

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

**ODS Health Plan, Inc.
Formulary ID #10183**

**Medicare Part D
Prior Authorization Criteria
Effective 01/01/2010**

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

ADCIRCA

DRUG NAME

ADCIRCA

COVERED USES:

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

6 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

AFINITOR

DRUG NAME

AFINITOR

COVERED USES:

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

6 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

ALFERON N

DRUG NAME

ALFERON N

COVERED USES:

FOR THE INTRALESIONAL TREATMENT OF REFRACTORY OR RECURRING EXTERNAL CONDYLOMATA ACUMINATA IN PATIENTS 18 YEARS OF AGE OR OLDER.

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

12 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

ALOXI

DRUG NAME

ALOXI

COVERED USES:

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

3 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
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PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

AMEVIVE

DRUG NAME

AMEVIVE

COVERED USES:

TREATMENT OF ADULT PATIENTS WITH MODERATE TO SEVERE CHRONIC PLAQUE PSORIASIS WHO ARE CANDIDATES FOR SYSTEMIC THERAPY OR PHOTOTHERAPY.

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

INITIAL 3 MONTHS AND RENEWAL 12 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

AMPYRA

DRUG NAME

AMPYRA

COVERED USES:

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

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

INITIAL 3 MONTHS AND RENEWAL 12 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
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PRIOR AUTHORIZATION GROUP DESCRIPTION
ANTINAUSEA AGENTS

DRUG NAME

ANZEMET | GRANISETRON HCL | GRANISOL | KYTRIL |
ONDANSETRON HCL | ONDANSETRON ODT | ZOFRAN | ZOFRAN
ODT

COVERED USES:

PREVENTION OF NAUSEA AND VOMITING ASSOCIATED WITH
CANCER CHEMOTHERAPY. PREVENTION OF NAUSEA AND
VOMITING ASSOCIATED WITH RADIATION THERAPY.

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

3 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
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PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
ANTIVIRAL HEPATITIS C AGENTS

DRUG NAME

COPEGUS | INFERGEN | PEGASYS | PEGINTRON | PEGINTRON
REDIPEN | REBETOL | RIBAPAK | RIBASPHERE | RIBAVIRIN

COVERED USES:

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

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

INITIAL 4 TO 6 MONTHS BASED ON DIAGNOSIS AND RENEWAL 8
MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
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PRIOR AUTHORIZATION GROUP DESCRIPTION

APOKYN

DRUG NAME

APOKYN

COVERED USES:

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

COVERAGE DURATION:

6 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
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PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

ARANESP

DRUG NAME

ARANESP

COVERED USES:

TREATMENT OF ANEMIA ASSOCIATED WITH CHRONIC RENAL FAILURE, INCLUDING PATIENTS ON DIALYSIS AND PATIENTS NOT ON DIALYSIS, AND THE TREATMENT OF ANEMIA IN PATIENTS WITH NONMYELOID MALIGNANCIES IN WHICH ANEMIA IS CAUSED BY THE EFFECT OF COADMINISTERED CHEMOTHERAPY.

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

6 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
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PRIOR AUTHORIZATION GROUP DESCRIPTION

BONIVA

DRUG NAME

BONIVA

COVERED USES:

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D.

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

12 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
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PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
BOTULINUM TOXIN AGENTS

DRUG NAME
BOTOX | MYOBLOC

COVERED USES:
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D.

EXCLUSION CRITERIA:
COSMETIC TREATMENTS

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
12 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
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PRIOR AUTHORIZATION GROUP DESCRIPTION

BVD ADMIN EDIT

DRUG NAME

ABELCET | ACTEMRA | ACYCLOVIR SODIUM | ADACEL |
ADRIAMYCIN | ALDURAZYME | AMBISOME | AMINOSYN |
AMINOSYN II | AMINOSYN II 3.5%-DEXTROSE 25% | AMINOSYN II
3.5%-DEXTROSE 5% | AMINOSYN II 4.25% M-DEXT 10% |
AMINOSYN II 4.25%-DEXTROSE 25% | AMINOSYN II 5% IN 25%
DEXTROSE | AMINOSYN II IN DEXTROSE | AMINOSYN II W/ELEC
IN DEX W/CA | AMINOSYN M | AMINOSYN W/ELECTROLYTES |
AMINOSYN-HBC | AMINOSYN-HF | AMINOSYN-PF | AMPHOTEC |
AMPHOTERICIN B | AZASAN | AZATHIOPRINE | AZATHIOPRINE
SODIUM | BLEOMYCIN SULFATE | BOOSTRIX | CARIMUNE NF
NANOFILTERED | CELLCEPT | CEREDASE | CEREZYME |
CERVARIX | CLADRIBINE | CLINIMIX | CLINIMIX E | CLINISOL |
CYCLOPHOSPHAMIDE | CYCLOSPORINE | CYCLOSPORINE
MODIFIED | CYTARABINE | CYTOVENE | CYTOXAN | DAPTACEL |
DEXTROSE IN WATER | DIPHTHERIA-TETANUS TOXOID | DOXIL |
DOXORUBICIN HCL | ELAPRASE | ELITEK | FABRAZYME |
FLEBOGAMMA DIF | FLUOROURACIL | FOSCARNET SODIUM |
FOSCAVIR | FREAMINE HBC | FREAMINE III | FREAMINE III
WITH ELECTROLYTES | GAMASTAN S-D | GAMMAGARD LIQUID |
GAMUNEX | GENGRAF | HEPATAMINE | HEPATASOL |
HERCEPTIN | IFEX | IFOSFAMIDE | IFOSFAMIDE-MESNA |
IMURAN | INFANRIX | INTRALIPID | ISTODAX | IXEMPRA |
LEUSTATIN | LIPOSYN II | LIPOSYN III | METHOTREXATE |
MITOMYCIN | MYCOPHENOLATE MOFETIL | MYFORTIC |
MYOZYME | NAGLAZYME | NEORAL | NEPHRAMINE | NEXIUM
I.V. | NOVAMINE | OCTAGAM | ORENCIA | ORTHOCLONE OKT-3 |
POLYGAM S-D | PREMASOL | PRIVIGEN | PROCALAMINE |
PROGRAF | PROSOL | PROTONIX IV | QUICK MIX WITH LYTES |
RAPAMUNE | REMICADE | REMODULIN | RENAMIN |
RHEUMATREX | SANDIMMUNE | SIMULECT | SYNAGIS |
TACROLIMUS | TETANUS DIPHTHERIA TOXOIDS | TETANUS
TOXOID ADSORBED | TETANUS-DIPHTERIA-DECAVAC |
TRAVASOL | TRAVASOL W/ELECTROLYTES | TRAVASOL WITH
DEXTROSE | TRAVASOL WITH ELECTROLYTES | TREXALL |
TRIHIBIT | TRIPEDIA | TROPHAMINE | VIBATIV | VINBLASTINE
SULFATE | VINCRISTINE SULFATE | VIVAGLOBIN | VPRIV |
ZENAPAX

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
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PA CRITERIA GUIDELINES**

COVERED USES:

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.

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

N/A

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

BYETTA

DRUG NAME

BYETTA

COVERED USES:

AS ADJUNCTIVE THERAPY TO IMPROVE GLYCEMIC CONTROL IN PATIENTS WITH TYPE 2 DIABETES MELLITUS WHO ARE TAKING METFORMIN, A SULFONYLUREA, A THIAZOLIDINEDIONE, A COMBINATION OF METFORMIN AND A SULFONYLUREA, OR A COMBINATION OF METFORMIN AND A THIAZOLIDINEDIONE, BUT HAVE NOT ACHIEVED ADEQUATE GLYCEMIC CONTROL.

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

12 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
COPAXONE

DRUG NAME
COPAXONE

COVERED USES:
FOR REDUCTION OF THE FREQUENCY OF RELAPSES IN
PATIENTS WITH RELAPSING-REMITTING MS

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
INITIAL 6 MONTHS AND RENEWAL 12 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
EMEND

DRUG NAME
EMEND

COVERED USES:
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D.

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
3 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

ENBREL

DRUG NAME

ENBREL

COVERED USES:

FOR REDUCING SIGNS AND SYMPTOMS IN PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS, TREATMENT OF ADULT PATIENTS 18 YEARS OF AGE AND OLDER WITH CHRONIC MODERATE TO SEVERE PLAQUE PSORIASIS WHO ARE CANDIDATES FOR SYSTEMIC THERAPY OR PHOTOTHERAPY, REDUCING SIGNS AND SYMPTOMS OF MODERATELY TO SEVERELY ACTIVE POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS IN PATIENTS 2 YEARS OF AGE AND OLDER, REDUCING SIGNS AND SYMPTOMS, INHIBITING THE PROGRESSION OF STRUCTURAL DAMAGE OF ACTIVE ARTHRITIS, AND IMPROVING PHYSICAL FUNCTION IN PATIENTS WITH PSORIATIC ARTHRITIS, AND REDUCING SIGNS AND SYMPTOMS, INDUCING MAJOR CLINICAL RESPONSE, INHIBITING THE PROGRESSION OF STRUCTURAL DAMAGE, AND IMPROVING PHYSICAL FUNCTION IN PATIENTS WITH MODERATELY TO SEVERELY ACTIVE RHEUMATOID ARTHRITIS.

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

INITIAL 6 MONTHS AND RENEWAL 12 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
EPOETIN

DRUG NAME
EPOGEN | PROCRIT

COVERED USES:
FOR THE TREATMENT OF ANEMIA IN PATIENTS WITH NONMYELOID MALIGNANCIES IN WHICH ANEMIA IS DUE TO THE EFFECT OF COADMINISTERED CHEMOTHERAPY, THE TREATMENT OF ANEMIA ASSOCIATED WITH CRF, INCLUDING PATIENTS ON DIALYSIS (END-STAGE RENAL DISEASE) AND PATIENTS NOT ON DIALYSIS, THE TREATMENT OF ANEMIA RELATED TO THERAPY WITH ZIDOVUDINE IN HIV-INFECTED PATIENTS, THE TREATMENT OF ANEMIC PATIENTS (HEMOGLOBIN OF MORE THAN 10 TO LESS THAN OR EQUAL TO 13 G/DL) WHO ARE AT HIGH RISK FOR PERIOPERATIVE BLOOD LOSS FROM ELECTIVE, NONCARDIAC, NONVASCULAR SURGERY TO REDUCE THE NEED FOR ALLOGENEIC BLOOD TRANSFUSIONS.

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
6 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
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PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
EXJADE

DRUG NAME
EXJADE

COVERED USES:
FOR THE TREATMENT OF CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS (TRANSFUSIONAL HEMOSIDEROSIS) IN PATIENTS 2 YEARS OF AGE AND OLDER WHO ARE UNABLE TO TOLERATE OR HAVE NOT RESPONDED TO FIRST LINE INJECTABLE THERAPY.

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
6 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
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PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

FORTEO

DRUG NAME

FORTEO

COVERED USES:

TREATMENT OF POSTMENOPAUSAL WOMEN WITH OSTEOPOROSIS WHO ARE AT HIGH RISK FOR FRACTURE. THESE INCLUDE WOMEN WITH A HISTORY OF OSTEOPOROTIC FRACTURE, OR WHO HAVE MULTIPLE RISK FACTORS FOR FRACTURE, OR WHO HAVE FAILED OR ARE INTOLERANT OF PREVIOUS OSTEOPOROSIS THERAPY, BASED UPON PHYSICIAN ASSESSMENT. TREATMENT TO INCREASE BONE MASS IN MEN WITH PRIMARY OR HYPOGONADAL OSTEOPOROSIS WHO ARE AT HIGH RISK FOR FRACTURE. THESE INCLUDE MEN WITH A HISTORY OF OSTEOPOROTIC FRACTURE, OR WHO HAVE MULTIPLE RISK FACTORS FOR FRACTURE, OR WHO HAVE FAILED OR ARE INTOLERANT TO PREVIOUS OSTEOPOROSIS THERAPY, BASED UPON PHYSICIAN ASSESSMENT.

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

12 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
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PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
HUMIRA

DRUG NAME
CIMZIA | HUMIRA | SIMPONI

COVERED USES:
FOR REDUCING SIGNS AND SYMPTOMS IN PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS, REDUCING SIGNS AND SYMPTOMS AND INDUCING AND MAINTAINING CLINICAL REMISSION IN ADULT PATIENTS WITH MODERATELY TO SEVERELY ACTIVE CROHN DISEASE WHO HAVE HAD AN INADEQUATE RESPONSE TO CONVENTIONAL THERAPY, REDUCING SIGNS AND SYMPTOMS OF MODERATELY TO SEVERELY ACTIVE POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS IN PATIENTS 4 YEARS OF AGE AND OLDER, THE TREATMENT OF ADULT PATIENTS WITH MODERATE TO SEVERE CHRONIC PLAQUE PSORIASIS WHO ARE CANDIDATES FOR SYSTEMIC THERAPY OR PHOTOTHERAPY, AND WHEN OTHER SYSTEMIC THERAPIES ARE MEDICALLY LESS APPROPRIATE, REDUCING SIGNS AND SYMPTOMS OF ACTIVE ARTHRITIS, INHIBITING THE PROGRESSION OF STRUCTURAL DAMAGE, AND IMPROVING PHYSICAL FUNCTION IN PATIENTS WITH PSORIATIC ARTHRITIS, AND SIGNS AND SYMPTOMS, INDUCING MAJOR CLINICAL RESPONSE, INHIBITING THE PROGRESSION OF STRUCTURAL DAMAGE, AND IMPROVING PHYSICAL FUNCTION IN ADULT PATIENTS WITH MODERATELY TO SEVERELY ACTIVE RHEUMATOID ARTHRITIS.

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
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COVERAGE DURATION:

INITIAL 3 MONTHS AND RENEWAL 12 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
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PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
IMMUNOMODULATORS

DRUG NAME
ACTIMMUNE

COVERED USES:
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
6 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
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PRIOR AUTHORIZATION GROUP DESCRIPTION
INCRELEX

DRUG NAME
INCRELEX

COVERED USES:
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
6 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
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PRIOR AUTHORIZATION GROUP DESCRIPTION
INSPRA

DRUG NAME
INSPRA

COVERED USES:
TREATMENT OF HYPERTENSION AND TO IMPROVE SURVIVAL OF STABLE PATIENTS WITH LEFT VENTRICULAR SYSTOLIC DYSFUNCTION (EJECTION FRACTION LESS THAN OR EQUAL TO 40%) AND CLINICAL EVIDENCE OF HEART FAILURE AFTER AN ACUTE MYOCARDIAL INFARCTION.

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
12 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
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PRIOR AUTHORIZATION GROUP DESCRIPTION
INTERFERON AGENTS FOR MS

DRUG NAME

AVONEX | AVONEX ADMINISTRATION PACK | BETASERON |
EXTAVIA | REBIF

COVERED USES:

TREATMENT OF RELAPSING FORMS OF MULTIPLE SCLEROSIS
(MS) TO REDUCE THE FREQUENCY OF CLINICAL
EXACERBATIONS.

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

6 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

KINERET

DRUG NAME

KINERET

COVERED USES:

FOR THE REDUCTION IN SIGNS AND SYMPTOMS OF MODERATELY TO SEVERELY ACTIVE RA IN PATIENTS 18 YEARS OF AGE AND OLDER WHO HAVE FAILED 1 OR MORE DISEASE-MODIFYING ANTIRHEUMATIC DRUGS (DMARDS).

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

INITIAL 3 MONTHS AND RENEWAL 12 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
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PRIOR AUTHORIZATION GROUP DESCRIPTION

KUVAN

DRUG NAME

KUVAN

COVERED USES:

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

6 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
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PRIOR AUTHORIZATION GROUP DESCRIPTION

LETARIS

DRUG NAME

LETARIS

COVERED USES:

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

6 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
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PRIOR AUTHORIZATION GROUP DESCRIPTION
LEUKINE

DRUG NAME
LEUKINE

COVERED USES:
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D.

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
6 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
NEULASTA

DRUG NAME
NEULASTA

COVERED USES:
TO DECREASE THE INCIDENCE OF INFECTION, AS MANIFESTED BY FEBRILE NEUTROPENIA, IN PATIENTS WITH NONMYELOID MALIGNANCIES RECEIVING MYELOSUPPRESSIVE ANTICANCER DRUGS ASSOCIATED WITH A CLINICALLY SIGNIFICANT INCIDENCE OF FEBRILE NEUTROPENIA.

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
3 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
NEUMEGA

DRUG NAME
NEUMEGA

COVERED USES:
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
6 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
NEUPOGEN

DRUG NAME
NEUPOGEN

COVERED USES:
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D.

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
3 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

NUVIGIL

DRUG NAME

NUVIGIL

COVERED USES:

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

6 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
OCTREOTIDE

DRUG NAME

OCTREOTIDE ACETATE | SANDOSTATIN | SANDOSTATIN LAR

COVERED USES:

TO REDUCE BLOOD LEVELS OF GROWTH HORMONE AND IGF-I (SOMATOMEDIN C) IN ACROMEGALY PATIENTS WHO HAVE HAD INADEQUATE RESPONSE TO OR CANNOT BE TREATED WITH SURGICAL RESECTION, PITUITARY IRRADIATION, AND BROMOCRIPTINE MESYLATE AT MAXIMALLY TOLERATED DOSES. SYSTEMIC TREATMENT OF PATIENTS WITH METASTATIC CARCINOID TUMORS WHERE IT SUPPRESSES OR INHIBITS THE SEVERE DIARRHEA AND FLUSHING EPISODES ASSOCIATED WITH THE DISEASE, THE TREATMENT OF THE PROFUSE WATERY DIARRHEA ASSOCIATED WITH VASOACTIVE INTESTINAL PEPTIDE TUMORS.

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

12 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
OFATUMUMAB

DRUG NAME
ARZERRA

COVERED USES:
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
6 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

PAZOPANIB

DRUG NAME

VOTRIENT

COVERED USES:

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

6 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
PROMACTA

DRUG NAME
PROMACTA

COVERED USES:
ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D.

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
6 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
PROVIGIL

DRUG NAME
PROVIGIL

COVERED USES:
TO IMPROVE WAKEFULNESS IN PATIENTS WITH EXCESSIVE SLEEPINESS ASSOCIATED WITH NARCOLEPSY, OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME (OSAHS), AND SHIFT WORK SLEEP DISORDER (SWSD). SYSTEMIC TREATMENT OF PATIENTS WITH MULTIPLE SCLEROSIS (MS).

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
12 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

RELISTOR

DRUG NAME

RELISTOR

COVERED USES:

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D.

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

6 MONTH

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
RESPIRATORY ENZYMES

DRUG NAME

ARALAST NP | PROLASTIN C | ZEMAIRA

COVERED USES:

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

6 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

REVATIO

DRUG NAME

REVATIO

COVERED USES:

FOR THE TREATMENT OF PAH (WORLD HEALTH ORGANIZATION GROUP 1) TO IMPROVE EXERCISE ABILITY

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

6 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

RIBAVIRIN

DRUG NAME

RIBAVIRIN

COVERED USES:

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D.

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

12 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
RIFAXIMIN

DRUG NAME
XIFAXAN

COVERED USES:
TREATMENT OF PATIENTS WITH HEPATIC ENCEPHALOPATHY.
TREATMENT OF PATIENTS 12 YEARS OF AGE WITH TRAVELERS
DIARRHEA CAUSED BY NONINVASIVE STRAINS OF ESCHERICHIA
COLI.

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
12 MONTHS FOR HE AND 10 DAYS FOR TD

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
SA OPIOIDS

DRUG NAME

ACTIQ | FENTANYL CITRATE | FENTORA

COVERED USES:

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D.

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

INITIAL 6 MONTH AND RENEWAL 6 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

SOMATROPIN

DRUG NAME

GENOTROPIN | HUMATROPE | NORDITROPIN NORDIFLEX |
NUTROPIN | NUTROPIN AQ | OMNITROPE | SAIZEN | SEROSTIM
| TEV-TROPIN | ZORBTIVE

COVERED USES:

TREATMENT OF CHILDREN WHO HAVE GROWTH FAILURE DUE TO AN INADEQUATE SECRETION OF NORMAL ENDOGENOUS GROWTH HORMONE, THE TREATMENT OF SHORT STATURE ASSOCIATED WITH TURNER SYNDROME IN PATIENTS WHOSE EPIPHYSES ARE NOT CLOSED, THE TREATMENT OF IDIOPATHIC SHORT STATURE, ALSO CALLED NONGROWTH-HORMONE-DEFICIENT SHORT STATURE, DEFINED BY HEIGHT STANDARD DEVIATION SCORE LESS THAN OR EQUAL TO (-)2.25, AND ASSOCIATED WITH GROWTH RATES UNLIKELY TO PERMIT ATTAINMENT OF ADULT HEIGHT IN THE NORMAL RANGE, IN CHILDREN WHOSE EPIPHYSES ARE NOT CLOSED AND FOR WHOM DIAGNOSTIC EVALUATION EXCLUDES OTHER CAUSES ASSOCIATED WITH SHORT STATURE THAT SHOULD BE OBSERVED OR TREATED BY OTHER MEANS, THE TREATMENT OF SHORT STATURE OR GROWTH FAILURE IN CHILDREN WITH SHORT STATURE HOMEBOX-CONTAINING GENE (SHOX) DEFICIENCY WHOSE EPIPHYSES ARE NOT CLOSED, AND THE REPLACEMENT OF ENDOGENOUS GROWTH HORMONE IN ADULTS WITH GROWTH HORMONE DEFICIENCY WHO HAVE GROWTH HORMONE DEFICIENCY EITHER ALONE, OR WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASE, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, OR TRAUMA, AND WHO WERE GROWTH HORMONE DEFICIENT DURING CHILDHOOD AS A RESULT OF CONGENITAL, GENETIC, ACQUIRED, OR IDIOPATHIC CAUSES.

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

COVERAGE DURATION:

12 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
SOMATULINE

DRUG NAME
SOMATULINE DEPOT

COVERED USES:
FOR THE LONG-TERM TREATMENT OF ACROMEGALIC PATIENTS WHO HAVE HAD AN INADEQUATE RESPONSE TO SURGERY AND/OR RADIOTHERAPY, OR FOR WHOM SURGERY AND/OR RADIOTHERAPY IS NOT AN OPTION.

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
6 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

SOMAVERT

DRUG NAME

SOMAVERT

COVERED USES:

FOR THE TREATMENT OF ACROMEGALY IN PATIENTS WHO HAVE HAD AN INADEQUATE RESPONSE TO SURGERY AND/OR RADIATION THERAPY AND/OR OTHER MEDICAL THERAPIES, OR FOR WHOM THESE THERAPIES ARE NOT APPROPRIATE.

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

6 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
SORIATANE

DRUG NAME
SORIATANE | SORIATANE CK

COVERED USES:
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
6 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
SYMLIN

DRUG NAME
SYMLIN | SYMLINPEN 120 | SYMLINPEN 60

COVERED USES:
AS AN ADJUNCT TREATMENT IN PATIENTS WHO USE MEALTIME INSULIN THERAPY AND WHO HAVE FAILED TO ACHIEVE DESIRED GLUCOSE CONTROL DESPITE OPTIMAL INSULIN THERAPY.

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
6 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
TRACLEER

DRUG NAME
TRACLEER

COVERED USES:
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
6 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

TYSABRI

DRUG NAME

TYSABRI

COVERED USES:

FOR INDUCING AND MAINTAINING CLINICAL RESPONSE AND REMISSION IN ADULT PATIENTS WITH MODERATELY TO SEVERELY ACTIVE CROHN DISEASE WITH EVIDENCE OF INFLAMMATION WHO HAVE HAD AN INADEQUATE RESPONSE TO, OR ARE UNABLE TO TOLERATE, CONVENTIONAL CROHN DISEASE THERAPIES AND INHIBITORS OF TUMOR NECROSIS FACTOR-ALPHA AND FOR THE TREATMENT OF PATIENTS WITH RELAPSING FORMS OF MULTIPLE SCLEROSIS TO DELAY THE ACCUMULATION OF PHYSICAL DISABILITY AND TO REDUCE THE FREQUENCY OF CLINICAL EXACERBATIONS.

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

6 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION
USTEKINUMAB

DRUG NAME
STELARA

COVERED USES:
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED
FOR PART D

EXCLUSION CRITERIA:
N/A

REQUIRED MEDICAL INFORMATION:
N/A

AGE RESTRICTIONS:
N/A

PRESCRIBER RESTRICTIONS:
N/A

COVERAGE DURATION:
6 MONTHS

OTHER CRITERIA:
N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

XOLAIR

DRUG NAME

XOLAIR

COVERED USES:

TREATMENT OF MODERATE TO SEVERE PERSISTENT ASTHMA IN PATIENTS WHO HAVE A POSITIVE SKIN TEST OR IN VITRO REACTIVITY TO A PERENNIAL AEROALLERGEN AND WHOSE SYMPTOMS ARE INADEQUATELY CONTROLLED WITH INHALED CORTICOSTEROIDS.

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

6 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

XYREM

DRUG NAME

XYREM

COVERED USES:

TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS AND
CATAPLEXY IN PATIENTS WITH NARCOLEPSY IN PATIENTS WHO
HAVE FAILED FIRST LINE THERAPY.

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

6 MONTHS

OTHER CRITERIA:

N/A

**ODS HEALTH PLAN, INC. Contract S5975 and H3813
MEDICARE FORMULARY 005
PA CRITERIA GUIDELINES**

PRIOR AUTHORIZATION GROUP DESCRIPTION

ZOMETA

DRUG NAME

ZOMETA

COVERED USES:

FOR THE TREATMENT OF HYPERCALCEMIA OF MALIGNANCY AND THE TREATMENT OF PATIENTS WITH MULTIPLE MYELOMA AND PATIENTS WITH DOCUMENTED BONE METASTASES FROM SOLID TUMORS, IN CONJUNCTION WITH STANDARD ANTINEOPLASTIC THERAPY

EXCLUSION CRITERIA:

N/A

REQUIRED MEDICAL INFORMATION:

N/A

AGE RESTRICTIONS:

N/A

PRESCRIBER RESTRICTIONS:

N/A

COVERAGE DURATION:

6 MONTHS

OTHER CRITERIA:

N/A