

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

Updated 3/2020

### ACNE AGENTS\_NVT

#### Products Affected

- *adapalene 0.3% gel pump*
- *adapalene topical cream*
- *adapalene topical gel*
- *avita*
- *tretinoin*
- *tretinoin (emollient)*
- *tretinoin microspheres topical gel*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### ADAGEN\_NVT

---

#### Products Affected

- ADAGEN

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### ADCIRCA\_NVT 2017

---

#### Products Affected

- *alyq*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### ADEMPAS\_NVT 2016

#### Products Affected

- ADEMPAS

PA Criteria	Criteria Details
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.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### AFINITOR\_NVT 2017

---

**Products Affected**

- AFINITOR
- AFINITOR DISPERZ

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### ALECENSA\_NVT

---

#### Products Affected

- ALECENSA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### ALIQOPA\_CCHP\_2018

---

#### Products Affected

- ALIQOPA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### AMPYRA\_NVT 2018

#### Products Affected

- *dalfampridine*

PA Criteria	Criteria Details
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.
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### ANDROGENS\_PREFERRED\_NVT 2017

#### Products Affected

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

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### APTIOM\_NVT

---

#### Products Affected

- APTIOM

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### ARCALYST\_NVT 2014

---

#### Products Affected

- ARCALYST

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

Updated 3/2020

# ARIPIRAZOLE ODT, ARISTADA, FANAPT, LATUDA

### Products Affected

- ABILIFY MAINTENA
- ABILIFY MYCITE
- *aripiprazole oral tablet, disintegrating*
- ARISTADA
- ARISTADA INITIO
- FANAPT
- LATUDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO 2 OF THE FOLLOWING FOR EACH INDICATION: BIPOLAR DISORDER: ARIPIRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, ZIPRASIDONE. SCHIZOPHRENIA: ARIPIRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, ZIPRASIDONE. IRRITABILITY WITH AUTISTIC DISORDER: ARIPIRAZOLE, RISPERIDONE. PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO 1 OF THE FOLLOWING FOR EACH INDICATION: BIPOLAR DEPRESSION: OLANZAPINE. MAJOR DEPRESSIVE DISORDER: ARIPIRAZOLE. TOURETTE SYNDROME: ARIPIRAZOLE. ACUTE MANIC/MIXED EPISODES WITH BIPOLAR DISORDER: ARIPIRAZOLE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### ARIXTRA\_NVT 2016

---

#### Products Affected

- *fondaparinux*

PA Criteria	Criteria Details
Exclusion Criteria	Body weight less than 50 kg (venous thromboembolism prophylaxis only)
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### AUBAGIO\_NVT 2018

---

#### Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### AYVAKIT

---

#### Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### BALVERSA

---

#### Products Affected

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

PA Criteria	Criteria Details
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
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### BELEODAQ\_NVT 2015

---

#### Products Affected

- BELEODAQ

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### BENLYSTA

#### Products Affected

- BENLYSTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	AUTOANTIBODY POSITIVE LUPUS TEST.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEMBER IS CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. NO APPROVAL FOR DIAGNOSIS OF SEVERE ACTIVE LUPUS NEPHRITIS, SEVERE CENTRAL NERVOUS SYSTEM LUPUS OR CONCURRENT USE OF BIOLOGIC AGENTS OR INTRAVENOUS CYCLOPHOSPHAMIDE. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### BESPONSA\_CCHP\_2018

---

#### Products Affected

- BESPONSA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### BOSULIF\_NVT 2014

---

#### Products Affected

- BOSULIF

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### BRANDED CLOBAZAM

---

#### Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### BRIGATINIB

---

#### Products Affected

- ALUNBRIG

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### BRIVIACT\_NVT

---

#### Products Affected

- BRIVIACT INTRAVENOUS
- BRIVIACT ORAL SOLUTION
- BRIVIACT ORAL TABLET

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### BRUKINSA

---

#### Products Affected

- BRUKINSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### CABOMETYX\_NVT

---

#### Products Affected

- CABOMETYX

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### CALQUENCE\_CCHP\_2018

---

#### Products Affected

- CALQUENCE

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### CAPRELSA\_NVT

---

#### Products Affected

- CAPRELSA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### CARBAGLU\_NVT 2016

---

#### Products Affected

- CARBAGLU

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### CAYSTON\_NVT 2017

---

#### Products Affected

- CAYSTON

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### CESAMET\_NVT 2017

---

#### Products Affected

- CESAMET

PA Criteria	Criteria Details
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.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### CHOLBAM\_NVT

#### Products Affected

- CHOLBAM

PA Criteria	Criteria Details
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.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

Updated 3/2020

### CIMZIA\_NVT 2018

#### Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS/ANKYLOSING SPONDYLITIS/ACTIVE NON-RADIOGRAPHIC SPONDYLOARTHRITIS: 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. PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: RA/PSO/NRASA:6 MONTHS.PSA/AS:4 MONTHS.CD:12 MONTHS. RENEWAL: 12 MONTHS FOR ALL DIAGNOSES.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF ANY TWO PREFERRED AGENTS (HUMIRA, ENBREL, XELJANZ/XELJANZ XR) AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF ANY TWO (HUMIRA, ENBREL, COSENTYX, XELJANZ/XELJANZ XR) AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. ANKYLOSING SPONDYLITIS: PREVIOUS TRIAL OF ANY TWO (HUMIRA, ENBREL, COSENTYX). CROHN'S DISEASE (CD): PREVIOUS TRIAL OF HUMIRA AND ONE CONVENTIONAL AGENT SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE,



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

PA Criteria	Criteria Details
	MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### CINRYZE\_NVT 2015

---

**Products Affected**

- BERINERT INTRAVENOUS KIT
- CINRYZE
- FIRAZYR
- *icatibant*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### COMETRIQ\_NVT 2014

---

#### Products Affected

- COMETRIQ

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### COPIKTRA

---

#### Products Affected

- COPIKTRA

PA Criteria	Criteria Details
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 OR HEMATOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### CORLANOR\_NVT

#### Products Affected

- CORLANOR ORAL TABLET

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

Updated 3/2020

### COSENTYX\_NVT 2018

#### Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING AT LEAST 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECT THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	18 YEARS OR OLDER
Prescriber Restrictions	PLAQUE PSORIASIS (PSO): PRESCRIBED BY, OR IN CONSULTATION WITH, A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY, OR IN CONSULTATION WITH, A RHEUMATOLOGIST OR DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS): 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 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 ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### COTELLIC\_NVT

---

#### Products Affected

- COTELLIC

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### CYRAMZA\_NVT

---

#### Products Affected

- CYRAMZA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### CYSTAGON\_NVT 2017

---

#### Products Affected

- CYSTAGON

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### CYSTARAN\_NVT 2015

---

#### Products Affected

- CYSTARAN

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### DARZALEX\_NVT

---

#### Products Affected

- DARZALEX

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### DAURISMO

---

#### Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### DESOXYN\_NVT 2017

---

#### Products Affected

- *methamphetamine*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### DRONABINOL\_NVT 2016

#### Products Affected

- *dronabinol*

PA Criteria	Criteria Details
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.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### DUPIXENT

#### Products Affected

- DUPIXENT

PA Criteria	Criteria Details
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
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### DURVALUMAB

---

#### Products Affected

- IMFINZI

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### EMPLICITI\_NVT

---

#### Products Affected

- EMPLICITI

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

Updated 3/2020

### ENBREL\_NVT PA 2018

#### Products Affected

- ENBREL
- ENBREL MINI
- ENBREL SURECLICK

PA Criteria	Criteria Details
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. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: 2 YEARS OR OLDER. PLAQUE PSORIASIS: 4 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. PLAQUE 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 OR XELJANZ/XELJANZ XR. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF HUMIRA. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL WITH ANY TWO PREFERRED AGENTS: HUMIRA, STELARA, XELJANZ/XELJANZ XR, COSENTYX. ANKYLOSING SPONDYLITIS (AS), PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL WITH ANY TWO PREFERRED AGENTS: HUMIRA, COSENTYX, SKYRIZI, STELARA .
Indications	All FDA-approved Indications.

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

PA Criteria	Criteria Details
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### ENTRESTO (CCHP)

#### Products Affected

- ENTRESTO

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### EPANED\_NVT\_2017

---

#### Products Affected

- EPANED ORAL SOLUTION

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### EPCLUSA\_NVT\_2018

#### Products Affected

- EPCLUSA

PA Criteria	Criteria Details
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.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### EPIDIOLEX\_2019

---

#### Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
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	12 MONTHS
Other Criteria	AT LEAST ONE PRIOR ANTIEPILEPTIC DRUG
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### ERIVEDGE\_NVT 2017

---

#### Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### ERLEADA

#### Products Affected

- ERLEADA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	NON METASTATIC CASTRATION RESISTANT PROSTATE CANCER: THE PATIENT HAS HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS) AND MEETS ONE OF THE FOLLOWING: (1) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) AGONIST OR ANTAGONIST OR (2) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### ERWINAZE\_NVT 2014

---

#### Products Affected

- ERWINAZE

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### EXTAVIA\_MI\_2018

---

#### Products Affected

- EXTAVIA SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	TRIAL WITH TWO OF THE FOLLOWING AGENTS FOR MULTIPLE SCLEROSIS: AVONEX, PLEGRIDY, AND REBIF
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### FARYDAK\_NVT 2016

---

#### Products Affected

- FARYDAK

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### FERRIPROX\_NVT

---

#### Products Affected

- FERRIPROX ORAL SOLUTION
- FERRIPROX ORAL TABLET 500 MG

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### FIRMAGON\_NVT 2015

---

#### Products Affected

- FIRMAGON KIT W DILUENT  
SYRINGE

PA Criteria	Criteria Details
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
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### FOLOTYN\_NVT 2015

---

#### Products Affected

- FOLOTYN

PA Criteria	Criteria Details
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.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### FORTEO\_NVT 2016

---

#### Products Affected

- FORTEO
- PROLIA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### FYCOMPA\_NVT 2014

---

#### Products Affected

- FYCOMPA ORAL SUSPENSION
- FYCOMPA ORAL TABLET

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### GARDASIL\_NVT 2015

---

#### Products Affected

- GARDASIL 9 (PF)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PA not required for members age 9-45.
Prescriber Restrictions	
Coverage Duration	Approved for duration of plan year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### GATTEX\_NVT 2016

---

#### Products Affected

- GATTEX 30-VIAL

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### GILENYA\_NVT 2018

---

#### Products Affected

- GILENYA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### GILOTRIF\_NVT

#### Products Affected

- GILOTRIF

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### GLATIRAMER\_MI\_2018

---

#### Products Affected

- *glatiramer*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### GLEEVEC\_NVT 2015

---

#### Products Affected

- *imatinib*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## GROWTH HORMONES\_NVT 2015

### Products Affected

- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### HARVONI\_NVT PA 2018

#### Products Affected

- HARVONI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	Member must be 3 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), OR TIPRANA VIR/RITONA VIR.
Indications	All FDA-approved Indications.
Off Label Uses	

## HEPATITIS B AGENTS\_CCHP 2014

### Products Affected

- *adefovir*
- BARACLUDE ORAL SOLUTION
- PEGASYS
- PEGASYS PROCLICK  
SUBCUTANEOUS PEN INJECTOR 180  
MCG/0.5 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	THIS SECTION APPLIES TO BARACLUDE, ADEFOVIR, 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. SWITCHING ANTIVIRAL AGENTS SHOULD BE CONSIDERED AFTER MEDICATION COMPLIANCE HAS BEEN DETERMINED.
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 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### HETLIOZ\_NVT

---

#### Products Affected

- HETLIOZ

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### HOFH\_NVT 2016

---

#### Products Affected

- JUXTAPID

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

Updated 3/2020

### 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
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
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE,

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

PA Criteria	Criteria Details
	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.
Indications	All FDA-approved Indications.
Off Label Uses	

## HYDROXYPROGESTERONE\_NVT

### Products Affected

- *hydroxyprogesterone cap(ppres)*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### IBRANCE\_NVT

---

#### Products Affected

- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGY SPECIALIST
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### ICLUSIG\_NVT 2014

---

#### Products Affected

- ICLUSIG

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### IDHIFA\_CCHP\_2018

#### Products Affected

- IDHIFA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### IMBRUVICA\_NVT 2014

---

**Products Affected**

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

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### INCRELEX\_NVT 2015

#### Products Affected

- INCRELEX

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### INLYTA\_NAVITUS

---

#### Products Affected

- INLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RESTRICTED TO OR IN CONSULT WITH ONCOLOGY SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### INREBIC

---

#### Products Affected

- INREBIC

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### INTERFERON\_MI\_2018

#### Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### IPF\_NVT 2016

#### Products Affected

- ESBRIET ORAL CAPSULE
- OFEV

PA Criteria	Criteria Details
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.
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### IRESSA\_NVT

---

#### Products Affected

- IRESSA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### ISTODAX\_NVT 2015

---

#### Products Affected

- *romidepsin*

PA Criteria	Criteria Details
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.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### ITRACONAZOLE\_NVT 2015

#### Products Affected

- *itraconazole oral capsule*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### IVIG\_NVT 2017

#### Products Affected

- BIVIGAM
- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %
- GAMASTAN
- 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
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### JAKAFI\_NVT 2014

---

#### Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RESTRICTED TO OR IN CONSULT WITH ONCOLOGY OR HEMATOLOGY SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### KADCYLA\_NVT

---

#### Products Affected

- KADCYLA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### KALYDECO\_NAVITUS

#### Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PATIENT IS NOT ON CONCURRENT THERAPY WITH OTHER IVACAFTOR-CONTAINING PRODUCTS. RENEWAL: THERE IS CLINICAL DOCUMENTATION OF MAINTAINED OR IMPROVEMENT IN FEV1, BMI, OR REDUCTION IN NUMBER OF EXACERBATIONS
Age Restrictions	
Prescriber Restrictions	RESTRICTED TO OR IN CONSULT WITH PULMONOLOGIST OR CYSTIC FIBROSIS SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### KEYTRUDA\_NVT 2015

---

#### Products Affected

- KEYTRUDA INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### KINERET\_NVT 2018

#### Products Affected

- KINERET

PA Criteria	Criteria Details
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 ANY TWO PREFERRED AGENTS (HUMIRA, ENBREL, XELJANZ/XELJANZ XR) AND ONE DMARD (DISEASE MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### KORLYM\_NVT

---

#### Products Affected

- KORLYM

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### KUVAN\_NVT 2017

---

#### Products Affected

- KUVAN

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### KYPROLIS\_NVT\_2017

---

#### Products Affected

- KYPROLIS

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### LARTRUVO\_NVT\_2017

---

#### Products Affected

- LARTRUVO

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### LENVIMA\_NVT 2016

---

#### Products Affected

- LENVIMA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### LETAIRIS\_NVT 2015

---

#### Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### LIDOCAINE PATCH\_NVT 2015

#### Products Affected

- *lidocaine topical adhesive patch,medicated 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	TRIAL AND FAILURE OF GABAPENTIN OF FOUR WEEKS OR MORE
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### LINZESS

---

#### Products Affected

- LINZESS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS TRIED AND FAILED POLYETHYLENE GLYCOL (MIRALAX).
Age Restrictions	AGE 18 YEARS AND OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### LOBRENA

---

#### Products Affected

- LORBRENA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### LONSURF\_NVT

---

#### Products Affected

- LONSURF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY AN ONCOLOGY SPECIALIST OR IN CONSULTATION WITH AN ONCOLOGY SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### LYNPARZA\_NVT 2015

---

#### Products Affected

- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### MAVYRET\_CCHP\_2018

#### Products Affected

- MAVYRET

PA Criteria	Criteria Details
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.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### MEGESTROL SUSP\_NVT 2017

#### Products Affected

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

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### MEGESTROL TABS\_NVT 2017

#### Products Affected

- *megestrol oral tablet*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### MEKINIST\_NVT 2016

---

#### Products Affected

- MEKINIST

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### MEKTOVI BRAFTOVI 2018

---

#### Products Affected

- BRAFTOVI
- MEKTOVI

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### MIDOSTAURIN

---

#### Products Affected

- RYDAPT

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### MOVANTIK\_NVT 2016

---

#### Products Affected

- MOVANTIK

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### MYLOTARG\_CCHP\_2018

---

#### Products Affected

- MYLOTARG

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### NATPARA (CCHP2017)

---

#### Products Affected

- NATPARA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### NERLYNX\_CCHP\_2018

---

#### Products Affected

- NERLYNX

PA Criteria	Criteria Details
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
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### NEXAVAR\_NVT 2015

---

#### Products Affected

- NEXAVAR

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### NINLARO\_NVT

---

#### Products Affected

- NINLARO

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### NIRAPARIB TOSYLATE

---

#### Products Affected

- ZEJULA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### NORTHERA\_NVT 2016

---

#### Products Affected

- NORTHERA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### NOXAFIL\_NVT 2015

#### Products Affected

- NOXAFIL ORAL
- *posaconazole oral tablet, delayed release (dr/ec)*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### NUBEQA

#### Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A UROLOGIST OR ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	CONCURRENTLY RECEIVING GONADOTROPIN-RELEASING HORMONE ANALOG OR HAD BILATERAL ORCHIECTOMY
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### NUCALA\_NVT PA 2017

#### Products Affected

- NUCALA

PA Criteria	Criteria Details
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 6 years old.
Prescriber Restrictions	Prescribed by, or in consultation with, an Allergy Specialist, Immunologist, Rheumatologist, or Pulmonary Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### NUPLAZID\_NVT

#### Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### NUVIGIL\_NVT 2015

#### Products Affected

- *armodafinil*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### ODOMZO\_NVT 2017

---

#### Products Affected

- ODOMZO

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### OPDIVO\_NVT 2015

---

#### Products Affected

- OPDIVO

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### OPSUMIT\_NVT

---

#### Products Affected

- OPSUMIT

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## ORAL FENTANYL\_NVT 2017

### Products Affected

- *fentanyl citrate*
- FENTORA

PA Criteria	Criteria Details
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.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### ORENCIA\_NVT 2018

#### Products Affected

- ORENCIA
- ORENCIA (WITH MALTOSE)
- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, JUVENILE IDIOPATHIC ARTHRITIS, PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: RA/PSA: 6 MONTHS. JIA: 4 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA) OR JUVENILE IDIOPATHIC ARTHRITIS (JIA): PREVIOUS TRIAL OF ANY TWO PREFERRED AGENTS (HUMIRA, ENBREL, XELJANZ/XELJANZ XR) AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PSORIATIC ARTHRITIS: PREVIOUS TRIAL OF ANY TWO PREFERRED AGENTS (HUMIRA, ENBREL, COSENTYX, XELJANZ/XELJANZ XR, STELARA)
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### ORFADIN\_NVT 2015

#### Products Affected

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

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### ORKAMBI\_NVT

---

#### Products Affected

- ORKAMBI

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### PA\_RESTASIS

#### Products Affected

- RESTASIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: 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. RENEWAL: CLINICAL DOCUMENTATION OF IMPROVED RESPONSE TO THERAPY
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### PALIPERIDONE ER, INVEGA SUSTENNA

#### Products Affected

- INVEGA SUSTENNA
- *paliperidone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO 2 OF THE FOLLOWING FOR EACH INDICATION: SCHIZOPHRENIA: ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, ZIPRASIDONE. PATIENT HAS NO TRIALS REQUIRED FOR THE FOLLOWING INDICATIONS: SCHIZOAFFECTIVE DISORDER.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### PERJETA\_NVT 2014

---

#### Products Affected

- PERJETA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### PIQRAY

---

#### Products Affected

- PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X 1), 300 MG/DAY (150 MG X 2)

PA Criteria	Criteria Details
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
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### POMALYST\_NVT 2014

---

#### Products Affected

- POMALYST

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### PROGESTERONE\_NVT 2015

---

#### Products Affected

- CRINONE

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### PROMACTA\_NVT 2017

---

#### Products Affected

- PROMACTA ORAL TABLET

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### RAVICTI\_NVT 2016

---

#### Products Affected

- RAVICTI

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### RELISTOR\_NVT 2015

---

#### Products Affected

- RELISTOR SUBCUTANEOUS SOLUTION
- RELISTOR SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

Updated 3/2020

### REMICADE\_NVT 2018

#### Products Affected

- REMICADE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: 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, 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 ANY TWO PREFERRED AGENTS (HUMIRA, ENBREL, XELJANZ/XELJANZ XR) AND CONCURRENT USE WITH METHOTREXATE. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF ANY TWO PREFERRED AGENTS (HUMIRA, ENBREL, COSENTYX, XELJANZ/XELJANZ XR, STELARA). ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF ANY TWO PREFERRED AGENTS (HUMIRA, ENBREL, COSENTYX). PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF ANY TWO PREFERRED AGENTS (HUMIRA, ENBREL, COSENTYX, SKYRIZI, STELARA) AND ONE PREFERRED SYSTEMIC THERAPY (TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF TWO PREFERRED AGENTS (HUMIRA AND



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

PA Criteria	Criteria Details
	STELARA) AND ONE CONVENTIONAL AGENT SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF BOTH (HUMIRA AND XELJANZ/XELJANZ XR) AND ONE CONVENTIONAL AGENT SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

Updated 3/2020

### REPATHA\_2019

#### Products Affected

- REPATHA SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	dual therapy with another PCSK-9 inhibitor, Kynamro (mipomersen), or Juxtapid (lomitapide)
<b>Required Medical Information</b>	For initiation of therapy patient must: A) have one of the following conditions: 1) prior clinical atherosclerotic cardiovascular disease (ASCVD) (see Other Criteria), 2) primary hyperlipidemia [including 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 primary hyperlipidemia (including 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) primary hyperlipidemia [including HeFH (see Other Criteria)], or 3) HoFH (see Other Criteria), AND B) demonstrate a reduction of LDL-C on PCSK9 inhibitor therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a Cardiologist, Lipidologist, or Endocrinologist
<b>Coverage Duration</b>	Initial: 3 months. Renewal: contract year subject to formulary change and member eligibility
<b>Other Criteria</b>	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 evidence of mutation in the LDLR, Apo B, OR PCSK9 gain of function

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

PA Criteria	Criteria Details
	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.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### REVATIO\_NVT 2017

---

#### Products Affected

- *sildenafil (pulm.hypertension) oral tablet*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### REVLIMID\_NVT 2015

---

#### Products Affected

- REVLIMID

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### REXULTI

#### Products Affected

- REXULTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO 2 OF THE FOLLOWING FOR EACH INDICATION: SCHIZOPHRENIA: ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, ZIPRASIDONE. PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO 1 OF THE FOLLOWING FOR EACH INDICATION: MAJOR DEPRESSIVE DISORDER: ARIPIPRAZOLE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### 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
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### RINVOQ

#### Products Affected

- RINVOQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY, OR GIVEN IN CONSULTATION WITH, A RHEUMATOLOGIST,
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	RHEUMATOID ARTHRITIS (RA): INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### RISPERDAL

#### Products Affected

- PERSERIS
- RISPERDAL CONSTA

PA Criteria	Criteria Details
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. PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO 1 OF THE FOLLOWING FOR EACH INDICATION: BIPOLAR DEPRESSION: OLANZAPINE. ACUTE MANIC/MIXED EPISODES WITH BIPOLAR DISORDER: ARIPIPRAZOLE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### ROZLYTREK

---

#### Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### RUBRACA\_NVT\_2017

---

#### Products Affected

- RUBRACA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### RUCONEST\_NVT 2015

---

#### Products Affected

- RUCONEST

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### SABRIL\_NVT 2017

---

#### Products Affected

- *vigabatrin*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### SAPHRIS

#### Products Affected

- SAPHRIS

PA Criteria	Criteria Details
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. PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO 1 OF THE FOLLOWING FOR EACH INDICATION: ACUTE MANIC/MIXED EPISODES WITH BIPOLAR DISORDER: ARIPIPRAZOLE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### SIGNIFOR\_NVT 2015

---

#### Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### SIMPONI\_NVT 2018

#### Products Affected

- SIMPONI
- SIMPONI ARIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF TWO PREFERRED AGENTS (HUMIRA, ENBREL, XELJANZ/XELJANZ XR) AND CONCURRENT USE WITH METHOTREXATE. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF TWO PREFERRED AGENTS (HUMIRA, ENBREL, COSENTYX, STELARA, XELJANZ/XELJANZ XR). ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF TWO PREFERRED AGENTS (HUMIRA, ENBREL, COSENTYX). ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF TWO PREFERRED AGENTS (HUMIRA, XELJANZ/XELJANZ XR) AND ONE OF THE FOLLOWING CONVENTIONAL AGENTS SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDINOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### SIRTURO\_NVT

---

#### Products Affected

- SIRTURO

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### SIVEXTRO\_NVT 2015

---

#### Products Affected

- SIVEXTRO

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### SKYRIZI

#### Products Affected

- SKYRIZI SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY, SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### SOLARAZE\_NVT 2017

---

#### Products Affected

- *diclofenac sodium topical gel 3 %*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### SOLTAMOX\_NVT

---

#### Products Affected

- SOLTAMOX

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### SOMAVERT\_NVT 2017

---

#### Products Affected

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

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### SOVALDI\_NVT PA 2018

#### Products Affected

- SOVALDI

PA Criteria	Criteria Details
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.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### SPRITAM\_NVT 2017

---

#### Products Affected

- SPRITAM

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### SPRYCEL\_NVT 2017

---

#### Products Affected

- SPRYCEL

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

Updated 3/2020

### STELARA

#### Products Affected

- STELARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL FOR PSORIATIC ARTHRITIS OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: PSA, PSO, CD: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION AT LEAST ONE CONVENTIONAL THERAPY 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 OR CONTRAINDICATION TO AT LEAST ONE CONVENTIONAL THERAPY SUCH AS CORTICOSTEROIDS

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

PA Criteria	Criteria Details
	(I.E. BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### STIVARGA\_NVT 2014

---

#### Products Affected

- STIVARGA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### STRENSIQ (CCHP)

---

#### Products Affected

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

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### SUCRAID\_NVT 2017

---

#### Products Affected

- SUCRAID

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### SUTENT\_NVT 2017

---

#### Products Affected

- SUTENT

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### SYLATRON\_NAVITUS

---

#### Products Affected

- SYLATRON

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

Updated 3/2020

### SYNAGIS\_NVT 2015

#### Products Affected

- SYNAGIS INTRAMUSCULAR  
SOLUTION 50 MG/0.5 ML

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### SYPRINE\_NVT 2017

---

#### Products Affected

- *trientine*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### TAFINLAR\_NVT 2016

#### Products Affected

- TAFINLAR

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### TAGRISSO\_NVT

#### Products Affected

- TAGRISSO

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### TALZENNA\_2019

---

#### Products Affected

- TALZENNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RESTRICTED TO OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### TARCEVA\_NVT 2017

---

#### Products Affected

- *erlotinib*
- TARCEVA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### TARGRETIN\_NVT 2015

---

#### Products Affected

- *bexarotene*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### TASIGNA\_NVT 2017

#### Products Affected

- TASIGNA

PA Criteria	Criteria Details
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.
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### TECENTRIQ\_NVT

---

#### Products Affected

- TECENTRIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH ONCOLOGY SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### 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
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

# TESTOSTERONE

### Products Affected

- *testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)*

PA Criteria	Criteria Details
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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### THALOMID\_NVT 2015

---

#### Products Affected

- THALOMID

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### TIBSOVO

#### Products Affected

- TIBSOVO

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### TIGAN\_NVT 2017

---

#### Products Affected

- *trimethobenzamide oral*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### TIRF

---

#### Products Affected

- *modafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### TOBI\_NVT 2015

#### Products Affected

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

PA Criteria	Criteria Details
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	Approval will be based off BvD coverage determination.
Indications	All FDA-approved Indications.
Off Label Uses	



## TOPICAL STEROIDS\_NVT 2017

### Products Affected

- *amcinonide topical cream*
- *amcinonide topical ointment*
- *betamethasone valerate topical foam*
- *clobetasol topical foam*
- *clobetasol topical lotion*
- *clobetasol topical shampoo*
- *clobetasol topical spray,non-aerosol*
- *clobetasol-emollient topical foam*
- CLODAN
- *cormax scalp*
- DESONATE
- *desonide topical cream*
- *desonide topical lotion*
- *fluticasone propionate topical lotion*
- *hydrocort buty 0.1% lipo cream*
- *hydrocortisone butyrate topical cream*
- TRIDESILON

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

Updated 3/2020

### TOTAL PARENTERAL NUTRITION AGENT

#### Products Affected

- AMINOSYN 7 % WITH ELECTROLYTES
- AMINOSYN 8.5 %-ELECTROLYTES
- AMINOSYN II 10 %
- AMINOSYN II 7 %
- AMINOSYN II 8.5 %
- AMINOSYN II 8.5 %-ELECTROLYTES
- AMINOSYN-HBC 7%
- AMINOSYN-PF 10 %
- AMINOSYN-PF 7 % (SULFITE-FREE)
- AMINOSYN-RF 5.2 %
- CLINIMIX 5%/D15W SULFITE FREE
- CLINIMIX 5%/D25W SULFITE-FREE
- CLINIMIX 4.25%-D25W SULF-FREE
- CLINIMIX 4.25%/D10W SULF FREE
- CLINIMIX 4.25%/D5W SULFIT FREE
- CLINIMIX 5%-D20W(SULFITE-FREE)
- CLINIMIX E 2.75%/D10W SUL FREE
- CLINIMIX E 2.75%/D5W SULF FREE
- CLINIMIX E 4.25%/D10W SUL FREE
- CLINIMIX E 4.25%/D25W SUL FREE
- CLINIMIX E 4.25%/D5W SULF FREE
- CLINIMIX E 5%/D15W SULFIT FREE
- CLINIMIX E 5%/D20W SULFIT FREE
- CLINIMIX E 5%/D25W SULFIT FREE
- CLINISOL SF 15 %
- FREAMINE HBC 6.9 %
- HEPATAMINE 8%
- NEPHRAMINE 5.4 %
- PLENAMINE
- PREMASOL 10 %
- PREMASOL 6 %
- PROCALAMINE 3%
- PROSOL 20 %
- TRAVASOL 10 %
- TROPHAMINE 10 %

PA Criteria	Criteria Details
Exclusion Criteria	PATIENTS RECEIVING TOTAL PARENTERAL NUTRITION FOR A NONFUNCTIONING DIGESTIVE TRACT.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

PA Criteria	Criteria Details
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### TRACLEER\_NVT 2015

---

#### Products Affected

- TRACLEER ORAL TABLET

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### TREANDA\_NVT 2015

---

#### Products Affected

- TREANDA INTRAVENOUS RECON SOLN

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### TROKENDI\_NVT 2014

#### Products Affected

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

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### TURALIO

---

#### Products Affected

- TURALIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### TYKERB\_NVT

#### Products Affected

- TYKERB

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### TYSABRI\_NVT 2018

#### Products Affected

- TYSABRI

PA Criteria	Criteria Details
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: GILENYA, MAYZENT, MAVENCLAD, COPAXONE, REBIF, AVONEX, PLEGRIDY, TEDFIDERA, OR AUBAGIO. CROHN'S DISEASE: TRIAL OF A HUMIRA AND STELARA. NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH A TNF (TUMOR NECROSIS FACTOR) INHIBITOR: ENBREL, CIMZIA, REMICADE, SIMPONI, OR SIMPONI ARIA.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### UCERIS\_NVT

#### Products Affected

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

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### UPTRAVI\_NVT 2017

---

#### Products Affected

- UPTRAVI ORAL TABLET
- UPTRAVI ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### VALCHLOR\_NVT 2017

#### Products Affected

- VALCHLOR

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### VENCLEXTA\_NVT

---

#### Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### VENTAVIS\_NVT 2015

---

#### Products Affected

- VENTAVIS

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### VERZENIO\_CCHP\_2018

#### Products Affected

- VERZENIO

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### VITRAKVI\_2018

---

#### Products Affected

- VITRAKVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY AN ONCOLOGY SPECIALIST OR IN CONSULTATION WITH AN ONCOLOGY SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### VIZIMPRO

---

#### Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RESTRICTED TO OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### VORICONAZOLE\_NVT 2015

#### Products Affected

- *voriconazole*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### VOSEVI\_CCHP\_2018

#### Products Affected

- VOSEVI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Severe renal impairment, ESRD or on hemodialysis. Moderate or severe hepatic impairment (Child-Pugh B or C).
<b>Required Medical Information</b>	HCV RNA level within past 6 months
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	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.
<b>Coverage Duration</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### VOTRIENT\_NVT

#### Products Affected

- VOTRIENT

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### VRAYLAR

#### Products Affected

- VRAYLAR

PA Criteria	Criteria Details
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. PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO 1 OF THE FOLLOWING FOR EACH INDICATION: BIPOLAR DEPRESSION: OLANZAPINE. ACUTE MANIC/MIXED EPISODES WITH BIPOLAR DISORDER: ARIPIPRAZOLE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### XALKORI\_NVT

---

#### Products Affected

- XALKORI

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### XELJANZ\_NVT\_18

#### Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	RA: INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS: PREVIOUS TRIAL OF ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. ULCERATIVE COLITIS: PREVIOUS TRIAL OF ONE CONVENTIONAL THERAPY SUCH AS CORTICOSTEROIDS (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### XENAZINE\_NVT 2015

#### Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### XGEVA\_NVT 2015

---

#### Products Affected

- XGEVA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

Updated 3/2020

### XOLAIR\_NVT PA 2015

#### Products Affected

- XOLAIR SUBCUTANEOUS RECON SOLN

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### XOSPATA

---

#### Products Affected

- XOSPATA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### 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
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.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### XTANDI\_NVT

---

#### Products Affected

- XTANDI

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### XYREM\_NVT 2017

---

#### Products Affected

- XYREM

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### YERVOY\_NVT 2015

---

#### Products Affected

- YERVOY

PA Criteria	Criteria Details
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
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### YONDELIS\_NVT\_2017

---

#### Products Affected

- YONDELIS

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### YONSA\_2018

#### Products Affected

- YONSA

PA Criteria	Criteria Details
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
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### ZALTRAP\_NVT 2014

---

#### Products Affected

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

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### ZAVESCA\_NVT 2017

---

#### Products Affected

- *miglustat*

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### ZELBORAF\_NVT 2017

---

#### Products Affected

- ZELBORAF

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
*Updated 3/2020*

### ZOLINZA\_NVT 2015

---

#### Products Affected

- ZOLINZA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

### ZORTRESS\_NVT 2015

---

#### Products Affected

- ZORTRESS

PA Criteria	Criteria Details
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.
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### ZYDELIG\_NVT

#### Products Affected

- ZYDELIG

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### ZYKADIA\_NVT

#### Products Affected

- ZYKADIA

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	



## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### ZYTIGA\_NVT 2015

---

#### Products Affected

- *abiraterone*
- ZYTIGA ORAL TABLET 500 MG

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria  
Updated 3/2020

### ZYVOX\_NVT 2015

---

#### Products Affected

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

PA Criteria	Criteria Details
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	
Indications	All FDA-approved Indications.
Off Label Uses	

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

Updated 3/2020

### INDEX

#### A

ABILIFY MAINTENA .....	12
ABILIFY MYCITE .....	12
abiraterone .....	231
ADAGEN .....	2
adapalene 0.3% gel pump .....	1
adapalene topical cream .....	1
adapalene topical gel .....	1
adefovir .....	73
ADEMPAS .....	4
AFINITOR .....	5
AFINITOR DISPERZ .....	5
ALECENSA .....	6
ALIQOPA .....	7
ALUNBRIG .....	22
alyq .....	3
ambrisentan .....	102
amcinonide topical cream .....	192
amcinonide topical ointment .....	192
AMINOSYN 7 % WITH ELECTROLYTES .....	193
AMINOSYN 8.5 %-ELECTROLYTES .....	193
AMINOSYN II 10 % .....	193
AMINOSYN II 7 % .....	193
AMINOSYN II 8.5 % .....	193
AMINOSYN II 8.5 %-ELECTROLYTES .....	193
AMINOSYN-HBC 7% .....	193
AMINOSYN-PF 10 % .....	193
AMINOSYN-PF 7 % (SULFITE-FREE) .....	193
AMINOSYN-RF 5.2 % .....	193
ANDRODERM TRANSDERMAL PATCH 24 HOUR 2 MG/24 HOUR, 4 MG/24 HR .....	9
ANDROGEL TRANSDERMAL GEL IN PACKET 1.62 % (20.25 MG/1.25 GRAM) .....	9
APTIOM .....	10
ARCALYST .....	11
aripiprazole oral tablet, disintegrating .....	12
ARISTADA .....	12
ARISTADA INITIO .....	12

armodafinil .....	126
AUBAGIO .....	14
avita .....	1
AVONEX (WITH ALBUMIN) .....	86
AVONEX INTRAMUSCULAR PEN INJECTOR .....	86
AVONEX INTRAMUSCULAR PEN INJECTOR KIT .....	86
AVONEX INTRAMUSCULAR SYRINGE KIT .....	86
AYVAKIT .....	15
<b>B</b>	
BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG .....	16
BARACLUDGE ORAL SOLUTION .....	73
BELEODAQ .....	17
BENLYSTA .....	18
BERINERT INTRAVENOUS KIT .....	34
BESPONSA .....	19
betamethasone valerate topical foam .....	192
bexarotene .....	182
BIVIGAM .....	91
BOSULIF .....	20
BRAFTOVI .....	112
BRIVIACT INTRAVENOUS .....	23
BRIVIACT ORAL SOLUTION .....	23
BRIVIACT ORAL TABLET .....	23
BRUKINSA .....	24
budesonide oral tablet, delayed and ext. release .....	200
<b>C</b>	
CABOMETYX .....	25
CALQUENCE .....	26
CAPRELSA .....	27
CARBAGLU .....	28
CAYSTON .....	29
CESAMET .....	30
CHOLBAM .....	31
CIMZIA .....	32, 33
CIMZIA POWDER FOR RECONST .....	32, 33
CINRYZE .....	34
CLINIMIX 5%/D15W SULFITE FREE .....	193

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

Updated 3/2020

CLINIMIX 5%/D25W SULFITE-FREE	193
CLINIMIX 4.25%/D10W SULF FREE	193
CLINIMIX 4.25%/D5W SULFIT FREE	193
CLINIMIX 4.25%-D25W SULF-FREE	193
CLINIMIX 5%-D20W(SULFITE-FREE)	193
CLINIMIX E 2.75%/D10W SUL FREE	193
CLINIMIX E 2.75%/D5W SULF FREE	193
CLINIMIX E 4.25%/D10W SUL FREE	193
CLINIMIX E 4.25%/D25W SUL FREE	193
CLINIMIX E 4.25%/D5W SULF FREE	193
CLINIMIX E 5%/D15W SULFIT FREE	193
CLINIMIX E 5%/D20W SULFIT FREE	193
CLINIMIX E 5%/D25W SULFIT FREE	193
CLINISOL SF 15 %	193
clobetasol topical foam	192
clobetasol topical lotion	192
clobetasol topical shampoo	192
clobetasol topical spray,non-aerosol	192
clobetasol-emollient topical foam	192
CLODAN	192
COMETRIQ	35
COPIKTRA	36
CORLANOR ORAL TABLET	37
cormax scalp	192
COSENTYX (2 SYRINGES)	38
COSENTYX PEN (2 PENS)	38
COTELLIC	39
CRINONE	139
CYRAMZA	40
CYSTAGON	41
CYSTARAN	42
<b>D</b>	
dalfampridine	8
DARZALEX	43
DAURISMO ORAL TABLET 100 MG, 25 MG	44
DESONATE	192
desonide topical cream	192
desonide topical lotion	192
diclofenac sodium topical gel 3 %	163
dronabinol	46
DUPIXENT	47

<b>E</b>	
EMPLICITI	49
ENBREL	50
ENBREL MINI	50
ENBREL SURECLICK	50
ENTRESTO	51
EPANED ORAL SOLUTION	52
EPCLUSA	53
EPIDIOLEX	54
ERIVEDGE	55
ERLEADA	56
erlotinib	181
ERWINAZE	57
ESBRIET ORAL CAPSULE	87
EXTAVIA SUBCUTANEOUS KIT	58
<b>F</b>	
FANAPT	12
FARYDAK	59
fentanyl citrate	130
FENTORA	130
FERRIPROX ORAL SOLUTION	60
FERRIPROX ORAL TABLET 500 MG	60
FIRAZYR	34
FIRMAGON KIT W DILUENT SYRINGE	61
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %	91
fluticasone propionate topical lotion	192
FOLOTYN	62
fondaparinux	13
FORTEO	63
FREAMINE HBC 6.9 %	193
FYCOMPA ORAL SUSPENSION	64
FYCOMPA ORAL TABLET	64
<b>G</b>	
GAMASTAN	91
GAMMAGARD LIQUID	91
GAMMAGARD S-D (IGA < 1 MCG/ML)	91
GAMMAKED INJECTION SOLUTION 10 GRAM/100 ML (10 %)	91
GAMMAPLEX (WITH SORBITOL)	91
GAMUNEX-C INJECTION SOLUTION 20 GRAM/200 ML (10 %)	91

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

Updated 3/2020

GARDASIL 9 (PF).....	65
GATTEX 30-VIAL .....	66
GILENYA .....	67
GILOTRIF .....	68
glatiramer.....	69

### H

HARVONI.....	72
HEPATAMINE 8%.....	193
HETLIOZ .....	74
HUMIRA .....	76, 77
HUMIRA PEDIATRIC CROHNS START .....	76, 77
HUMIRA PEN .....	76, 77
HUMIRA PEN CROHNS-UC-HS START .....	76, 77
HUMIRA PEN PSOR-UEITS-ADOL HS .....	76, 77
HUMIRA(CF) .....	76, 77
HUMIRA(CF) PEDI CROHNS STARTER .....	76, 77
HUMIRA(CF) PEN CROHNS-UC-HS ...	76, 77
HUMIRA(CF) PEN PSOR-UV-ADOL HS .....	76, 77
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	76, 77
hydrocort buty 0.1% lipo cream .....	192
hydrocortisone butyrate topical cream ....	192
hydroxyprogesterone cap(ppres) .....	78

### I

IBRANCE.....	79
icatibant .....	34
ICLUSIG .....	80
IDHIFA.....	81
imatinib.....	70
IMBRUVICA ORAL CAPSULE.....	82
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG.....	82
IMFINZI .....	48
INCRELEX .....	83
INLYTA .....	84
INREBIC .....	85
INVEGA SUSTENNA .....	135

IRESSA .....	88
itraconazole oral capsule .....	90

### J

JAKAFI .....	92
JUXTAPID .....	75

### K

KADCYLA.....	93
KALYDECO .....	94
KEYTRUDA INTRAVENOUS SOLUTION .....	95
KINERET .....	96
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.....	150
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3).....	150
KORLYM.....	97
KUVAN.....	98
KYPROLIS.....	99

### L

LARTRUVO .....	100
LATUDA.....	12
LENVIMA.....	101
lidocaine topical adhesive patch,medicated 5 %.....	103
linezolid .....	232
linezolid 600 mg/300 ml-0.9% nacl .....	232
linezolid in dextrose 5% .....	232
LINZESS .....	104
LONSURF .....	106
LORBRENA.....	105
LYNPARZA ORAL TABLET.....	107

### M

MAVYRET .....	108
megestrol oral suspension 400 mg/10 ml (40 mg/ml) .....	109
megestrol oral tablet .....	110
MEKINIST .....	111
MEKTOVI.....	112
methamphetamine.....	45
miglustat .....	225

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

Updated 3/2020

modafinil.....	190
MOVANTIK .....	114
MYLOTARG .....	115
<b>N</b>	
NATPARA .....	116
NEPHRAMINE 5.4 %.....	193
NERLYNX.....	117
NEXAVAR.....	118
NINLARO .....	119
nitisinone .....	132
NORDITROPIN FLEXPPO .....	71
NORTHERA .....	121
NOXAFIL ORAL.....	122
NUBEQA .....	123
NUCALA .....	124
NUPLAZID ORAL CAPSULE .....	125
NUPLAZID ORAL TABLET 10 MG ...	125
<b>O</b>	
OCTAGAM.....	91
ODOMZO.....	127
OFEV.....	87
OPDIVO .....	128
OPSUMIT.....	129
ORENCIA .....	131
ORENCIA (WITH MALTOSE) .....	131
ORENCIA CLICKJECT .....	131
ORFADIN ORAL CAPSULE 10 MG, 2	
MG, 5 MG .....	132
ORKAMBI .....	133
<b>P</b>	
paliperidone .....	135
PEGASYS .....	73
PEGASYS PROCLICK SUBCUTANEOUS	
PEN INJECTOR 180 MCG/0.5 ML .....	73
PERJETA .....	136
PERSERIS.....	152
PIQRAY ORAL TABLET 200 MG/DAY	
(200 MG X 1), 250 MG/DAY (200 MG	
X1-50 MG X1), 300 MG/DAY (150 MG	
X 2).....	137
PLEGRIDY SUBCUTANEOUS PEN	
INJECTOR .....	86
PLEGRIDY SUBCUTANEOUS SYRINGE	
125 MCG/0.5 ML.....	86

PLENAMINE .....	193
POMALYST.....	138
posaconazole oral tablet,delayed release	
(dr/ec) .....	122
PREMASOL 10 % .....	193
PREMASOL 6 % .....	193
PRIVIGEN .....	91
PROCALAMINE 3%.....	193
PROLIA.....	63
PROMACTA ORAL TABLET.....	140
PROSOL 20 % .....	193
<b>R</b>	
RAVICTI.....	141
RELISTOR SUBCUTANEOUS	
SOLUTION .....	142
RELISTOR SUBCUTANEOUS SYRINGE	
.....	142
REMICADE .....	143, 144
REPATHA SYRINGE .....	145, 146
RESTASIS.....	134
REVLIMID.....	148
REXULTI .....	149
RINVOQ.....	151
RISPERDAL CONSTA .....	152
romidepsin .....	89
ROZLYTREK ORAL CAPSULE 100 MG,	
200 MG.....	153
RUBRACA.....	154
RUCONEST .....	155
RYDAPT .....	113
<b>S</b>	
SAPHRIS.....	157
SIGNIFOR.....	158
sildenafil (pulm.hypertension) oral tablet	
.....	147
SIMPONI.....	159
SIMPONI ARIA .....	159
SIRTURO .....	160
SIVEXTRO .....	161
SKYRIZI SUBCUTANEOUS SYRINGE	
.....	162
SOLTAMOX.....	164
SOMAVERT SUBCUTANEOUS RECON	
SOLN 15 MG, 20 MG, 25 MG, 30 MG	
.....	165

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

Updated 3/2020

SOVALDI.....	166	trimethobenzamide oral .....	189
SPRITAM.....	167	TROPHAMINE 10 %.....	193
SPRYCEL.....	168	TURALIO.....	197
STELARA .....	169, 170	TYKERB .....	198
STIVARGA .....	171	TYSABRI .....	199
STRENSIQ SUBCUTANEOUS		<b>U</b>	
SOLUTION 40 MG/ML, 80 MG/0.8 ML		UCERIS RECTAL .....	200
.....	172	UPTRAVI ORAL TABLET.....	201
SUCRAID.....	173	UPTRAVI ORAL TABLETS,DOSE PACK	
SUTENT.....	174	.....	201
SYLATRON.....	175	<b>V</b>	
SYMPAZAN .....	21	VALCHLOR .....	202
SYNAGIS INTRAMUSCULAR		VENCLEXTA .....	203
SOLUTION 50 MG/0.5 ML.....	176	VENCLEXTA STARTING PACK.....	203
<b>T</b>		VENTAVIS .....	204
TAFINLAR .....	178	VERZENIO .....	205
TAGRISO.....	179	vigabatrin .....	156
TALZENNA.....	180	VITRAKVI.....	206
TARCEVA .....	181	VIZIMPRO.....	207
TASIGNA.....	183	voriconazole .....	208
TECENTRIQ.....	184	VOSEVI .....	209
TECFIDERA ORAL		VOTRIENT .....	210
CAPSULE,DELAYED		VRAYLAR.....	211
RELEASE(DR/EC) 120 MG, 120 MG		<b>X</b>	
(14)- 240 MG (46), 240 MG.....	185	XALKORI .....	212
testosterone transdermal gel in metered-dose		XELJANZ.....	213
pump 12.5 mg/ 1.25 gram (1 %).....	186	XELJANZ XR.....	213
tetrabenazine .....	214	XGEVA .....	215
THALOMID.....	187	XOLAIR SUBCUTANEOUS RECON	
TIBSOVO.....	188	SOLN.....	216
TOBI PODHALER INHALATION		XOSPATA.....	217
CAPSULE, W/INHALATION DEVICE		XPOVIO ORAL TABLET 100 MG/WEEK	
.....	191	(20 MG X 5), 160 MG/WEEK (20 MG X	
tobramycin in 0.225 % nacl.....	191	8), 60 MG/WEEK (20 MG X 3), 80	
topiramate oral capsule,sprinkle,er 24hr .	196	MG/WEEK (20 MG X 4).....	218
TRACLEER ORAL TABLET .....	194	XTANDI.....	219
TRAVASOL 10 % .....	193	XYREM.....	220
TREANDA INTRAVENOUS RECON		<b>Y</b>	
SOLN.....	195	YERVOY .....	221
tretinoin.....	1	YONDELIS .....	222
tretinoin (emollient).....	1	YONSA .....	223
tretinoin microspheres topical gel .....	1	<b>Z</b>	
TRIDESILON.....	192	ZALTRAP INTRAVENOUS SOLUTION	
trientine .....	177	100 MG/4 ML (25 MG/ML) .....	224

## 2020 Chinese Community Health Plan Senior Select Program (HMO SNP)

Prior Authorization Criteria

*Updated 3/2020*

ZEJULA .....	120
ZELBORAF .....	226
ZOLINZA .....	227
ZORTRESS .....	228

ZYDELIG .....	229
ZYKADIA .....	230
ZYTIGA ORAL TABLET 500 MG .....	231