

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ACNE AGENTS_NVT

Products Affected

- *adapalene 0.3% gel pump*
- *adapalene topical cream*
- *adapalene topical gel*
- *adapalene-benzoyl peroxide*
- *avita*
- AZELEX
- RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.06 %, 0.08 %
- *tretinoin*
- *tretinoin microspheres topical gel*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ADAGEN_NVT

Products Affected

- ADAGEN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ADCIRCA_NVT 2017

Products Affected

- ADCIRCA
- *alyq*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ADEMPAS_NVT 2016

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For diagnosis of Pulmonary Arterial Hypertension, trial of one (1) of the following: Letairis, Opsumit or Tracleer. For diagnosis of Persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4), trial of prior therapy is not required.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

AFINITOR_NVT 2017

Products Affected

- AFINITOR
- AFINITOR DISPERZ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ALECENSA_NVT

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ALIQOPA_CCHP_2018

Products Affected

- ALIQOPA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Relapsed follicular lymphoma (FL) after at least two prior systemic therapies
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

AMITIZA_NVT 2015

Products Affected

- AMITIZA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has tried and failed Miralax (glycolax).
Age Restrictions	Age 18 and above.
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

AMPYRA_NVT 2018

Products Affected

- AMPYRA
- *dalfampridine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	WALKING DISABILITY SUCH AS MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS OR UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA.
Age Restrictions	
Prescriber Restrictions	NEUROLOGIST
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT IN WALKING ABILITY.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria

Updated 11/2019

ANDROGENS_NON-PREFERRED_NVT 2017

Products Affected

- AXIRON 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %)
- METHITEST
- methyltestosterone oral capsule
- testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation, testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram), 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Two morning testosterone levels fall below the normal range for a healthy adult male. Patient must have tried and failed ANDRODERM and ANDROGEL. For Methitest, if prescribed for delay in sexual development or metastasis from malignant tumor of breast, inoperable metastatic disease (skeletal) in women 1 to 5 years postmenopausal, testosterone levels and previous trial of ANDRODERM and ANDROGEL not required. For patients on testosterone replacement therapy, documentation of at least one (1) morning testosterone level from the last 12 months is required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria

Updated 11/2019

ANDROGENS_PREFERRED_NVT 2017

Products Affected

- ANDRODERM TRANSDERMAL PATCH 24 HOUR 2 MG/24 HOUR, 4 MG/24 HR
- ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)
- ANDROGEL TRANSDERMAL GEL IN PACKET 1.62 % (20.25 MG/1.25 GRAM), 1.62 % (40.5 MG/2.5 GRAM)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Two morning testosterone levels fall below the normal range for a healthy adult male. For patients on testosterone replacement therapy, documentation of at least one (1) morning testosterone level from the last 12 months is required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

APTIOM_NVT

Products Affected

- APTIOM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ARCALYST_NVT 2014

Products Affected

- ARCALYST

PA Criteria	Criteria Details
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, a Rheumatology Specialist, Dermatologist, or Immunologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ARIXTRA_NVT 2016

Products Affected

- *fondaparinux*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Body weight less than 50 kg (venous thromboembolism prophylaxis only)
Required Medical Information	Patient has history of Heparin Induced Thrombocytopenia (HIT) or HIT is medically suspected. Or, prescribed for prevention or treatment of DVT in an orthopedic surgery patient.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria

Updated 11/2019

ATYPICAL_ANTIPSYCHOTICS_NVT 2017

Products Affected

- ABILIFY MAINTENA
- ABILIFY MYCITE
- *aripiprazole oral tablet, disintegrating*
- ARISTADA
- ARISTADA INITIO
- FANAPT
- INVEGA SUSTENNA
- INVEGA TRINZA
- LATUDA
- *paliperidone*
- PERSERIS
- REXULTI
- RISPERDAL CONSTA
- SAPHRIS
- VRAYLAR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has tried and failed or was intolerant to 2 of the following for each indication: Bipolar Disorder: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone. Schizophrenia: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone. Irritability with Autistic Disorder: aripiprazole, risperidone. Patient has tried and failed or was intolerant to 1 of the following for each indication: Bipolar Depression: olanzapine. Major Depressive Disorder: aripiprazole. Tourette Syndrome: aripiprazole. Acute Manic/Mixed Episodes with Bipolar Disorder: aripiprazole. No trials required for the following indications: Schizoaffective Disorder.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

AUBAGIO_NVT 2018

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
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	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

BALVERSA

Products Affected

- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION OF FGFR3 OR FGFR2 MUTATION
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUS TRIAL OF AT LEAST ONE PLATINUM-CONTAINING CHEMOTHERAPY WITHIN 12 MONTHS

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

BELEODAQ_NVT 2015

Products Affected

- BELEODAQ

PA Criteria	Criteria Details
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 consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

BESPONSA_CCHP_2018

Products Affected

- BESPONSA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Relapsed or refractory B-cell precursor ALL
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

BOSULIF_NVT 2014

Products Affected

- BOSULIF

PA Criteria	Criteria Details
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 consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

BRIGATINIB

Products Affected

- ALUNBRIG

PA Criteria	Criteria Details
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 consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

BRIVIACT_NVT

Products Affected

- BRIVIACT INTRAVENOUS
- BRIVIACT ORAL SOLUTION
- BRIVIACT ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

CABOMETYX_NVT

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
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 Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

CALQUENCE_CCHP_2018

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

CAPRELSA_NVT

Products Affected

- CAPRELSA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncologist or Endocrinologist or under the direct consultation of an Oncologist or Endocrinologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

CARBAGLU_NVT 2016

Products Affected

- CARBAGLU

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

CAYSTON_NVT 2017

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Infectious Disease or Pulmonology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

CESAMET_NVT 2017

Products Affected

- CESAMET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

CHOLBAM_NVT

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
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, a hepatologist or pediatric gastroenterologist.
Coverage Duration	Initial will be 3 months, then if criteria is met approved for the rest of the plan year.
Other Criteria	Renewal requires documentation of stable or improved liver function.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

CIMZIA_NVT 2018

Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS/ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST OR RHEUMATOLOGIST. CROHN'S DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST.
Coverage Duration	INITIAL: RA: 6 MONTHS. PSA/AS/PSO: 4 MONTHS. CD: 12 MONTHS. RENEWAL: 12 MONTHS FOR ALL DIAGNOSES.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. ANKYLOSING SPONDYLITIS: PREVIOUS TRIAL OF HUMIRA. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF HUMIRA AND ONE CONVENTIONAL AGENT SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

PA Criteria	Criteria Details
	MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

CINRYZE_NVT 2015

Products Affected

- BERINERT INTRAVENOUS KIT
- CINRYZE
- FIRAZYR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

COMETRIQ_NVT 2014

Products Affected

- COMETRIQ

PA Criteria	Criteria Details
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 consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

COPIKTRA

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Prior treatment with at least two prior therapies
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

CORLANOR_NVT

Products Affected

- CORLANOR ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The patient is on a maximally tolerated dose of beta blocker or has a history of a documented intolerance, contraindication, or a hypersensitivity to beta blocker.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

COSENTYX_NVT 2018

Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX PEN (2 PENS)

PA Criteria	Criteria Details
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: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	PLAQUE PSORIASIS (PSO): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST
Coverage Duration	INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS FOR ALL DIAGNOSES
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL WITH HUMIRA AND ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL WITH HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL WITH HUMIRA.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

COTELLIC_NVT

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

CYRAMZA_NVT

Products Affected

- CYRAMZA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

CYSTAGON_NVT 2017

Products Affected

- CYSTAGON

PA Criteria	Criteria Details
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, Geneticist, Nephrologist or Metabolic Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

CYSTARAN_NVT 2015

Products Affected

- CYSTARAN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For the treatment of corneal cystine crystal accumulation in patients with cystinosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Ophthalmologist or Geneticist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

DARZALEX_NVT

Products Affected

- DARZALEX

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

DAURISMO

Products Affected

- DAURISMO

PA Criteria	Criteria Details
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 Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

DESOXYN_NVT 2017

Products Affected

- *methamphetamine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

DRONABINOL_NVT 2016

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of loss of appetite due to AIDS OR chemotherapy induced nausea and vomiting
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

DUPIXENT

Products Affected

- DUPIXENT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	ASTHMA: 1) oral corticosteroid-dependent asthma OR eosinophilic asthma (peripheral blood eosinophil level greater than or equal to 150 cells/mcl in past 12 months) AND 2) poor asthma control or recurrent exacerbation requiring additional treatment (additional treatment may include oral corticosteroids, hospitalizations, or frequent office visits). ATOPIC DERMATITIS: diagnosis of moderate or severely uncontrolled atopic dermatitis.
Age Restrictions	
Prescriber Restrictions	ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST, ALLERGIST, IMMUNOLOGIST. ATOPIC DERMATITIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	ASTHMA: Concurrent use of a maximally tolerated dose of an ICS/LABA in patients who are not otherwise intolerant altogether, or for whom ICS/LABAs are contraindicated. ATOPIC DERMATITIS: Trial of or contraindication to two formulary topical corticosteroids

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

DURVALUMAB

Products Affected

- IMFINZI

PA Criteria	Criteria Details
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 consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

EMPLICITI_NVT

Products Affected

- EMLICITI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or Hematology Specialist, or in consultation with an Oncology Specialist or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria

Updated 11/2019

ENBREL_NVT PA 2018

Products Affected

- ENBREL
- ENBREL SURECLICK
- ENBREL MINI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING AT LEAST 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS, PSORIATIC ARTHRITIS: 18 YEARS OR OLDER
Prescriber Restrictions	RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: RA: 6 MONTHS. PJIA: 3 MONTHS. PSA/AS/PSO: 4 MONTHS. RENEWAL: 12 MONTHS FOR ALL DIAGNOSES
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: ORENCIA, XELJANZ, CIMZIA. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ORENCIA. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: CIMZIA, OR COSENTYX. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: CIMZIA OR COSENTYX. PLAQUE

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

PA Criteria	Criteria Details
	PSORIASIS (PSO): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY COSENTYX.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ENTRESTO (CCHP)

Products Affected

- ENTRESTO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Initial Authorization: Diagnosis of heart failure (with or without hypertension). Ejection fraction is less than or equal to 40 percent. Heart failure is classified as one of the following: New York Heart Association Class II - IV. Patient does not have a history of angioedema associated with use of the following: Angiotensin converting enzyme (ACE) Inhibitor therapy, Angiotensin receptor blocker (ARB) therapy. Patient will discontinue use of any concomitant ACE Inhibitor or ARB before initiating treatment with Entresto. ACE inhibitors must be discontinued at least 36 hours prior to initiation of Entresto. Patient is not concomitantly on aliskiren therapy. Patient is not pregnant. Reauthorization: Documentation of positive clinical response to therapy.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

EPANED_NVT_2017

Products Affected

- EPANED ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Approval requires attestation of patient's inability to swallow solid dosage forms of enalapril.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

EPCLUSA_NVT_2018

Products Affected

- EPCLUSA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
Exclusion Criteria	
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)
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. HCV RNA LEVEL WITHIN PAST 6 MONTHS. 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, TIPRANAVIR/RITONAVIR OR TOPOTECAN. PATIENT MUST NOT HAVE SEVERE RENAL IMPAIRMENT, ESRD OR ON HEMODIALYSIS. RIBAVIRIN USE REQUIRED FOR PATIENTS WITH DECOMPENSATED CIRRHOSIS.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

EPIDIOLEX_2019

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of Lennox-Gastaut or Dravet Syndrome.
Age Restrictions	2 years of age or older.
Prescriber Restrictions	Prescribed by, or in consultation with, an epileptologist or neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	At least one prior antiepileptic drug.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ERIVEDGE_NVT 2017

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
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 Oncology Specialist or Dermatologist.
Coverage Duration	Covered for duration of plan year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ERWINAZE_NVT 2014

Products Affected

- ERWINAZE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to Oncology Specialists or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

EXTAVIA_MI_2018

Products Affected

- BETASERON SUBCUTANEOUS KIT
- EXTAVIA SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	TRIAL WITH TWO OF THE FOLLOWING AGENTS FOR MULTIPLE SCLEROSIS: AUBAGIO, AVONEX, GILENYA, PLEGRIDY, TECFIDERA, AND GLATIRAMER
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

FARYDAK_NVT 2016

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology or Hematology Specialist or in consultation with an Oncology or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

FERRIPROX_NVT

Products Affected

- FERRIPROX ORAL SOLUTION
- FERRIPROX ORAL TABLET 500 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to Hematology Specialists or in consult with Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

FIRMAGON_NVT 2015

Products Affected

- FIRMAGON KIT W DILUENT
SYRINGE

PA Criteria	Criteria Details
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 Oncologist or Urologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval subject to BvD determination

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

FLECTOR PATCH_NVT 2015

Products Affected

- *diclofenac epolamine*
- FLECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

FOLOTYN_NVT 2015

Products Affected

- FOLOTYN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or on consultation with Hematologist or Oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval subject to BvD determination.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

FORTEO_NVT 2016

Products Affected

- FORTEO
- PROLIA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Member has had at least 1 fracture, OR member has BMD screening results of -2.5 or below, OR member has previously used and failed a bisphosphonate.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

FYCOMPA_NVT 2014

Products Affected

- FYCOMPA ORAL SUSPENSION
- FYCOMPA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

GARDASIL_NVT 2015

Products Affected

- GARDASIL 9 (PF)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PA not required for members age 9-26.
Prescriber Restrictions	
Coverage Duration	Approved for duration of plan year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

GATTEX_NVT 2016

Products Affected

- GATTEX 30-VIAL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of short bowel syndrome. Dependent on parenteral support for at least 12 months and at least 3 days per week.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

GILENYA_NVT 2018

Products Affected

- GILENYA

PA Criteria	Criteria Details
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	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

GILOTRIF_NVT

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
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 Oncology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

GLATIRAMER_MI_2018

Products Affected

- COPAXONE SUBCUTANEOUS SYRINGE
- *glatiramer*

PA Criteria	Criteria Details
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	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

GLEEVEC_NVT 2015

Products Affected

- *imatinib*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by Oncologist or Hematologist, or under the direct consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

GROWTH HORMONES_NVT 2015

Products Affected

- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The criteria for approval of growth hormones in adults require the diagnosis of Somatropin Deficiency Syndrome (defined by failure to stimulate Growth Hormone secretion (peak GH level of 10mcg/L or less) by one of the acceptable provocative tests). This may include adults who as children had Growth Hormone deficiency or adults with known pituitary disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

HARVONI_NVT PA 2018

Products Affected

- HARVONI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	Member must be 12 years of age or older.
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST).
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, SOFOSBUVIR (AS A SINGLE AGENT), STRIBILD (ELVITAGRAVIR/COBICISTAT/EMTRICITABINE /TENOFIVIR), OR TIPRANAVIR/RITONAVIR.

HEPATITIS B AGENTS_CCHP 2014

Products Affected

- *adefovir*
- BARACLUDE ORAL SOLUTION
- PEGASYS
- PEGASYS PROCLICK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	This section applies to Baraclude, adefovir, lamivudine (hbv), and Pegasys (when used for Hep B): Initiation of treatment (one of the following): HBV DNA greater than 2000IU/ml AND alanine aminotransferase (ALT) greater than upper limit of normal (ULN)-(male ALT greater than 30 U/L and female ALT to greater than 19U/L). OR Histologic evidence of cirrhosis AND detectable HBV DNA levels. OR Histologic evidence of decompensated cirrhosis (these cases should be referred to GI). Nonresponse to antiviral treatment - Defined as HBV DNA levels decreasing less than 2 log drop from baseline after 6 months.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a Gastroenterologist or Infectious Disease Specialist.
Coverage Duration	Initial coverage approved for 6 months. Continual coverage approved for duration of contract year.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

HETLIOZ_NVT

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient is totally blind.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

HOFH_NVT 2016

Products Affected

- JUXTAPID
- KYNAMRO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Untreated LDL greater than 500 mg/dL OR treated LDL greater than or equal to 300 mg/dL. Concurrent use of maximum statin dose (atorvastatin or rosuvastatin) and one other lipid lowering agent (include dates and reasons for discontinuation). For patients with statin intolerance, concurrent use of maximum statin dose not required. Chart documentation showing the most recent full lipid panel, including Apo-B within the past 12 months.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a Lipidologist, Cardiologist, or an Endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria

Updated 11/2019

HUMIRA_NVT 2018

Products Affected

- HUMIRA
- HUMIRA PEDIATRIC CROHNS START
- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA(CF)
- HUMIRA(CF) PEDI CROHNS STARTER
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PSOR-UV-ADOL HS
- HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	INITIAL: POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: CURRENT WEIGHT. PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIS PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. Hidradenitis Suppurativa (HS): Prescriber must be a Dermatologist.
Coverage Duration	INITIAL: RA:6 MOS.PSA/AS:4 MOS.PJIA:5 MOS.PSO/CD/UC/HS: 3 MOS.UVEITIS:6 MOS.RENEWAL: 12 MOS FOR ALL

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria

Updated 11/2019

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. ANKYLOSING SPONDYLITIS: TRIAL OF FORMULARY AGENTS NOT REQUIRED. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF ONE OF THE FOLLOWING CONVENTIONAL THERAPIES SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF ONE CONVENTIONAL AGENT SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF ONE CONVENTIONAL AGENT SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.</p>

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

HYDROXYPROGESTERONE_NVT

Products Affected

- *hydroxyprogesterone caproate*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

IBRANCE_NVT

Products Affected

- IBRANCE

PA Criteria	Criteria Details
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 Oncology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ICLUSIG_NVT 2014

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
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 consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

IDHIFA_CCHP_2018

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA-approved test
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

IMBRUVICA_NVT 2014

Products Affected

- IMBRUVICA ORAL CAPSULE
- IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncologist, Hemotologist or Transplant specialist, or under the direct consultation of an Oncologist, Hemotologist or Transplant specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

INCRELEX_NVT 2015

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For the long-term treatment of growth failure in children with severe primary insulin-like growth factor-1 (IGF-1) deficiency (primary IGFD) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

INLYTA_NAVITUS

Products Affected

- INLYTA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Oncology Specialist.
Coverage Duration	Covered for duration of plan year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

INREBIC

Products Affected

- INREBIC

PA Criteria	Criteria Details
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 ONCOLOGIST OR HEMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

INTERFERON_MI_2018

Products Affected

- AVONEX (WITH ALBUMIN)
- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT
- PLEGRIDY SUBCUTANEOUS PEN INJECTOR
- PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML
- REBIF (WITH ALBUMIN)
- REBIF REBIDOSE
- REBIF TITRATION PACK

PA Criteria	Criteria Details
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	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

IPF_NVT 2016

Products Affected

- ESBRIET ORAL CAPSULE
- OFEV

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Definitive diagnosis of idiopathic pulmonary fibrosis defined by the following: No known cause of lung fibrosis AND one of the following: A. Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) B. High-resolution computed tomography indicates definite UIP pattern C. High-resolution computed tomography indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP
Age Restrictions	
Prescriber Restrictions	Prescribed by a Pulmonology Specialist or in consultation with a Pulmonology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Will not be used in combination with other medications used to treat IPF.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

IRESSA_NVT

Products Affected

- IRESSA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ISTODAX_NVT 2015

Products Affected

- ISTODAX
- *romidepsin*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or consultation with Hematologist or Oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval subject to BvD determination.

ITRACONAZOLE_NVT 2015

Products Affected

- *itraconazole*
- SPORANOX ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For onychomycosis or diffuse dermatologic fungal infections: 1. fungal infection is confirmed by a positive KOH test, fungal culture or nail biopsy. 2. For onychomycosis, must fail terbinafine. For dermatologic infections, must fail one topical antifungal medication.
Age Restrictions	
Prescriber Restrictions	Infectious Disease Specialists, Pulmonologist or Dermatologist, Podiatrist or have consulted with an Infectious Disease Specialist, Pulmonologist or Dermatologist or Podiatrist concerning the patient.
Coverage Duration	Approved for 6 months.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

IVIG_NVT 2017

Products Affected

- BIVIGAM
- CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 6 GRAM
- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %
- GAMASTAN S/D
- GAMMAGARD LIQUID
- GAMMAGARD S-D (IGA < 1 MCG/ML)
- GAMMAKED INJECTION SOLUTION 10 GRAM/100 ML (10 %)
- GAMMAPLEX (WITH SORBITOL)
- GAMUNEX-C INJECTION SOLUTION 20 GRAM/200 ML (10 %)
- OCTAGAM
- PRIVIGEN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

JAKAFI_NVT 2014

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Oncology or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

KADCYLA_NVT

Products Affected

- KADCYLA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

KALYDECO_NAVITUS

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Pulmonology Specialist.
Coverage Duration	Covered for duration of plan year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

KEYTRUDA_NVT 2015

Products Affected

- KEYTRUDA INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
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 consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

KINERET_NVT 2018

Products Affected

- KINERET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: RA: 6 MONTHS, NOMID/CAPS: 12 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: ORENCIA, XELJANZ, CIMZIA.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

KORLYM_NVT

Products Affected

- KORLYM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded by Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

KUVAN_NVT 2017

Products Affected

- KUVAN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For continuing therapy the patient must have shown a 20% drop in Phenylalanine levels after 2 months of Kuvan treatment.
Age Restrictions	
Prescriber Restrictions	Prescribed by a Medical Geneticist or Metabolic Specialist.
Coverage Duration	Initial = 3 months, then if criteria is met approved for the rest of the plan year.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

KYPROLIS_NVT_2017

Products Affected

- KYPROLIS

PA Criteria	Criteria Details
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 Oncologist or Hematologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

LARTRUVO_NVT_2017

Products Affected

- LARTRUVO

PA Criteria	Criteria Details
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 Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

LENVIMA_NVT 2016

Products Affected

- LENVIMA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

LETAIRIS_NVT 2015

Products Affected

- *ambrisentan*
- LETAIRIS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

LIDOCAINE PATCH_NVT 2015

Products Affected

- *lidocaine topical adhesive patch, medicated*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Management of neuropathic pain associated with diabetic peripheral neuropathy and postherpetic neuralgia.
Exclusion Criteria	
Required Medical Information	Trial and failure of gabapentin of four weeks or more
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

LOBRENA

Products Affected

- LORBRENA

PA Criteria	Criteria Details
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 consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

LONSURF_NVT

Products Affected

- LONSURF

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

LYNPARZA_NVT 2015

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to Oncology Specialist or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

MAVENCLAD

Products Affected

- MAVENCLAD (10 TABLET PACK)
- MAVENCLAD (4 TABLET PACK)
- MAVENCLAD (5 TABLET PACK)
- MAVENCLAD (6 TABLET PACK)
- MAVENCLAD (7 TABLET PACK)
- MAVENCLAD (8 TABLET PACK)
- MAVENCLAD (9 TABLET PACK)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO PRE TREATMENT BASELINE AND THE PATIENT DOES NOT HAVE LYMPHOPENIA.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A NEUROLOGIST
Coverage Duration	48 WEEKS
Other Criteria	INITIAL: THE PATIENT MEETS ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING AGENTS: AUBAGIO, AVONEX, GILENYA, PLEGRIDY, REBIF, TECFIDERA, OR GLATIRAMER ACETATE, OR 2) PHYSICIAN ATTESTATION THAT THE PATIENT SHOWS SIGNS OF SEVERE DISEASE REQUIRING HIGH EFFICACY DISEASE MODIFYING TREATMENT (DMT).

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

MAVYRET_CCHP_2018

Products Affected

- MAVYRET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Criteria will be applied consistent with current AASLD-IDSA guidance and additional consideration for coverage consistent with FDA labeling.
Exclusion Criteria	Moderate or severe hepatic impairment (Child Pugh B Or C)
Required Medical Information	HCV RNA level within past 6 months
Age Restrictions	
Prescriber Restrictions	Prescribed by or given 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/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance. Trial of a preferred formulary alternative including Harvoni or Epclusa when these agents are considered acceptable for treatment of the specific genotype per AASLD/IDSA guidance. Patient is not concurrently taking any of the following medications not recommended or contraindicated by the manufacturer: carbamazepine, rifampin, ethinyl estradiol-containing medication, atazanavir, darunavir, lopinavir, ritonavir, efavirenz, atorvastatin, lovastatin, simvastatin, rosuvastatin at doses greater than 10mg, or cyclosporine at doses greater than 100mg per day. Patient must not have prior failure of a DAA regimen with NS5A inhibitor and HCV protease inhibitor.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

MAYZENT

Products Affected

- MAYZENT ORAL TABLET 0.25 MG, 2 MG
- MAYZENT STARTER PACK

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO PRE TREATMENT BASELINE AND THE PATIENT DOES NOT HAVE LYMPHOPENIA.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A NEUROLOGIST
Coverage Duration	12 MONTHS
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

MEGESTROL SUSP_NVT 2017

Products Affected

- *megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

MEGESTROL TABS_NVT 2017

Products Affected

- *megestrol oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

MEKINIST_NVT 2016

Products Affected

- MEKINIST

PA Criteria	Criteria Details
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 consult with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

MEKTOVI BRAFTOVI 2018

Products Affected

- BRAFTOVI
- MEKTOVI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	(1) BRAF V600E or V600K mutations as detected by an FDA-approved test (2) Not used as a single agent
Age Restrictions	
Prescriber Restrictions	prescribed by or given in consultation with an oncology specialist
Coverage Duration	APPROVED FOR DURATION OF CONTRACT YEAR SUBJECT TO FORMULARY CHANGE AND MEMBER ELIGIBILITY.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

MEPERIDINE_NVT 2017

Products Affected

- *meperidine (pf) injection solution 100 mg/ml, 25 mg/ml, 50 mg/ml*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

MIDOSTAURIN

Products Affected

- RYDAPT

PA Criteria	Criteria Details
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 consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

MOVANTIK_NVT 2016

Products Affected

- MOVANTIK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Initial Therapy: Member must meet all criteria. 1. Opioid-induced constipation. 2. Failed two laxative/bowel therapies -- polyethylene glycol and lactulose.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	4 Months
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

MYLOTARG_CCHP_2018

Products Affected

- MYLOTARG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Adults: newly diagnosed CD33+ AML. Children over the age of 2: refractory CD33+ AML
Age Restrictions	Patients age 2 and greater
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

NATPARA (CCHP2017)

Products Affected

- NATPARA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	PTH below reference range within the last 12 months (2 readings)
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

NERLYNX_CCHP_2018

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Early stage HER2+ breast cancer after adjuvant trastuzumab-based therapy
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Duration of treatment not to exceed one year

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

NEXAVAR_NVT 2015

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Require patient to be at least 18 years old.
Prescriber Restrictions	Prescribed by a Oncologist or under the direct consultation of an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

NINLARO_NVT

Products Affected

- NINLARO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or Hematology Specialist, or in consultation with an Oncology Specialist or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

NIRAPARIB TOSYLATE

Products Affected

- ZEJULA

PA Criteria	Criteria Details
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 consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

NORTHERA_NVT 2016

Products Affected

- NORTHERA

PA Criteria	Criteria Details
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, a Neurology Specialist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

NOXAFIL_NVT 2015

Products Affected

- NOXAFIL ORAL
- *posaconazole*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

NUCALA_NVT PA 2017

Products Affected

- NUCALA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Asthma: Peripheral blood eosinophil count of greater than or equal to 150 cells per microliter. History of 2 or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids plus an additional controller(s). An exception is made for patients with intolerance or contraindication to high-dose inhaled corticosteroids and additional controller(s). Eosinophilic granulomatosis with polyangiitis (EGPA): Diagnosis of EGPA.
Age Restrictions	Member must be at least 12 years old.
Prescriber Restrictions	Prescribed by, or in consultation with, an Allergy Specialist, Immunologist, or Pulmonary Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

NUPLAZID_NVT

Products Affected

- NUPLAZID

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

NUVIGIL_NVT 2015

Products Affected

- *armodafinil*
- *modafinil*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of narcolepsy, OR obstructive sleep apnea/hypopnea syndrome, OR shift work sleep disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ODOMZO_NVT 2017

Products Affected

- ODOMZO

PA Criteria	Criteria Details
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 Oncology Specialist or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ONFI_NVT

Products Affected

- ONFI ORAL SUSPENSION
- ONFI ORAL TABLET 10 MG, 20 MG
- SYMPAZAN

PA Criteria	Criteria Details
Covered Uses	All FDA Approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

OPDIVO_NVT 2015

Products Affected

- OPDIVO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to Oncology Specialist or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

OPSUMIT_NVT

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

ORAL FENTANYL_NVT 2017

Products Affected

- *fentanyl citrate*
- FENTORA
- LAZANDA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Breakthrough cancer pain and opioid tolerance. Documented tolerance to opioids defined as patients taking around the clock medicine consisting of at least 60mg of oral morphine daily, at least 25mcg of transdermal fentanyl per hour, at least 30mg of oxycodone daily, at least 8mg of oral hydromorphone daily, or an equianalgesic dose of another opioid daily for a week or longer.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Trial of fentanyl lozenge before another branded fentanyl product.

ORENCIA_NVT 2018

Products Affected

- ORENCIA
- ORENCIA (WITH MALTOSE)
- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, JUVENILE IDIOPATHIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST
Coverage Duration	INITIAL: RA: 6 MOS. JIA: 4 MOS. PSA: 12 MOS. RENEWAL: 12 MOS ALL INDICATIONS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. JUVENILE IDIOPATHIC ARTHRITIS (JIA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ORFADIN_NVT 2015

Products Affected

- ORFADIN ORAL CAPSULE 10 MG, 2 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ORKAMBI_NVT

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) Lung function (FEV1, ppFEV1), 2) BMI, 3) Pulmonary exacerbation history to be collected initially and at continuation.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, pulmonologist.
Coverage Duration	Initial and continuation approval of 6 months to assess required medical info
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

PA_RESTASIS

Products Affected

- RESTASIS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Clinical documentation of diagnosis of moderate-severe dry eye, and that potentially exacerbating exogenous factors such as antihistamine or diuretic use, exposure to cigarette smoke, and environmental factors have been maximally managed.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

PERJETA_NVT 2014

Products Affected

- PERJETA

PA Criteria	Criteria Details
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 Oncologist or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

PIQRAY

Products Affected

- PIQRAY

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	PATIENT HAS PROGRESSED ON, OR AFTER, PREVIOUS TREATMENT WITH ENDOCRINE-BASED REGIMEN
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	PIQRAY WILL BE USED CONCURRENTLY WITH FULVESTRANT

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

POMALYST_NVT 2014

Products Affected

- POMALYST

PA Criteria	Criteria Details
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 Oncologist or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

POTELIGEO

Products Affected

- POTELIGEO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	Patient has tried and failed at least one prior systemic therapy
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

PROGESTERONE_NVT 2015

Products Affected

- CRINONE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

PROMACTA_NVT 2017

Products Affected

- PROMACTA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

RAVICTI_NVT 2016

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Requires trial of sodium phenylbutyrate powder.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a Metabolic Specialist or Geneticist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

RECTIVE_2019

Products Affected

- RECTIV

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

RELISTOR_NVT 2015

Products Affected

- RELISTOR SUBCUTANEOUS SOLUTION
- RELISTOR SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Initial Therapy: Member must meet both of the following: 1.Opioid-induced constipation. 2. Trial, or intolerance to, 2 laxative/bowel therapies-polyethylene glycol + Lactulose.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	4 Months
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria

Updated 11/2019

REMICADE_NVT 2018

Products Affected

- REMICADE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: 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: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: GASTROENTEROLOGIST.
Coverage Duration	INITIAL: CD/UC: 8 MO. RA: 6 MO. PSA/AS/PSO: 4 MO. RENEWAL FOR ALL INDICATIONS: 12 MO.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: ORENCIA, XELJANZ, CIMZIA. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: CIMZIA, OR COSENTYX. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY CIMZIA OR COSENTYX. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY COSENTYX. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY CIMZIA. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY SIMPONI.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria

Updated 11/2019

REPATHA_2019

Products Affected

- REPATHA PUSHTRONEX
- REPATHA SURECLICK
- REPATHA SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	dual therapy with another PCSK-9 inhibitor, Kynamro (mipomersen), or Juxtapid (lomitapide)
Required Medical Information	For initiation of therapy patient must: A) have one of the following conditions: 1) prior clinical atherosclerotic cardiovascular disease (ASCVD) (see Other Criteria), 2) heterozygous familial hypercholesterolemia (HeFH) (see Other Criteria), or 3) homozygous familial hypercholesterolemia (HoFH) (see Other Criteria), AND B) for patients with prior clinical ASCVD or HeFH, current LDL-C level is over 70 mg/dL, AND one of the following requirements is met: 1) patient has been treated for 8 weeks or more with a high-intensity statin (atorvastatin 40mg or greater OR rosuvastatin 20mg or greater) in combination with ezetimibe, OR 2) patient is intolerant to statins demonstrated by the failure of 2 or more statins, including an attempt with a low-intensity (pitivastatin OR pravastatin) and alternatively-dosed statin (twice weekly low-dose rosuvastatin OR atorvastatin). For continuation of therapy, patient must: A) have one of the following conditions: 1) prior clinical ASCVD (see Other Criteria), 2) HeFH (see Other Criteria), or 3) HoFH (see Other Criteria), AND B) demonstrate a reduction of LDL-C on PCSK9 inhibitor therapy
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a Cardiologist, Lipidologist, or Endocrinologist
Coverage Duration	Initial: 3 months. Renewal: contract year subject to formulary change and member eligibility
Other Criteria	Clinical ASCVD defined as acute coronary syndromes, myocardial infarction, stable or unstable angina, coronary or other arterial revascularization procedure, prior stroke or transient ischemic attack, or peripheral arterial disease of presumed atherosclerotic origin. Diagnosis of HeFH must be confirmed by one of the following: 1) DNA-based

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

PA Criteria	Criteria Details
	evidence of mutation in the LDLR, Apo B, OR PCSK9 gain of function mutation, 2) Untreated LDL-C greater than 190 mg/dl AND tendon xanthomas in patient or first/second degree relative, 3) Untreated LDL-C greater than 190 mg/dl AND either first degree relative less than 60 years of age or second degree relative less than 50 years of age with premature heart disease, OR 4) untreated LDL-C greater than 190 mg/dl AND first or second degree relative with total cholesterol greater than 290 mg/dL. Diagnosis of HoFH confirmed by the following: 1) two parents diagnosed with HeFH OR genetic confirmation of LDL receptor mutation, AND 2) untreated total cholesterol greater 290 mg/dL or LDL-C greater 190 mg/dL, AND 3) either xanthomas present at 10 years of age or younger OR atherosclerotic disease at 20 years of age or younger.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

REVATIO_NVT 2017

Products Affected

- REVATIO INTRAVENOUS
- REVATIO ORAL TABLET
- *sildenafil (antihypertensive) intravenous*
- *sildenafil (antihypertensive) oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

REVLIMID_NVT 2015

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

RIBOCICLIB_MI_2018

Products Affected

- KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG, 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG
- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ROZEREM_NVT 2015

Products Affected

- ROZEREM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For approval, a prior use of zolpidem is required OR patient has had history of scheduled drug dependence
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of the contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

RUBRACA_NVT_2017

Products Affected

- RUBRACA

PA Criteria	Criteria Details
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 Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

RUCONEST_NVT 2015

Products Affected

- RUCONEST

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

SABRIL_NVT 2017

Products Affected

- SABRIL
- *vigabatrin*

PA Criteria	Criteria Details
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, a Neurologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

SIGNIFOR_NVT 2015

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded by Part D.
Exclusion Criteria	
Required Medical Information	Prescribed for the treatment of an adult patient with Cushing disease AND Pituitary surgery is not an option OR Pituitary surgery was not curative
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with an endocrinologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

SIMPONI_NVT 2018

Products Affected

- SIMPONI
- SIMPONI ARIA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA AND ONE OF THE FOLLOWING PREFERRED AGENTS: ORENCIA, XELJANZ OR CIMZIA. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF HUMIRA AND ONE OF THE FOLLOWING PREFERRED AGENTS: CIMZIA OR ORENCIA. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF HUMIRA AND CIMZIA. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF HUMIRA AND ONE OF THE FOLLOWING CONVENTIONAL AGENTS SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDINOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

SIRTURO_NVT

Products Affected

- SIRTURO

PA Criteria	Criteria Details
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 infectious disease specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

SIVEXTRO_NVT 2015

Products Affected

- SIVEXTRO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to Infectious Disease Specialist or in consult with Infectious Disease Specialist.
Coverage Duration	Approved for 6 months subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

SOLARAZE_NVT 2017

Products Affected

- *diclofenac sodium topical gel 3 %*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

SOLTAMOX_NVT

Products Affected

- SOLTAMOX

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

SOMAVERT_NVT 2017

Products Affected

- SOMAVERT SUBCUTANEOUS
RECON SOLN 15 MG, 20 MG, 25 MG,
30 MG

PA Criteria	Criteria Details
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	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

SOVALDI_NVT PA 2018

Products Affected

- SOVALDI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	Member must be 12 years of age or older.
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATIONS WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST)
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

SPRITAM_NVT 2017

Products Affected

- SPRITAM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Member must have a trial or contraindication to generic levetiracetam.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

SPRYCEL_NVT 2017

Products Affected

- SPRYCEL

PA Criteria	Criteria Details
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 Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

STIVARGA_NVT 2014

Products Affected

- STIVARGA

PA Criteria	Criteria Details
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 consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

STRENSIQ (CCHP)

Products Affected

- STRENSIQ SUBCUTANEOUS
SOLUTION 40 MG/ML, 80 MG/0.8 ML

PA Criteria	Criteria Details
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, a Pediatric Endocrinologist, Metabolic Specialist, or Genetic Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

SUCRAID_NVT 2017

Products Affected

- SUCRAID

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

SUTENT_NVT 2017

Products Affected

- SUTENT

PA Criteria	Criteria Details
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 consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

SYLATRON_NAVITUS

Products Affected

- SYLATRON

PA Criteria	Criteria Details
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 consult with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

SYNAGIS_NVT 2015

Products Affected

- SYNAGIS INTRAMUSCULAR
SOLUTION 50 MG/0.5 ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Approve up to five (MAXIMUM) monthly doses of Synagis when an infant or child meets the criteria for one of the following conditions: Infants and children younger than 24 months with chronic lung disease of prematurity (CLD previously known as bronchopulmonary dysplasia) receiving medical therapy within 6 months before the start of the RSV season OR Infants born before 32 weeks of gestation even if they do not have CLD OR Infants born at 32 to less than 35 weeks of gestation, particularly when at least 1 of the following 2 risk factors is present: the infant attends child care, or 1 or more siblings or other children younger than 5 years live permanently in the same household OR Infants with congenital abnormalities of the airway or neuromuscular disease OR Infants and children 24 months or younger with hemodynamically significant cyanotic or acyanotic congenital heart disease (CHD).
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an ICU physician, Neonatologist, Pediatric Specialist, Pulmonologist, Cardiologist, Infectious Disease Specialist, or Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

SYPRINE_NVT 2017

Products Affected

- SYPRINE
- *trientine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

TAFINLAR_NVT 2016

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
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 consult with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

TAGRISSO_NVT

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

TALZENNA_2019

Products Affected

- TALZENNA

PA Criteria	Criteria Details
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 oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

TARCEVA_NVT 2017

Products Affected

- *erlotinib*
- TARCEVA

PA Criteria	Criteria Details
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 consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

TARGRETIN_NVT 2015

Products Affected

- *bexarotene*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Oncology or Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

TASIGNA_NVT 2017

Products Affected

- TASIGNA

PA Criteria	Criteria Details
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 consult with Oncology Specialist or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Requires trial of Sprycel for FDA indications that are shared.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

TECENTRIQ_NVT

Products Affected

- TECENTRIQ

PA Criteria	Criteria Details
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 Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

TECFIDERA_MI_2018

Products Affected

- TECFIDERA ORAL
CAPSULE, DELAYED
- RELEASE(DR/EC) 120 MG, 120 MG
(14)- 240 MG (46), 240 MG

PA Criteria	Criteria Details
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	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

THALOMID_NVT 2015

Products Affected

- THALOMID

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Oncology Specialist or infectious disease specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

TIBSOVO

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	IDH1 mutation detected by an FDA-approved test
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

TIGAN_NVT 2017

Products Affected

- *trimethobenzamide oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

TOBI_NVT 2015

Products Affected

- TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE
- *tobramycin in 0.225 % nacl*
- *tobramycin with nebulizer*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Infectious Disease or Pulmonology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

TOPICAL STEROIDS_NVT 2017

Products Affected

- *amcinonide topical cream*
- *amcinonide topical ointment*
- APEXICON E
- *betamethasone valerate topical foam*
- *clobetasol*
- *clobetasol-emollient*
- CLODAN
- CLODERM
- *cormax scalp*
- DESONATE
- *desonide topical cream*
- *desonide topical lotion*
- *fluticasone propionate topical lotion*
- *halcinonide*
- HALOG
- *hydrocort buty 0.1% lipo cream*
- *hydrocortisone butyrate topical cream*
- PANDEL
- TRIDESILON

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Requires trial of two formulary topical steroids
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

TRACLEER_NVT 2015

Products Affected

- TRACLEER ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Pulmonology or Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

TREANDA_NVT 2015

Products Affected

- TREANDA INTRAVENOUS RECON SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

TROKENDI_NVT 2014

Products Affected

- *topiramate oral capsule, sprinkle, er 24hr*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has tried and failed topiramate (TOPAMAX) AND patient has a diagnosis of partial-onset seizures, primary generalized tonic-clonic seizures, seizures associated with Lennox-Gastaut syndrome, or migraines where topiramate ER is being used for migraine prophylaxis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

TYKERB_NVT

Products Affected

- TYKERB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Tykerb is prescribed in combination with capecitabine (Xeloda) AND The patient has advanced or metastatic breast cancer with tumor over-expression of HER2 AND The patient has recieved prior therapy including an anthracycline and a taxane and trastumab. Tykerb is prescribed in combination with letrozole for the treatment of postmenopausal women with hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated.
Age Restrictions	
Prescriber Restrictions	Approval requires the prescriber to be an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

TYSABRI_NVT 2018

Products Affected

- TYSABRI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CROHN'S DISEASE: GASTROENTEROLOGIST.
Coverage Duration	MULTIPLE SCLEROSIS: 12 MONTHS. CROHN'S DISEASE: 6 MONTHS RENEWAL: CROHN'S: 12 MONTHS
Other Criteria	MULTIPLE SCLEROSIS: TRIAL OF ONE OF THE FOLLOWING PREFERRED AGENTS FOR MULTIPLE SCLEROSIS: COPAXONE, REBIF, AVONEX, PLEGRIDY, TEDFIDERA, OR AUBAGIO. CROHN'S DISEASE: TRIAL OF A HUMIRA FOLLOWED BY CIMZIA. NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH A TNF (TUMOR NECROSIS FACTOR) INHIBITOR: ENBREL, CIMZIA, REMICADE, SIMPONI, OR SIMPONI ARIA.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

UCERIS_NVT

Products Affected

- *budesonide oral tablet, delayed and ext. release*
- UCERIS RECTAL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has active mild to moderate ulcerative colitis and has tried and failed or was intolerant to mesalamine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

UPTRAVI_NVT 2017

Products Affected

- UPTRAVI ORAL TABLET
- UPTRAVI ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

VALCHLOR_NVT 2017

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has received prior skin-directed therapy such as topical steroids.
Age Restrictions	
Prescriber Restrictions	Prescribed by Oncology Specialist or Dermatology Specialist or in consultation with an Oncology or Dermatology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

VASCEPA_NVT 2016

Products Affected

- VASCEPA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has triglyceride level greater than or equal to 500 mg/dl.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

VENCLEXTA_NVT

Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
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 Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

VENTAVIS_NVT 2015

Products Affected

- VENTAVIS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restrictions	Restricted to or on consult with Pulmonology or Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

VERZENIO_CCHP_2018

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of HR+ HER2- advanced or metastatic breast cancer
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

VITRAKVI_2018

Products Affected

- VITRAKVI

PA Criteria	Criteria Details
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 Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

VIZIMPRO

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
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 oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

VORICONAZOLE_NVT 2015

Products Affected

- *voriconazole*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease Specialist or Oncologist or in consultation with an Infectious Disease Specialist or Oncologist concerning the patient.
Coverage Duration	Approved for six months subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

VOSEVI_CCHP_2018

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Criteria will be applied consistent with current AASLD-IDSA guidance and additional consideration for coverage consistent with FDA labeling.
Exclusion Criteria	Severe renal impairment, ESRD or on hemodialysis. Moderate or severe hepatic impairment (Child-Pugh B or C).
Required Medical Information	HCV RNA level within past 6 months
Age Restrictions	
Prescriber Restrictions	Prescribed by or given 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/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance. Patient is not concurrently taking any of the following medications not recommended by the manufacturer: amiodarone, carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, cyclosporine, pitavastatin, pravastatin (doses above 40mg), rosuvastatin, methotrexate, mitoxantrone, imatinib, irinotecan, lapatinib, sulfasalazine, topotecan, or HIV regimen that contains efavirenz, atazanavir, lopinavir or tipranavir/ritonavir.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

VOTRIENT_NVT

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Require the prescriber to be an Oncologist or be in under the direct consultation with an Oncologist.
Coverage Duration	Approved for duration of plan year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

XALKORI_NVT

Products Affected

- XALKORI

PA Criteria	Criteria Details
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 consult with Oncology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

XELJANZ_NVT_18

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	RA: INITIAL: 6 MONTHS. UC: 6 MONTHS. PSA: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

XENAZINE_NVT 2015

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has chorea due to Huntington's Disease.
Age Restrictions	
Prescriber Restrictions	Prescribed by a Neurologist or in consultation with a Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

XGEVA_NVT 2015

Products Affected

- XGEVA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

XIFAXAN 550MG_NVT 2017

Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Prior Authorization required for quantities greater than 2 tablets per day. For quantities of 3 tablets per day, a diagnosis of IBS-D is required.

XOLAIR_NVT PA 2015**Products Affected**

- XOLAIR SUBCUTANEOUS RECON SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1. If for moderate to severe persistent asthma: There must be objective evidence of reversible airway obstruction AND the patient's IgE level must be within the following range (patients 12 years or older: between 30 IU/ml and 700 IU/ml, OR patients 6 to 12 years: up to 1,300IU/mL), AND the patient must have a positive skin test or RAST test for specific allergic sensitivity and one of the following: Inadequately controlled asthma despite medium dose of inhaled corticosteroids for at least 3 months in combination with a trial of long-acting inhaled beta-agonists OR a leukotriene modifier and systemic steroids OR high dose inhaled corticosteroids are required to maintain adequate asthma control OR intolerance or contraindication to the previously listed drugs. 2. If for chronic idiopathic urticaria, patient remains symptomatic despite H1 antihistamine treatment or has intolerance or contraindication to H1 antihistamine treatment.
Age Restrictions	If for moderate to severe persistent asthma, patient must be at least 6 years old. If for chronic idiopathic urticaria, patient must be at least 12 years old.
Prescriber Restrictions	Prescribed by, or in consultation with, an Allergy Specialist, Pulmonary Specialist, Dermatologist, or Immunologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

XOSPATA

Products Affected

- XOSPATA

PA Criteria	Criteria Details
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 Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

XPOVIO

Products Affected

- XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5), 160 MG/WEEK (20 MG X 8), 60 MG/WEEK (20 MG X 3), 80 MG/WEEK (20 MG X 4)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RESTRICTED TO, OR IN CONSULTATION WITH, AN ONCOLOGIST OR HEMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	XPOVIO IS USED IN COMBINATION WITH DEXAMETHASONE.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

XTANDI_NVT

Products Affected

- ERLEADA
- XTANDI

PA Criteria	Criteria Details
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 consult with Oncology Specialist
Coverage Duration	Covered for duration of plan year subject to member eligibility and formulary change.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

XYREM_NVT 2017

Products Affected

- XYREM

PA Criteria	Criteria Details
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, a neurologist, pulmonologist, or sleep specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

YERVOY_NVT 2015

Products Affected

- YERVOY

PA Criteria	Criteria Details
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 Oncologist or Dermatologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval based on BvD determination

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

YONDELIS_NVT_2017

Products Affected

- YONDELIS

PA Criteria	Criteria Details
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 Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

YONSA_2018

Products Affected

- YONSA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: FOR METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: (1) DOCUMENTATION OF INTOLERANCE TO, OR A CONTRAINDICATION TO ABIRATERONE (ZYTIGA) AND (2) YONSA IS BEING USED IN COMBINATION WITH METHYLPREDNISOLONE
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A ONCOLOGIST
Coverage Duration	6 MONTHS
Other Criteria	SUBSEQUENT APPROVAL AFTER 6 MONTHS WILL REQUIRE DOCUMENTATION OF CONTINUED DISEASE IMPROVEMENT OR LACK OF DISEASE PROGRESSION

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ZALTRAP_NVT 2014

Products Affected

- ZALTRAP INTRAVENOUS SOLUTION
100 MG/4 ML (25 MG/ML)

PA Criteria	Criteria Details
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 consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ZAVESCA_NVT 2017

Products Affected

- *miglustat*

PA Criteria	Criteria Details
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, a Clinical Geneticist, Medical Biochemical Geneticist, Hematologist, or Metabolic Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ZELBORAF_NVT 2017

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
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 Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

ZEPATIER_NVT_2018

Products Affected

- ZEPATIER

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
Exclusion Criteria	MODERATE OR SEVERE LIVER IMPAIRMENT (CHILD PUGH B OR C)
Required Medical Information	HCV RNA LEVEL WITHIN THE PAST 6 MONTHS. FOR GENOTYPE 1A -TESTING FOR NS5A POLYMORPHISMS ASSOCIATED WITH RESISTANCE.
Age Restrictions	Member must be 18 years of age or older
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST)
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. NO CONCURRENT USE WITH THE FOLLOWING AGENTS: PHENYTOIN, CARBAMAZEPINE, RIFAMPIN, EFAVIRENZ, ATAZANAVIR, DARUNAVIR, LOPINAVIR, SAQUINAVIR, TIPRANAVIR, CYCLOSPORINE, NAFCILLIN, KETOCONAZOLE, MODAFINIL, BOSENTAN, ETRAVIRINE, ELVITEGRAVIR/COBICISTAT/EMTRICITABINE/TENOFOVIR, ATORVASTATIN AT DOSES GREATER THAN 20MG PER DAY OR ROSUVASTATIN AT DOSES GREATER THAN 10MG PER DAY.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ZOLINZA_NVT 2015

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Oncology or Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ZONTIVITY_NVT

Products Affected

- ZONTIVITY

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by a Cardiology Specialist or in consultation with an Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ZORTRESS_NVT 2015

Products Affected

- ZORTRESS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Coverage determination based on Med-B vs. Med-D review.

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ZYDELIG_NVT

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	DIAGNOSIS A: Patient has relapsed CLL, defined as CLL progression less than 24 months since the completion of the last prior therapy AND Idelalisib (ZYDELIG) will be used in combination with rituximab (RITUXAN). DIAGNOSIS B and C: Patient has relapsed follicular B-cell non-Hodgkin lymphoma (FL) OR Patient has relapsed small lymphocytic lymphoma (SLL) AND Patient has received at least two (2) prior systemic therapies.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ZYKADIA_NVT

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Zykadia requires the prescriber to be an Oncologist or under the direct consultation of an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ZYTIGA_NVT 2015

Products Affected

- *abiraterone*
- ZYTIGA

PA Criteria	Criteria Details
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 consult with Oncology Specialist or Urology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

ZYVOX_NVT 2015

Products Affected

- *linezolid*
- *linezolid 600 mg/300 ml-0.9% nacl*
- *linezolid in dextrose 5%*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease Specialist or in consultation with an Infectious Disease Specialist concerning the patient.
Coverage Duration	Approved for 6 months subject to formulary change and member eligibility.
Other Criteria	

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria

Updated 11/2019

INDEX

A

ABILIFY MAINTENA	15
ABILIFY MYCITE	15
abiraterone.....	223
ADAGEN.....	2
adapalene 0.3% gel pump	1
adapalene topical cream.....	1
adapalene topical gel	1
adapalene-benzoyl peroxide.....	1
ADCIRCA.....	3
adefovir	71
ADEMPAS.....	4
AFINITOR.....	5
AFINITOR DISPERZ	5
ALECENSA.....	6
ALIQOPA	7
ALUNBRIG.....	21
alyq	3
ambrisentan	100
amcinonide topical cream	183
amcinonide topical ointment.....	183
AMITIZA.....	8
AMPYRA	9
ANDRODERM TRANSDERMAL PATCH 24 HOUR 2 MG/24 HOUR, 4 MG/24 HR	11
ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)	11
ANDROGEL TRANSDERMAL GEL IN PACKET 1.62 % (20.25 MG/1.25 GRAM), 1.62 % (40.5 MG/2.5 GRAM)11	
APEXICON E	183
APTIOM	12
ARCALYST.....	13
aripiprazole oral tablet,disintegrating	15
ARISTADA	15
ARISTADA INITIO.....	15
armodafinil.....	125
AUBAGIO	16
avita	1
AVONEX (WITH ALBUMIN)	84

AVONEX INTRAMUSCULAR PEN

INJECTOR KIT.....	84
AVONEX INTRAMUSCULAR SYRINGE KIT	84
AXIRON	10
AZELEX	1

B

BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG	17
BARACLUDE ORAL SOLUTION	71
BELEODAQ	18
BERINERT INTRAVENOUS KIT.....	32
BESPONSA	19
betamethasone valerate topical foam.....	183
BETASERON SUBCUTANEOUS KIT ..	55
bexarotene	175
BIVIGAM	89
BOSULIF	20
BRAFTOVI.....	111
BRIVIACT INTRAVENOUS.....	22
BRIVIACT ORAL SOLUTION	22
BRIVIACT ORAL TABLET	22
budesonide oral tablet,delayed and ext.release	189

C

CABOMETYX.....	23
CALQUENCE	24
CAPRELSA	25
CARBAGLU	26
CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 6 GRAM.....	89
CAYSTON	27
CESAMET	28
CHOLBAM	29
CIMZIA	30
CIMZIA POWDER FOR RECONST	30
CINRYZE	32
clobetasol.....	183
clobetasol-emollient.....	183
CLODAN	183
CLODERM	183

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria

Updated 11/2019

COMETRIQ.....	33
COPAXONE SUBCUTANEOUS SYRINGE	67
COPIKTRA.....	34
CORLANOR ORAL TABLET.....	35
cormax scalp.....	183
COSENTYX (2 SYRINGES)	36
COSENTYX PEN (2 PENS)	36
COTELLIC	37
CRINONE.....	139
CYRAMZA.....	38
CYSTAGON.....	39
CYSTARAN	40
D	
dalfampridine	9
DARZALEX	41
DAURISMO	42
DESONATE.....	183
desonide topical cream	183
desonide topical lotion.....	183
diclofenac epolamine.....	59
diclofenac sodium topical gel 3 %	158
dronabinol	44
DUPIXENT.....	45
E	
EMPLICITI.....	47
ENBREL.....	48
ENBREL MINI	48
ENBREL SURECLICK.....	48
ENTRESTO	49
EPANED ORAL SOLUTION	50
EPCLUSA.....	51
EPIDIOLEX.....	52
ERIVEDGE.....	53
ERLEADA.....	209
erlotinib	174
ERWINAZE.....	54
ESBRIET ORAL CAPSULE.....	85
EXTAVIA SUBCUTANEOUS KIT.....	55
F	
FANAPT.....	15
FARYDAK	56
fentanyl citrate.....	130
FENTORA	130

FERRIPROX ORAL SOLUTION	57
FERRIPROX ORAL TABLET 500 MG..	57
FIRAZYR.....	32
FIRMAGON KIT W DILUENT SYRINGE	58
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %.....	89
FLECTOR	59
fluticasone propionate topical lotion.....	183
FOLOTYN	60
fondaparinux.....	14
FORTEO	61
FYCOMPA ORAL SUSPENSION.....	62
FYCOMPA ORAL TABLET	62
G	
GAMASTAN S/D	89
GAMMAGARD LIQUID.....	89
GAMMAGARD S-D (IGA < 1 MCG/ML)	89
GAMMAKED INJECTION SOLUTION 10 GRAM/100 ML (10 %).....	89
GAMMAPLEX (WITH SORBITOL)	89
GAMUNEX-C INJECTION SOLUTION 20 GRAM/200 ML (10 %).....	89
GARDASIL 9 (PF).....	63
GATTEX 30-VIAL.....	64
GILENYA	65
GILOTRIF.....	66
glatiramer	67
H	
halcinonide	183
HALOG.....	183
HARVONI	70
HETLIOZ.....	72
HUMIRA.....	74
HUMIRA PEDIATRIC CROHNS START	74
HUMIRA PEN	74
HUMIRA PEN CROHNS-UC-HS START	74
HUMIRA PEN PSOR-UEVITS-ADOL HS	74
HUMIRA(CF)	74

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria

Updated 11/2019

HUMIRA(CF) PEDI CROHNS STARTER	74
HUMIRA(CF) PEN CROHNS-UC-HS ...	74
HUMIRA(CF) PEN PSOR-UV-ADOL HS	74
HUMIRA(CF) PEN SUBCUTANEOUS	
PEN INJECTOR KIT 40 MG/0.4 ML..	74
hydrocort buty 0.1% lipo cream.....	183
hydrocortisone butyrate topical cream....	183
hydroxyprogesterone caproate	76
I	
IBRANCE	77
ICLUSIG.....	78
IDHIFA.....	79
imatinib	68
IMBRUVICA ORAL CAPSULE	80
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG	80
IMFINZI	46
INCRELEX.....	81
INLYTA.....	82
INREBIC.....	83
INVEGA SUSTENNA	15
INVEGA TRINZA	15
IRESSA.....	86
ISTODAX.....	87
itraconazole	88
J	
JAKAFI.....	90
JUXTAPID.....	73
K	
KADCYLA	91
KALYDECO.....	92
KEYTRUDA INTRAVENOUS SOLUTION.....	93
KINERET	94
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)- 2.5 MG, 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG.....	149
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3).....	149

KORLYM	95
KUVAN	96
KYNAMRO	73
KYPROLIS	97
L	
LARTRUVO	98
LATUDA	15
LAZANDA.....	130
LENVIMA	99
LETAIRIS	100
lidocaine topical adhesive patch,medicated	101
linezolid.....	224
linezolid 600 mg/300 ml-0.9% nacl.....	224
linezolid in dextrose 5%.....	224
LONSURF.....	103
LORBRENA	102
LYNPARZA.....	104
M	
MAVENCLAD (10 TABLET PACK) ...	105
MAVENCLAD (4 TABLET PACK)	105
MAVENCLAD (5 TABLET PACK)	105
MAVENCLAD (6 TABLET PACK)	105
MAVENCLAD (7 TABLET PACK)	105
MAVENCLAD (8 TABLET PACK)	105
MAVENCLAD (9 TABLET PACK)	105
MAVYRET	106
MAYZENT ORAL TABLET 0.25 MG, 2 MG	107
MAYZENT STARTER PACK	107
megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml	108
megestrol oral tablet.....	109
MEKINIST.....	110
MEKTOVI	111
meperidine (pf) injection solution 100 mg/ml, 25 mg/ml, 50 mg/ml.....	112
methamphetamine.....	43
METHITEST.....	10
methyltestosterone oral capsule.....	10
miglustat.....	215
modafinil	125
MOVANTIK	114
MYLOTARG	115

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria

Updated 11/2019

N			
NATPARA.....	116	REBIF (WITH ALBUMIN).....	84
NERLYNX.....	117	REBIF REBIDOSE	84
NEXAVAR.....	118	REBIF TITRATION PACK.....	84
NINLARO.....	119	RECTIV	142
NORDITROPIN FLEXPPO.....	69	RELISTOR SUBCUTANEOUS	
NORTHERA.....	121	SOLUTION	143
NOXAFIL ORAL.....	122	RELISTOR SUBCUTANEOUS SYRINGE	
NUCALA.....	123	143
NUPLAZID.....	124	REMICADE	144
O		REPATHA PUSHTRONEX.....	145
OCTAGAM	89	REPATHA SURECLICK.....	145
ODOMZO	126	REPATHA SYRINGE.....	145
OFEV	85	RESTASIS	134
ONFI ORAL SUSPENSION	127	RETIN-A MICRO PUMP TOPICAL GEL	
ONFI ORAL TABLET 10 MG, 20 MG.	127	WITH PUMP 0.06 %, 0.08 %.....	1
OPDIVO	128	REVATIO INTRAVENOUS.....	147
OPSUMIT	129	REVATIO ORAL TABLET	147
ORENCIA.....	131	REVLIMID	148
ORENCIA (WITH MALTOSE).....	131	REXULTI.....	15
ORENCIA CLICKJECT.....	131	RISPERDAL CONSTA.....	15
ORFADIN ORAL CAPSULE 10 MG, 2		romidepsin.....	87
MG, 5 MG.....	132	ROZEREM.....	150
ORKAMBI.....	133	RUBRACA.....	151
P		RUCONEST.....	152
paliperidone.....	15	RYDAPT.....	113
PANDEL.....	183	S	
PEGASYS.....	71	SABRIL	153
PEGASYS PROCLICK.....	71	SAPHRIS	15
PERJETA.....	135	SIGNIFOR	154
PERSERIS	15	sildenafil (antihypertensive) intravenous	147
PIQRAY.....	136	sildenafil (antihypertensive) oral tablet ..	147
PLEGRIDY SUBCUTANEOUS PEN		SIMPONI	155
INJECTOR.....	84	SIMPONI ARIA	155
PLEGRIDY SUBCUTANEOUS SYRINGE		SIRTURO.....	156
125 MCG/0.5 ML.....	84	SIVEXTRO	157
POMALYST	137	SOLTAMOX.....	159
posaconazole	122	SOMAVERT SUBCUTANEOUS RECON	
POTELIGEO.....	138	SOLN 15 MG, 20 MG, 25 MG, 30 MG	
PRIVIGEN.....	89	160
PROLIA	61	SOVALDI	161
PROMACTA ORAL TABLET	140	SPORANOX ORAL SOLUTION.....	88
R		SPRITAM	162
RAVICTI	141	SPRYCEL	163
		STIVARGA.....	164

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria

Updated 11/2019

STRENSIQ SUBCUTANEOUS	
SOLUTION 40 MG/ML, 80 MG/0.8 ML	
.....	165
SUCRAID	166
SUTENT	167
SYLATRON	168
SYMPAZAN.....	127
SYNAGIS INTRAMUSCULAR	
SOLUTION 50 MG/0.5 ML	169
SYPRINE.....	170
T	
TAFINLAR.....	171
TAGRISSO	172
TALZENNA	173
TARCEVA.....	174
TASIGNA.....	176
TECENTRIQ.....	177
TECFIDERA ORAL	
CAPSULE,DELAYED	
RELEASE(DR/EC) 120 MG, 120 MG	
(14)- 240 MG (46), 240 MG	178
testosterone transdermal gel in metered-dose	
pump 10 mg/0.5 gram /actuation, 12.5	
mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram	
(1.62 %).....	10
testosterone transdermal gel in packet 1 %	
(25 mg/2.5gram), 1 % (50 mg/5 gram),	
1.62 % (20.25 mg/1.25 gram), 1.62 %	
(40.5 mg/2.5 gram)	10
tetrabenazine	203
THALOMID	179
TIBSOVO	180
TOBI PODHALER INHALATION	
CAPSULE, W/INHALATION DEVICE	
.....	182
tobramycin in 0.225 % nacl	182
tobramycin with nebulizer	182
topiramate oral capsule,sprinkle,er 24hr.	186
TRACLEER ORAL TABLET	184
TREANDA INTRAVENOUS RECON	
SOLN	185
tretinoin.....	1
tretinoin microspheres topical gel	1
TRIDESILON	183
trientine	170
trimethobenzamide oral.....	181
TYKERB.....	187
TYSABRI.....	188
U	
UCERIS RECTAL.....	189
UPTRAVI ORAL TABLET	190
UPTRAVI ORAL TABLETS,DOSE PACK	
.....	190
V	
VALCHLOR	191
VASCEPA.....	192
VENCLEXTA	193
VENCLEXTA STARTING PACK.....	193
VENTAVIS.....	194
VERZENIO	195
vigabatrin.....	153
VITRAKVI.....	196
VIZIMPRO.....	197
voriconazole	198
VOSEVI.....	199
VOTRIENT	200
VRAYLAR.....	15
X	
XALKORI.....	201
XELJANZ	202
XELJANZ XR.....	202
XGEVA.....	204
XIFAXAN ORAL TABLET 550 MG....	205
XOLAIR SUBCUTANEOUS RECON	
SOLN	206
XOSPATA	207
XPOVIO ORAL TABLET 100 MG/WEEK	
(20 MG X 5), 160 MG/WEEK (20 MG X	
8), 60 MG/WEEK (20 MG X 3), 80	
MG/WEEK (20 MG X 4).....	208
XTANDI	209
XYREM	210
Y	
YERVOY	211
YONDELIS	212
YONSA.....	213

2019 Chinese Community Health Plan Senior Program (HMO)

Prior Authorization Criteria
Updated 11/2019

Z		
ZALTRAP INTRAVENOUS SOLUTION		
100 MG/4 ML (25 MG/ML)	214	
ZEJULA	120	
ZELBORAF	216	
ZEPATIER	217	
		ZOLINZA 218
		ZONTIVITY 219
		ZORTRESS 220
		ZYDELIG 221
		ZYKADIA 222
		ZYTIGA 223