prior Authorization Formulary Criteria

Human Growth Hormone	1	All medically accepted indications not otherwise excluded from Part D.	Hormone therapy when applicable criteria have not been met may not be approved for, but not limited to, the following: Anabolic therapy, except for AIDS, provided to counteract acute or chronic catabolic illness (e.g. surgery, trauma, cancer, chronic hemodialysis) producing catabolic (protein wasting) changes in both adult and pediatric patients. Anabolic therapy to enhance body mass or strength for professional, recreational or social reasons, Constitutional delay of growth and development. Growth hormone treatment in combination with GnRH agonist (Lupron) as a	response (less than 10 ng/ml) to at least 1 of the following standard growth hormone stimulation tests: arginine, clonidine, glucagons, insulin induced hypoglycemia, l-dopa, or propranolol. OR Neonates with hypoglycemia and clinical and hormone evidence of hypopituitarism and low GH (at least one GH stimulation test is subnormal) OR presence of at least 3 other pituitary hormone deficiencies. Children who are born small for gest age (birth weight or length 2 or more SD below the mean for gest age), Child fails to manifest catch up growth by age 4 years (height 2 or more SD below the			1 year, except for AIDS-Wasting is 3 months	therapies are considered "reconstructive" when intended to address a significant variation from normal, related to accidental injury, disease, trauma, treatment of a disease or congenital defect. Reconstructive GH treatment in patients who do not have growth hormone deficiency may be approved if estimated final adult height, based on bone age, of greater than or equal to 2.5 SD below mean for conditions known to be responsive to growth hormone therapy, including: Chronic renal insufficiency, Idiopathic short stature, Prader-Willi syndrome, Noonan syndrome, Turner syndrome or other
----------------------	---	--	--	---	--	--	---	---

2010 True Blue HMO Prior Authorization Formulary Criteria

Humira	1	All medically accepted indications not otherwise excluded from Part D.	Using Humira in combination with other TNF agents or Kineret (anakinra), Tuberculosis or other active serious infections, including chronic or localized infections. Patients who have not had a tuberculin skin test or CDC-recommended equivalent to rule out latent tuberculosis, Latex allergy as Humira prefilled syringe cover contains latex, Multiple Sclerosis or other demyelinating disease, Individuals with CHF who develop new symptoms or worsening symptoms of pre-existing CHF, Concurrent administration of live vaccines.	Patient has active arthritis, with at least 3 swollen joints and 3 tender joint and Patient has presence of plaque psoriasis with a qualifying target lesion at least 2 cm, in diameter AND Patient has arthritis in any of the following distributions: Distal interphalangeal joint involvement, Polyarticular arthritis without rheumatoid nodules, Arthritis mutilans, Asymmetric arthritis, Ankylosing spondylitis-like arthritis. For Chronic moderate to severe plaque psoriasis, Patient has a diagnosis of moderate to severe plaque psoriasis with either of the following: Patient has greater than 10% of body surface area with plaque psoriasis OR	Patient is 18 years of age or older for all indications except JIA. Patient must be at least 4 years old for JIA.		1 year	severe active RA, Psoriatic Arthritis, Patient has an inadequate response to ONE disease-modifying anti-rheumatic agents (DMARD). For Ankylosing Spondylitis, Patient has failed, or is not indicated for treatment with ONE conventional therapy (e.g. sulfasalazine, methotrexate, or non-steroidal anti-inflammatory drugs). For Crohn's disease, Patient has had an inadequate response to ONE conventional therapy (e.g. sulfasalazine, oral mesalamine, corticosteroids, and antibiotics) who have not been previously treated with a tumor necrosis antagonist OR Patient has had an inadequate
--------	---	--	--	--	---	--	--------	--

2010 True Blue HMO Prior Authorization Formulary Criteria

Interferons for MS	1	All medically accepted indications not otherwise excluded from Part D.	Patients with primary progressive MS. Patients with secondary progressive MS without relapsing disease. Treatment of MS with INF-B agents or glatiramer acetate at dosages greater than approved by the U.S. FDA. Treatment of MS with combination therapy of any IFN-B agent, glatiramer acetate, or in combination with natalizumab.	Patients with a single demyelinating episode with consistent MRI findings, considered at high risk for clinically definite MS OR Patients with MS with relapsing or remitting disease OR Patients with secondary progressive MS with a history of superimposed relapses			1 year	
--------------------	---	--	--	---	--	--	--------	--

2010 True Blue HMO Prior Authorization Formulary Criteria

IVIG	0	All medically accepted indications not otherwise excluded from Part D.	IVIG may not be approved for treatment of Recurrent Spontaneous Abortion (RSA)				1 year	immunodeficiencies, including: Hypogammaglobulinemia, Congenital agammaglobulinemia (X-linked gammaglobulinemia), Common variable immunodeficiency, X-linked immunodeficiency with hyperimmunoglobulin M, OR Severe combined immunodeficiency, Wiskott-Aldrich syndrome Treatment of idiopathic thrombocytopenic purpura (ITP). Treatment of Kawasaki Syndrome. Patients with hypogammaglobulinemia and/or recurrent bacterial infection associated with B-cell chronic lymphocytic leukemia (CLL). To reduce the risk of graft-versus-host
Kineret	1	All medically accepted indications not otherwise excluded from Part D.	Patient using in combination with other TNF antagonists.		Patient must be 18 years of age or older		1 year	Patient has tried or had an inadequate response to ONE DMARD AND Patient has tried and failed Enbrel, Remicade or Humira in the previous 180 days.

2010 True Blue HMO Prior Authorization Formulary Criteria

Lotronex	0	All medically accepted indications not otherwise excluded from Part D.		Severe diarrhea-predominant Irritable Bowel Syndrome (IBS) where severe includes diarrhea and 1 of the following: Frequent and severe abdominal pain/discomfort, Frequent bowel urgency or fecal incontinence, Disability or restriction of daily activities due to IBS.			1 year	Patient is female AND Patient has chronic symptoms of IBS that have persisted for 6 months or longer AND Patient has a documented failure or intolerance to at least one anti-diarrheal agent.
Lunesta	0	All medically accepted indications not otherwise excluded from Part D.			Lunesta 3mg not covered for patients 65 and older		1 year	Patient has tried, failed or is intolerant to zolpidem (immediate release) in the previous 180 days.

2010 True Blue HMO Prior Authorization Formulary Criteria

Lupron	0	All medically accepted indications not otherwise excluded from Part D.	Patients with Breast Cancer receiving concurrent aromatase inhibitors.	For Prostate cancer: Palliative treatment of advanced or metastatic prostate cancer. Neoadjuvant or adjuvant therapy with radiation therapy in the management of localized prostate cancer in men with a high risk or very high risk of recurrence (Stage T3a or greater if staging is available or If stage is undetermined, a Gleason score of 8-10 or a PSA level greater than20 ng/ml). For Gynecology Uses: Endometriosis, Chronic pelvic pain – not to continue beyond three months if there is no symptomatic relief, To decrease endometrial thickness prior to endometrial ablation procedures, Preoperative			1 year, except for Endometriosis:6months, Uterine Fibroids:3months	
--------	---	--	--	---	--	--	--	--

2010 True Blue HMO Prior Authorization Formulary Criteria

Lyrica	0	All medically accepted indications not otherwise excluded from Part D.		For Fibromyalgia: Patient has widespread pain (on the left and right side of the body and above and below the waist) AND axial skeletal pain (cervical spine or anterior chest or thoracic spine or low back) present for at least 3 months AND Pain in at least 11 of 18 specific tender point sites after digital palpation with an approximate force of 4 kg. Tender point sites are bilateral and include the following: Occiput, Low Cervical, Trapezius, Supraspinatus, Second rib, Lateral epicondyle, Gluteal, Greater trochanter, Knee			1 year	For diabetic peripheral neuropathy, member had a trial and failure of an FDA approved medication for neuropathic pain within the past 180 days (Cymbalta). For post herpetic neuralgia, member had a trial and failure of an FDA approved medication for post herpetic neuralgia within the past 180 days (Gabapentin, Lidoderm patch). For Fibromyalgia, member had a trial and failure of an FDA approved medication for Fibromyalgia (Cymbalta).
Neumega	0	All medically accepted indications not otherwise excluded from Part D.					1 Year	
Nexavar	0	All medically accepted indications not otherwise excluded from Part D.					1 year	

2010 True Blue HMO Prior Authorization Formulary Criteria

non-pegylated interferons	0	All medically accepted indications not otherwise excluded from Part D.		Confirmed hepatitis C with compensated liver disease for Genotype 1 or 4: Detectable HCV RNA, Liver biopsy (unless contraindicated or not warranted by the treating physician's judgement) shows some fibrosis and inflammation or necrosis, For Genotype 2 or 3: Detectable HCV RNA. EVR: decrease in HCV RNA greater than 2 log to the power of 10 (i.e. from 1,200,000 to 12,000) from baseline OR a decrease in HCV RNA to undetectable levels at week 12 of initial therapy.	non-pegylated interferons may be approved for patients less than 18 years of age if other criteria are met		1yr except for Initial Tx of HepC Gen1: 15 wks, Tx of HepC Gen2or3: 24wks, CI to ribavirin: 48wks,	1: Intron-A or Roferon-A in combination with ribavirin may be approved in treatment naive patients less than 18 years of age or with renal failure who have compensated liver disease. Infergen in combination with ribavirin may be approved in patients who have not responded to therapy with a pegylated interferon and ribavirin who have confirmed hepatitis C (HCV) genotype 1 with compensated liver disease. All Non-Pegylated interferons in combination with ribavirin may be approved in patients with HCV genotype 1 currently receiving therapy who require an additional 36 weeks of treatment (to complete a total of
Oral Androgens	0	All medically accepted indications not otherwise excluded from Part D.					1 year	Android: Delay in sexual development AND/OR puberty, Male

2010 True Blue HMO Prior Authorization Formulary Criteria

Orencia	1	All medically accepted indications not otherwise excluded from Part D.	Using in combination with other tumor necrosis factor antagonists or Kineret.		For RA, Patient is 18 years of age or older. For JIA, Patient is 6 years of age or older		1 year	For RA, Patient has had an inadequate response to ONE DMARD AND Patient has tried and failed Humira, Remicade or Entrel in the previous 180 days. Patient may use as monotherapy or concomitantly with DMARDs other than TNF antagonists. For JIA, Patient has tried and failed Enbrel or Humira in the previous 180 days.
Pegylated Interferons	1	All medically accepted indications not otherwise excluded from Part D.	with ribavirin as monotherapy for the treatment of hepatitis C. Treatment of HCV with pegylated interferon beyond 48 weeks. Treatment of HCV with pegylated interferon as monotherapy or in combination with ribavirin in patients with any ONE of the following: Failure to respond to previous treatment with peginterferon alfa 2a, or peginterferon alfa 2b in combination with ribavirin. OR Major, uncontrolled depressive illness. OR Autoimmune hepatitis or other condition known to be exacerbated by interferon or ribavirin. OR Pregnancy or unwilling/unable to comply with adequate contraception. OR	Confirmed hepatitis C with compensated liver disease for Genotype 1 or 4: Detectable HCV RNA, Liver biopsy (unless contraindicated or not warranted by the treating physician's judgement) shows some fibrosis and inflammation or necrosis, EVR: a decrease in HCV RNA greater than 2 log 10 (i.e. from 1,200,000 to 12,000) from baseline OR a decrease in HCV RNA to undetectable levels at week 12 of initial therapy. For HCV Genotype 2 or 3: Detectable HCV RNA, compensated liver disease. For HCV Genotype 2 or 3 in patients who have had no response			HCV Gen 1 initial: 15wks, con't: up to 1 yr, Gen 2 or 3: 24wks, CI to ribavirin: 1 yr	Genotype 1 or 4: Pegylated interferon in combination with ribavirin may be approved in patients with confirmed HCV with compensated liver disease for up to an initial 12 weeks of therapy, in patients with compensated liver disease AND Treatment naive patients OR Patients with significant fibrosis or cirrhosis who received previous treatment using non-pegylated interferon monotherapy or non pegylated interferon with ribavirin or pegylated monotherapy who demonstrate no response or have relapsed OR Patient has not received previous treatment with pegylated interferon in

Updated 05-2010

2010 True Blue HMO Prior Authorization Formulary Criteria

Penlac	0	All medically accepted indications not otherwise excluded from Part D.		Patient has a confirmed fungal infection (i.e. physical exam).			1 year	Patient has had a trial of, or is contraindicated to Sporanox and Lamisil OR Patient has used Penlac within the previous 6 months. For Onychomycosis with no comorbidity, Evidence of functional impairment (such as loss of one or more toenails, pain, or swelling) is present.
Provigil	1	All medically accepted indications not otherwise excluded from Part D.		sleepiness due to Narcolepsy: Confirmed by Multiple sleep latency test (MLST) with mean sleep latency of less than 10 minutes with documented rapid eye movement (REM) sleep during at least 2 naps. Obstructive Sleep Apnea-Hypopnea syndrome: Confirmed by Epworth Sleepiness score greater than or equal to 10, despite treatment with continuous positive airway pressure (CPAP) AND Patient has excessive sleepiness or insomnia with frequent episodes of impaired breathing during sleep and ONE of the following associated feature: loud snoring, morning headaches or dry mouth upon			1 year	

Updated 05-2010

2010 True Blue HMO Prior Authorization Formulary Criteria

quinine	0	All medically accepted indications not otherwise excluded from Part D.					1 year	
Regranex	0	All medically accepted indications not otherwise excluded from Part D.		Ulcer is stage 3 or 4 of the IAET (International Association for Enterostomal Therapy) guide to wound staging.			1 year	The Patient has undergone sharp debridement of the ulcer.
Remicade	1	All medically accepted indications not otherwise excluded from Part D.	any murine proteins or other components of the product, Moderate to severe (NYHA Class III/IV) Congestive Heart Failure (CHF), Individuals with CHF who develop new symptoms or worsening symptoms of pre-existing CHF, Tuberculosis or other active serious infections or a history of recurrent infection or current chronic infection. Concurrent administration of live vaccines with Remicade. Patients who have not had a tuberculin skin test or CDC-recommended equivalent to rule out latent tuberculosis, Multiple sclerosis and other demyelinating diseases, In combination with other tumor necrosis factor blocking agents	Presence of plaque psoriasis with a qualifying target lesion at least 2 cm in diameter. AND Patient has arthritis in any ONE of the following distributions: Distal interphalangeal joint involvement, Polyarticular arthritis without rheumatoid nodules, Arthritis mutilans, Asymmetric arthritis or Ankylosing spondylitis-like arthritis. For moderate to severe plaque psoriasis: Greater than 5% of body surface area with plaque psoriasis OR Less than or equal to 5% body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or	For all indications except Crohn's Disease, Patient is 18 years of age or older. For Crohn's Disease, Patient is 6 years of age or older.		1 year	currently on methotrexate (if patient is intolerant to methotrexate, in combination with another immunosuppressive agent that has also been demonstrated to prevent the development of human anti-chimeric antibodies [HACA], i.e. azathioprine, cyclosporine, or sulfasalazine), AND Patient has had an inadequate response to ONE DMARD. For Crohn's Disease, Patient had an inadequate response to ONE conventional therapy [e.g. oral mesalamine, systemic corticosteroids, and immunosuppressants (6-mercaptopurine or azathioprine, cyclosporine)]. OR Patient has fistulizing

2010 True Blue HMO Prior Authorization Formulary Criteria

Revatio	0	All medically accepted indications not otherwise excluded from Part D.	Patient is NOT on concurrent therapy with oral erectile dysfunction drugs AND Patient is NOT on concurrent therapy with nitrates (nitric oxide is excluded) AND Patient does NOT have Retinitis Pigmentosa	Catheterization-proven diagnosis of Pulmonary Arterial Hypertension			1 year	
Revlimid	1	All medically accepted indications not otherwise excluded from Part D.					1 year	For transfusion-dependent anemia associated with low- or intermediate-1-risk myelodysplastic syndromes (MDS) associated with a deletion of 5q cytogenetic abnormality. For chronic lymphoid leukemia, relapsed or refractory disease.

2010 True Blue HMO Prior Authorization Formulary Criteria

Rituxan	0	All medically accepted indications not otherwise excluded from Part D.			For RA, Patient is 18 years of age or older.		1 year	For RA, Patient is currently taking methotrexate AND Patient has had an inadequate response to Enbrel and Remicade. For CD20-positive, B-cell non-Hodgkin's lymphoma, Patient has relapsed or refractory, low-grade or follicular disease. For Diffuse large B-cell, CD20-positive, non-Hodgkin's lymphoma, Rituxan is in combination with CHOP (cyclophosphamide, adriamycin, vincristine and prednisone) or other anthracycline-based chemotherapy regimens.
Sprycel	0	All medically accepted indications not otherwise excluded from Part D.			approved for 18 years of age and older		1 year	Has disease progression or developed intolerance while using other chemotherapy.
Subutex, Suboxone	0	All medically accepted indications not otherwise excluded from Part D.				Physician has a valid Data 2000 waiver or "X" number in addition to their DEA number documented on the prescription.	6 months	
Sutent	0	All medically accepted indications not otherwise excluded from Part D.					1 year	For GIST, Has disease progression or intolerance while on imatinib (Gleevec). For metastatic breast cancer, Patient was previously treated with chemotherapy.

Updated 05-2010

2010 True Blue HMO Prior Authorization Formulary Criteria

Synarel Nasal Solution	0	All medically accepted indications not otherwise excluded from Part D.		Precocious puberty, defined as sexual maturation before age 8 until age 11 in girls and before age 9 until age 12 in boys, and tumor has been ruled out by lab tests, CT, MRI, or ultrasound.			1 year	
Tarceva	0	All medically accepted indications not otherwise excluded from Part D.					1 year	For NSCLC, Experienced disease progression despite treatment with another antineoplastic agent. For pancreatic cancer, Tarceva will be used in combination with Gemzar (gemcitabine).
Targretin	1	All medically accepted indications not otherwise excluded from Part D.					1 year	For cutaneous T-cell lymphoma, Patient has received at least one prior systemic therapy including but not limited to: Psoralen + ultraviolet A (PUVA), Bexarotene, Denileukin, Methoxsalen, Vorinostat, Photophoresis (extra-corporeal photochemotherapy).
Tasigna	0	All medically accepted indications not otherwise excluded from Part D.					1 year	resistant or intolerant to prior therapy that included Gleevec (imatinib)
Thalomid	0	All medically accepted indications not otherwise excluded from Part D.			Patient is Age greater than 18 years		1 year	Approve a category X medicine for a woman taking prenatal vitamins if the member is not pregnant.

2010 True Blue HMO Prior Authorization Formulary Criteria

Topamax	0	All medically accepted indications not otherwise excluded from Part D.					1 year	
Topical Androgens	0	All medically accepted indications not otherwise excluded from Part D.					1 year	Patient is male. For hypogonadism or testicular hypofunction, testosterone level is provided for members beginning treatment with topical testosterone OR member is continuing successful treatment. For diagnosis other than hypogonadism or testicular hypofunction, testosterone level is provided and is below the reference laboratory range for members beginning treatment with topical testosterone OR member is continuing successful treatment.
Tykerb	0	All medically accepted indications not otherwise excluded from Part D.		Cancer has been confirmed HER2 positive			1 year	Using in combination with Xeloda (capecitabine) AND Prior therapy Herceptin, a taxane, (e.g., Paclitaxel, Abraxane, Onxol, Taxol, Docetaxel, Taxotere) AND an anthracycline (e.g., Doxorubicin, Adriamycin, Doxil, Epirubicin, Ellence)

Updated 05-2010

2010 True Blue HMO Prior Authorization Formulary Criteria

Tyzeka	0	All medically accepted indications not otherwise excluded from Part D.		chronic hepatitis B with evidence of viral replication and either evidence of persistent elevations in serum aminotransferases (ALT or AST) or histologically active disease.	Patient is 16 years of age or older		1 year	
Vectibix	1	All medically accepted indications not otherwise excluded from Part D.	For Metastatic colorectal carcinoma and Metastatic anal adenocarcinoma, patient has received prior treatment with cetuximab (Erbix) [Note: a course of cetuximab discontinued because of an adverse reaction is not considered prior treatment] or Vectibix is used in combination with other monoclonal antibodies or Vectibix is not being used for only one line (course) of therapy For NSCLC, patient has received prior treatment with Erbix or Vectibix is used in combination with other monoclonal antibodies.	For Metastatic colorectal carcinoma or Metastatic anal adenocarcinoma, KRAS gene mutation testing documented and the tumor is determined to be KRAS wild-type.			6 months	For Metastatic colorectal carcinoma or Metastatic anal adenocarcinoma, Patient's cancer has progressed on or following treatment with all of the following: Fluoropyrimidine-containing chemotherapy regimens [5-Fluorouracil (5-FU), Capecitabine (Xeloda), Floxuridine (FUDR)], Oxaliplatin (Eloxatin®)-containing chemotherapy regimens, Irinotecan (Campto®)-containing chemotherapy regimens.

2010 True Blue HMO Prior Authorization Formulary Criteria

Vfend	0	All medically accepted indications not otherwise excluded from Part D.	Requests for onychomycosis will not be approved.	Transitioning from inpatient treatment of IV antifungal to an outpatient setting, The physician indicates that Vfend is to be used to treat any other medical condition(s) AND the physician has confirmed sensitivity to Vfend.			1 year	For Disseminated (deep tissue) Candida infections in the abdomen, kidney, bladder wall or wounds, Patient has had an inadequate response or is contraindicated to one antifungal agent.
Vytorin	0	All medically accepted indications not otherwise excluded from Part D.					1 year	1. Patient has had at least a 30 day trial of Lipitor 40mg, 80mg or simvastatin 80mg and did not achieve LDL cholesterol goal OR 2. Patient requires greater than 50% reduction in LDL cholesterol OR 3. Patient has had a trial of simvastatin OR Lipitor (any strength) AND is intolerant or has adverse drug reaction

2010 True Blue HMO Prior Authorization Formulary Criteria

Xolair	1	All medically accepted indications not otherwise excluded from Part D.		<p>skin test or in vitro reactivity to a perennial aeroallergen, AND Patient has an FEV1 less than 80% predicted AND Patient's IgE level is equal to or greater than 30 IU/ml. Severe asthma as defined by the National Heart, Lung, and Blood Institute: Severe Persistent Asthma: symptoms throughout the day, extremely limited normal activity. Nocturnal symptoms are frequent, FEV1 or PEF is less than or equal to 60% predicted. Moderate Persistent Asthma as defined by the National Heart, Lung, and Blood Institute: Daily symptoms, daily use of inhaled short-acting beta2-agonist, somewhat limited</p>	Patient is 12 years of age or older		1 year	Patient's symptoms are inadequately controlled with combination controller therapy (medium to high dose inhaled corticosteroids plus long acting beta-2 agonists and/or Leukotriene receptor antagonists), or cannot tolerate these medications
--------	---	--	--	--	-------------------------------------	--	--------	---

2010 True Blue HMO Prior Authorization Formulary Criteria

Zetia	0	All medically accepted indications not otherwise excluded from Part D.					1 Year	Patient is concurrently taking a statin OR Patient has previously tried a statin and is not able to tolerate [i.e. myalgia, GI upset, elevated liver function tests (LFTs = ALT or AST) of 3x the upper normal limits (UNL)] OR Patient is using Zetia to treat homozygous familial sitosterolemia OR Patient has a condition that is contraindicated for statin therapy.
Zolinza	0	All medically accepted indications not otherwise excluded from Part D.					1 year	Patient has received at least two prior therapies including but not limited to: Topical methclorethamine, topical carmustine, Psoralen + ultraviolet A (PUVA), Methotrexate, Bexarotene, Denileukin diftitox, Interferon, Gemcitabine, Cyclophosphamide, Chlorambucil, Doxorubicin, Isotretinoin, Pentostatin, Fludarabine, Cladarabine, Glucocorticoids (e.g., prednisone, dexamethasone), Photophoresis (extra-corporeal photochemotherapy)

Updated 05-2010

2010 True Blue HMO Prior Authorization Formulary Criteria

Zyvox	1	All medically accepted indications not otherwise excluded from Part D.	colonized vancomycin-resistant enterococcus (VRE) infection. Confirmed non-colonized methicillin-resistant S. aureus (MRSA) infection. Patient has nosocomial or community acquired pneumonia caused by susceptible gram (+) organisms. Patient has failed or has contraindications to 1st line therapy. Patient has complicated and uncomplicated skin/skin structure infects (inc. diabetic foot infections w/o concomitant osteomyelitis). Patient started treatment with Zyvox in the hospital and requires continued outpatient therapy. Patient has failed treatment with or has a contraindication to			30 day supply/One time only	For confirmed non-colonized methicillin-resistant S. aureus (MRSA) infection, Patient has failed or has contraindications to 1st line therapy.
-------	---	--	--	--	--	-----------------------------	--

2010 True Blue HMO Prior Authorization Formulary Criteria

Pristiq	0	All medically accepted indications not otherwise excluded from Part D.					1 year	Trial of a generic selective serotonin reuptake inhibitor (SSRI) AND Trial of venlafaxine/Effexor XR and is unable to tolerate doses greater than 150mg OR Member is currently taking a medication that would interact with venlafaxine/Effexor XR (e.g. CYP2D6 inducers/inhibitors) where Pristiq would be the better drug of choice, please specify
ITP	0	All medically accepted indications not otherwise excluded from Part D.		Patient is at risk for bleed as a result of thrombocytopenia and clinical condition			1 year	Previous treatment failure of with one of the following interventions: a) corticosteroids or b) immunoglobulins or c) splenectomy
RELISTOR	0	All medically accepted indications not otherwise excluded from Part D.		Patient has advanced illness and receiving palliative care			1 year	Trial and failure of lactulose
XENAZINE	1	All medically accepted indications not otherwise excluded from Part D.					1 year	
LETAIRIS	1	All medically accepted indications not otherwise excluded from Part D.					1 year	Patient has had a trial of Tracleer OR Patient has been on Letairis in the previous 180 days

Updated 05-2010

2010 True Blue HMO Prior Authorization Formulary Criteria

AVASTIN	1	All medically accepted indications not otherwise excluded from Part D.					1 year	("wet") age-related macular degeneration, Patient has failed U.S. FDA-approved therapies OR Patient is likely to have a therapeutic response with the use of intravitreal bevacizumab (Avastin), which is comparable to results from other approved treatments. For Colon or Rectum metastatic carcinoma, Avastin is being used in combination with intravenous 5-fluorouracil based chemotherapy for first or second-line treatment. For NSCLC, Avastin is being used in combination with cisplatin or carboplatin and paclitaxel or docetaxel for the first-line treatment of patients with
---------	---	--	--	--	--	--	--------	---

2010 True Blue HMO Prior Authorization Formulary Criteria

HERCEPTIN	1	All medically accepted indications not otherwise excluded from Part D.	Concomitant used with other targeted biologic agents (including but not limited to erlotinib, cetuximab, panitumumab, bevacizumab and lapatinib).	evaluated with an assay validated to predict HER2 protein overexpression (Patients are considered HER2 positive if the breast cancer is immunohistochemistry (IHC) 3+ or fluorescent in situ hybridization (FISH) HER2 gene amplification positive AND Patients on neoadjuvant and adjuvant treatment regimens must undergo a cardiac assessment (MUGA or Echocardiogram) prior to initiation of therapy and again at 3 months, 6 months and 9 months, AND Treatment should only start or continue if the left ventricular ejection fraction (LVEF) is above the institutional lower limit of normal, AND			1 year	cancer, Using as a single agent or in combination with chemotherapy (any chemotherapy approved for use in breast cancer), either in treatment naïve patients or in patients already receiving chemotherapy. For lymph-node positive breast cancer, lymph-node negative disease with a tumor measuring greater than or equal to 1cm, Using as adjuvant therapy. For follow up phase lymph-node positive disease or lymph-node negative disease, Using as adjuvant therapy and given within 6-12 months since completion of adjuvant chemotherapy. For locally advanced breast cancer, using as neoadjuvant
SANCUSO	1	All medically accepted indications not otherwise excluded from Part D.					1 year	Member has tried and failed EITHER generic ondansetron or granisetron OR Member is unable to take oral medications or injectables are inappropriate.

2010 True Blue HMO Prior Authorization Formulary Criteria

ITRACONAZOLE	1	All medically accepted indications not otherwise excluded from Part D.					6 weeks, 3 months or 1 year depending on diagnosis (see duration in parenthesis).	For Onychomycosis of fingernails (6 weeks approval), Onychomycosis of toenails (3 months approval), Superficial Tinea Infections (6 weeks approval) and 1 year approval for fungal infections caused by Aspergillosis, Blastomycosis, Histoplasmosis, Paracoccidioidomycosis, Sporotrichosis, Cryptococcus, Coccidioidomycosis, Seborrheic dermatitis.
AFINITOR	1	All medically accepted indications not otherwise excluded from Part D.					1 year	Member has failed treatment with ONE of the following: Sutent (sunitinib) OR Nexavar (sorafenib)

2010 True Blue HMO Prior Authorization Formulary Criteria

SIMPONI	1	All medically accepted indications not otherwise excluded from Part D.	Currently receiving other TNF antagonists, abatacept (Orencia) or anakinra (Kineret). Tuberculosis, invasive fungal infection or other active serious infections, or a history of recurrent infections. Individuals who have not had a tuberculin skin test or a CDC-recommended equivalent to rule out latent tuberculosis.	For Psoriatic Arthritis, member has active arthritis, with 3 or more swollen joints and 3 or more tender joints AND presence of psoriasis with a qualifying target lesion at least 2cm in diameter AND member has arthritis in ANY of the following distributions, Distal interphalangeal joint involvement, Polyarticular arthritis, without rheumatoid nodules, Arthritis mutilans, Asymmetric arthritis, OR Ankylosing spondylitis-like arthritis	Patient is 18 years or older		1 year	Arthritis, member is taking in combination with methotrexate AND member has failed or had an inadequate response to ONE disease modifying anti-rheumatic drug (DMARD) in the previous 180 days (e.g. methotrexate, sulfasalazine, hydroxychloroquine) AND Patient has tried and failed Humira, Remicade or Enbrel in the previous 180 days. For Psoriatic Arthritis, member has failure of ONE DMARD therapy to achieve an adequate clinical response or a medical contraindication to the use of DMARD therapy AND Patient has tried and failed Humira, Remicade or Enbrel in the previous 180 days. For
Lamictal XR	1	All medically accepted indications not otherwise excluded from Part D.					1 year	Patient has tried and failed generic lamotrigine in the previous 180 days.
VOTRIENT	1	All medically accepted indications not otherwise excluded from Part D.					1 year	
Samsca	1	All medically accepted indications not otherwise excluded from Part D.		patient has regular monitoring of basic metabolic panel and blood pressure			1 year	

2010 True Blue HMO Prior Authorization Formulary Criteria

Istodax	1	All medically accepted indications not otherwise excluded from Part D.					1 year	Patient has received at least ONE prior therapies including but not limited to: Topical methclorethamine, topical carmustine, Psoralen + ultraviolet A (PUVA), Methotrexate, Bexarotene, Denileukin diftitox, Interferon, Gemcitabine, Cyclophosphamide, Chlorambucil, Doxorubicin, Isotretinoin, Pentostatin, Fludarabine, Cladarabine, Glucocorticoids (e.g., prednisone, dexamethasone), Photophoresis (extra-corporeal photochemotherapy)
Stelara	1	All medically accepted indications not otherwise excluded from Part D.	Using Stelara in combination with other immunosuppressive therapy or phototherapy. Known to be genetically deficient in IL-12 or IL-23. History of reversible posterior leukoencephalopathy syndrome (RPLS). History of recurrent infection, current chronic infection, clinically important infection or positive tuberculin skin test (TST) or a positive centers for disease control (CDC) recommended equivalent test.	Diagnosis of moderate to severe plaque psoriasis with either of the following: Patient has greater than 5% of body surface area with plaque psoriasis OR Less than or equal to 5% of body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).	Patient is 18 years of age or older,		1 year	Member has tried and failed ONE preferred anti psoriatic agent: Enbrel, Humira, or Remicade. Member has failed to respond to, is intolerant of, or has a medical contraindication to ANY of the following: phototherapy or any ONE systemic therapy (for example acitretin, methotrexate, cyclosporin)

Updated 05-2010

2010 True Blue HMO Prior Authorization Formulary Criteria

Uloric	1	All medically accepted indications not otherwise excluded from Part D.					1 year	Member has tried and failed generic allopurinol in the previous 180 days. OR Member has contraindication (hypersensitivity or allergic reactions, stevens-johnson syndrom, drug interaction) to allopurinol.
Colcrys	1	All medically accepted indications not otherwise excluded from Part D.	Member currently on a medication that is known to inhibit CYP3A4 and or P-Glycoprotien AND member has concomitant renal or hepatic impairment.				1 year	
Vibativ	1	All medically accepted indications not otherwise excluded from Part D.					30 day supply/One time only	Member has started therapy with Vibativ in an outpatient setting and requires continued outpatient therapy, OR for the treatment of complicated skin and skin structure infections caused by susceptible gram positive bacteria including MRSA, AND patient has failed treatment with vancomycin IV, OR Patient has a clinical rational why vancomycin can not be used first line (culture and sensitivity results)