

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

ABSTRAL

Drugs

Abstral

Covered Uses

All medically accepted indications not otherwise excluded from Part DAll medically accepted indications not otherwise excluded from Part D. Documentation of a diagnosis of breakthrough pain in individuals with cancer who are already receiving opioid therapy

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

Documentation of age 18 and older

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of tolerance to current opioid therapy (ie, adherence to one of the following regimens for one week or longer): At least 25 mcg of transdermal fentanyl hourly, At least 30 mg of oxycodone daily, At least 60 mg of oral morphine daily, At least 8 mg of oral hydromorphone daily, At least 25 mg of oral oxymorphone daily, An equianalgesic dose of another opioid OR Documentation of a trial and failure of generic oral transmucosal fentanyl citrate (generic oral transmucosal fentanyl citrate requires prior authorization) for at least one week or longer

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ACTEMRA

Drugs

Actemra

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Concurrent therapy with other biological disease-modifying anti-rheumatic drugs (DMARDs) OR Active infections OR Patient has been evaluated (i.e. tuberculin skin test) and has active tuberculosis

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

Deny if not prescribed by a Rheumatologist

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of trial and failure or contraindication to adalimumab (Humira)and etanercept (Enbrel)

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ACTIQ

Drugs

Actiq

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

Deny if age less than 16 years.

Prescriber Restriction

N/A

Coverage Duration

For non cancer pain and hospice patients authorization will be for 6 months.

Other Criteria

INITIAL REQUESTS: Documentation of a trial and failure of generic oral transmucosal fentanyl citrate for at least one week or longer AND Documentation of tolerance to current opioid therapy (ie, adherence to ONE of the following regimens for one week or longer): At least 25mcg of transdermal fentanyl hourly, At least 30mg of oxycodone daily, At least 60mg of oral morphine daily, At least 8 mg of oral hydromorphone daily, An equianalgesic dose of another opioid. SUBSEQUENT REQUESTS: Documentation of a diagnosis of breakthrough pain due to/associated with cancer AND Documentation to support the efficacy associated with the current regimen (eg, pain scores, clinical response).

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ACTOPLUS MET

Drugs

Actoplus MET, Actoplus Met XR

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of trial and failure with concurrent therapy with Actos and Metformin

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ADCIRCA

Drugs

Adcirca

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Documentation of concomitant nitrate use

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

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AFINITOR

Drugs

Afinitor

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

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ALTABAX

Drugs

Altabax

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

Deny if age less than 9 months

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

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ALVESCO

Drugs

Alvesco

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of Trial and failure or contraindication with Flovent

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Amevive

Drugs

Amevive

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

Deny if age is less than 18 years

Prescriber Restriction

Deny if not prescribed by a Dermatologist or Rheumatologist

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Patient had at least a 30 day trial and failure with ONE of the following drugs OR contraindication to all of the following drugs: Topical Calcipotriene containing products, Topical Anthralin, Topical Steroids, Topical immunomodulators (Elidel, Protopic), Topical retinoids, Efudex, Adalimumab (Humira), Etanercept (Enbrel)

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AMPYRA

Drugs

Ampyra

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of trial with at least ONE of the following medications: Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Copaxone (glatiramer acetate), Extavia (interferon beta-1b), Novantrone (mitoxantrone), Rebif (interferon beta-1a), Tysabri (natalizumab)

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AMRIX

Drugs

Amrix

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of trial and failure with at least 1 week therapy of cyclobenzaprine immediate release containing product AND Documentation of trial and failure with at least 1 week therapy of ONE of the following drugs: A baclofen containing product, A dantrolene containing product, A chlorzoxazone containing product, A methocarbamol containing product, A Metaxalone containing product, A carisoprodol containing product, A tizanidine containing product

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AMTURNIDE HYBRID

Drugs

Amturnide

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure of or intolerance to valsartan (Diovan/Diovan HCT) and generic Losartan/Losartan HCT.

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APLENZIN

Drugs

Aplenzin

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure with a bupropion-containing product OR Documentation of stabilization from an institutional setting OR Documentation of current stabilization for over four weeks with corresponding dates

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ARBs HYBRID

Drugs

Atacand, Atacand HCT, Avalide, Avapro, Benicar, Benicar HCT, Hyzaar, Micardis, Micardis HCT, Teveten, Teveten HCT

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure of or intolerance to valsartan (Diovan/Diovan HCT) and generic Losartan/Losartan HCT.

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ARZERRA

Drugs

Arzerra

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

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AZOR Hybrid

Drugs

Azor

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure of or intolerance to valsartan (Diovan/Diovan HCT) and generic Losartan/Losartan HCT.

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BANZEL

Drugs

Banzel

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

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BEPREVE

Drugs

Bepreve

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of trial and failure or contraindication to both Olopatadine hydrochloride ophthalmic solution (Patanol) and Azelastine hydrochloride ophthalmic solution (Optivar)

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BIDIL

Drugs

BiDil

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of trial and failure or contraindication or intolerance to concurrent therapy with an isosorbide dinitrate product and a hydralazine product

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BUPRENORPHINE

Drugs

buprenorphine

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

Deny if age less than 16 years

Prescriber Restriction

Documentation (special identification number must be provided) that prescriber has received a Drug Addiction Treatment Act (DATA) 2000 waiver OR Documentation that prescriber has applied for the DATA 2000 waiver

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of use for induction phase of treatment OR Documentation of use in a phase other than induction in patients who have a contraindication/intolerance to Suboxone OR Documentation that patient is pregnant

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BYETTA

Drugs

Byetta

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of type 2 diabetes mellitus with concurrent use of one of the following: oMetformin oA sulfonyleurea oA thiazolidinedione

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CADUET/LIPITOR

Drugs

Caduet, Lipitor

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure or contraindication/intolerance/allergy to ONE of the following agents: Lovastatin-containing product, Pravastatin-containing product, Simvastatin-containing product AND Documentation of a trial and failure or contraindication/intolerance/allergy to rosuvastatin calcium (Crestor)

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CAYSTON

Drugs

Cayston

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

Deny if age is less than 7 years old.

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of Pseudomonas Aeruginosa in the lungs AND Documentation of FEV1 that is 25% to 75% of predicted

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CELEBREX

Drugs

Celebrex

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Documentation of sulfa allergy OR Documentation of aspirin/NSAID allergy

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of familial adenomatous polyposis (FAP) OR Documentation of the failure of a meloxicam-containing product and one of the following: Documentation of the trial and failure of two additional non-steroidal anti-inflammatory drugs (NSAIDs), Documentation that the individual is 65 years of age or older, Documentation of a bleeding disorder, Documentation of concurrent systemic steroid treatment OR Documentation of concurrent warfarin use (within the last 90 days) OR Documentation of a history of gastrointestinal bleed, peptic ulcer, gastroesophageal reflux disease (GERD), or Barrett's esophagus OR Documentation of a concomitant condition in which celecoxib (Celebrex) offers a significant advantage over non-COX-2 selective NSAIDs and meloxicam (Mobic).

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CESAMET

Drugs

Cesamet

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of chemotherapy-induced nausea and vomiting AND Documentation of trial and failure of ondansetron containing product (Zofran?) and one of the following: granisetron HCL (Kytrel?) or aprepitant (Emend?)

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(Effective 01/01/2012)

CIMZIA

Drugs

Cimzia, Cimzia Powder for Reconst

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists OR Active infection or sepsis OR Patient has been evaluated (i.e. tuberculin skin test) and has active tuberculosis

Required Medical Information

N/A

Age Restriction

Deny if age less than 18 years.

Prescriber Restriction

Deny if not prescribed by a Gastroenterologist or Rheumatologist.

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

For diagnosis of Crohn's Disease: Patient had a trial and failure/contraindication/intolerance/allergy to Adalimumab (Humira) AND at least a 30 day trial and failure with one drug from any of the following groups or contraindication to all of the following groups: Infliximab (Remicade), Corticosteroids [Budesonide (Entocort EC), Prednisone, Hydrocortisone, Methylprednisolone], Aminosalicylates [Sulfasalazine, Mesalamine (Asacol, Rowasa, Canasa, Pentasa), Olsalazine (Dipentum), balsalazide (Colazal)], Immunomodulators [Azathioprine, 6-mercaptopurine, Cyclosporine, Sirolimus (Prograf), Methotrexate], Antibiotics [Metronidazole, Fluoroquinolones] OR For diagnosis of rheumatoid arthritis: Patient had a trial and failure/contraindication/intolerance/allergy to Adalimumab (Humira) AND Etanercept (Enbrel)

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DAYTRANA

Drugs

Daytrana

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

Deny if age less than 6 years

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of attention deficit hyperactivity disorder (ADHD) AND Documentation of a trial and failure or contraindication/ intolerance/allergy to two of the following agents:
o Adderal XR
o A long acting methylphenidate product
o Strattera
o A long acting dextroamphetamine containing product
o Desoxyn

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EDARBI

Drugs

Edarbi

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure of or intolerance to valsartan (Diovan/Diovan HCT) and generic Losartan/Losartan HCT.

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EDLUAR

Drugs

Edluar

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure of a zolpidem tartrate immediate-release-containing product for a minimum of 14 days AND Documentation of inability to swallow capsules/tablets (e.g. dysphagia, gastrointestinal [GI] tubes)

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(Effective 01/01/2012)

EFFIENT

Drugs

Effient

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

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EGRIFTA

Drugs

Egrifta

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

-hypothalamic-pituitary axis due to hypophysectomy, hypopituitarism, pituitary tumor/surgery, or head irradiation or trauma. -hypersensitivity to tesamorelin and/or mannitol. -malignancy, active (either newly diagnosed or recurrent) malignancies should be inactive and completely treated prior to initiating therapy. - pregnancy.

Required Medical Information

Requires Waist hip ratio greater than 0.88 for women or greater than 0.94 for men

Age Restriction

N/A

Prescriber Restriction

Deny if prescriber is not a HIV-infection specialist

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Patient is receiving antiretroviral therapy (ART) AND Revision of the ART regimen and weight loss efforts (dietary modification and exercise) have been ineffective in reducing the excess VAT AND No disruption of the hypothalamic-pituitary axis due to hypophysectomy or hypopituitarism or pituitary tumor or pituitary surgery or head irradiation or head trauma

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ENABLEX

Drugs

Enablex

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of Trial and failure or contraindication with two of the following agents: Vesicare, Toviaz, Detrol LA

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ENBREL

Drugs

Enbrel

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

? Concurrent therapy with Anakinra (Kineret?) or tumor necrosis factor antagonists OR ? Active infections or sepsis OR ? Patient has been evaluated (i.e. tuberculin skin test) and has active tuberculosis

Required Medical Information

N/A

Age Restriction

Deny if age less than 2 years

Prescriber Restriction

Deny if not prescribed by Rheumatologist or Dermatologist

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

For diagnoses of moderate to severe Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis or Juvenile Idiopathic Arthritis, patient had at least a 30 day trial and failure with ONE of the following disease-modifying anti-rheumatic drugs (DMARDs) OR contraindication to all of the following DMARDs: Methotrexate Hydroxychloroquine Leflunomide Azathioprine Sulfasalazine Adalimumab (Humira) OR For diagnosis of moderate to severe Plaque Psoriasis, patient had at least a 30 day trial and failure with ONE of the following drugs OR contraindication to all of the following drugs: Topical Calcipotriene containing products Topical Anthralin Topical Steroids Topical immunomodulators (Elidel, Protopic?) Topical retinoids Efudex Adalimumab (Humira)

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EXFORGE

Drugs

Exforge, Exforge HCT

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a greater than 30 day trial of concurrent use of DIOVAN/DIOVAN HCT and an amlodipine containing product

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EXJADE

Drugs

Exjade

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Serum ferritin levels consistently greater than 1000 mcg/L (as demonstrated with at least two lab values within the previous two months)

Age Restriction

Deny if age less than 2 years

Prescriber Restriction

N/A

Coverage Duration

Initial approval is valid for three months.

Other Criteria

CONTINUATION CRITERION Documentation of a decreased serum ferritin level compared with the baseline level.

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FANAPT

Drugs

Fanapt

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of diagnosis of schizophrenia and documentation of a trial and failure of, or contraindication to, at least one of the following medications: Aripiprazole (Abilify), Risperidone (Risperdal), Quetiapine fumarate (Seroquel), An olanzapine-containing product OR Documentation of continuous therapy with Iloperidone (Fanapt)

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FENTANYL CITRATE LOZENGE

Drugs

fentanyl citrate

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

Deny if age less than 16 years.

Prescriber Restriction

N/A

Coverage Duration

For non cancer pain and hospice patients authorization will be for 6 months.

Other Criteria

INITIAL REQUESTS Documentation of tolerance to current opioid therapy (ie, adherence to ONE of the following regimens for one week or longer): At least 25mcg of transdermal fentanyl hourly o At least 30mg of oxycodone daily o At least 60mg of oral morphine daily o At least 8 mg of oral hydromorphone daily o An equianalgesic dose of another opioid SUBSEQUENT REQUESTS: ? Documentation of a diagnosis of breakthrough pain due to/associated with cancer AND ? Documentation to support the efficacy associated with the current regimen (eg, pain scores, clinical response)

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FENTORA

Drugs

Fentora

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

Deny if age less than 18 years.

Prescriber Restriction

N/A

Coverage Duration

For non cancer pain and hospice patients authorization will be for 6 months.

Other Criteria

INITIAL REQUESTS Documentation of a trial and failure of generic oral transmucosal fentanyl citrate for at least one week or longer AND Documentation of tolerance to current opioid therapy (ie, adherence to ONE of the following regimens for one week or longer):
o At least 25mcg of transdermal fentanyl hourly
o At least 30mg of oxycodone daily
o At least 60mg of oral morphine daily
o At least 8 mg of oral hydromorphone daily
o An equianalgesic dose of another opioid
SUBSEQUENT REQUESTS: ? Documentation of a diagnosis of breakthrough pain due to/associated with cancer AND ? Documentation to support the efficacy associated with the current regimen (eg, pain scores, clinical response)

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FLECTOR

Drugs

Flector

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

?Documentation of the trial and failure or contraindication/intolerance to a meloxicam-containing product and ONE additional oral non-steroidal anti-inflammatory drug (NSAID).

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

FLONASE

Drugs

Flonase

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure or contraindication to a generic nasal corticosteroid (flunisolide or fluticasone propionate) OR Documentation of a trial and failure or contraindication to Mometasone (Nasonex)

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

FORTEO

Drugs

Forteo

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

A history of Paget's disease of the bone
A history of bone cancer or other cancers that have metastasized to the bone
Skeletal malignancies or other metabolic bone disease besides osteoporosis
Preexisting hypercalcemia
A woman who is pregnant or nursing
Increased baseline risk of osteosarcoma due to any one of the following:
oPaget's disease of the bone
oUnexplained elevations of alkaline phosphatase
oPediatric individuals or young adults with open epiphyses
oHistory of external beam or implant radiation therapy involving the skeleton

Required Medical Information

The T score of the individual's bone mineral density (BMD) is at least -2.5 standard deviations below the young adult mean.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documented diagnosis of primary (postmenopausal) or hypogonadal osteoporosis AND Patients 18 years of age or older AND Osteoporotic fractures or a history of osteoporotic fractures OR Multiple risk factors for a fracture AND Failure or intolerance with at least ONE of the following osteoporosis therapies: Bisphosphonates Hormone replacement therapy Selective-estrogen receptor modulators (SERMs) Calcitonin-salmon (miacalcin) No documentation of a contraindication to Forteo

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

GILENYA

Drugs

Gilenya

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of an inadequate response or a contraindication to one of the following: interferon beta-1a (Avonex), interferon beta-1b (Betaseron), glatiramer acetate (Copaxone), interferon beta-1b (Extavia), or interferon beta-1a (Rebif)

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

GLEEVEC

Drugs

Gleevec

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

GLUMETZA

Drugs

Glumetza

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure or intolerance/allergy/contraindication to ONE of the following agents: metformin IR, metformin ER containing products

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

Growth Hormone

Drugs

Genotropin, Genotropin Miniquick, Humatrope, Norditropin FlexPro, Norditropin Nordiflex, Nutropin, Nutropin AQ, Nutropin AQ Nuspin, Omnitrope, Saizen, Saizen click.easy, Serostim, Tev-Tropin, Zorbtive

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

HUMIRA

Drugs

Humira, Humira Crohn's Dis Start Pck

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

? Concurrent therapy with Anakinra (Kineret?) or tumor necrosis factor antagonists OR ? Active infections or sepsis OR ? Patient has been evaluated (i.e. tuberculin skin test) and has active tuberculosis

Required Medical Information

N/A

Age Restriction

Deny if age less than 4 years.

Prescriber Restriction

Deny if not prescribed by a Rheumatologist, Dermatologist or Gastroenterologist.

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

? For diagnoses of moderate to severe Rheumatoid Arthritis, Ankylosing Spondylitis, moderate to severe Juvenile Idiopathic Arthritis (JIA) or Psoriatic Arthritis, patient had at least a 30 day trial and failure with ONE of the following disease-modifying anti-rheumatic drugs (DMARDs) OR contraindication to all of the following DMARDs: ? Methotrexate ? Hydroxychloroquine ? Leflunomide ? Azathioprine ? Sulfasalazine ? Etanercept (Enbrel?) OR ? For diagnosis of moderate to severe Plaque Psoriasis, patient had at least a 30 day trial and failure with ONE of the following drugs OR contraindication to all of the following drugs: ? Topical Calcipotriene containing products ? Topical Anthralin ? Topical Steroids ? Topical immunomodulators (Elidel?, Protopic?) ? Topical retinoids OR ? For diagnosis of Crohn's Disease, Patient had at least a 30 day trial and failure with Infliximab (Remicade?) OR at least a 30 day trial and failure with ONE drug from any TWO of the following groups or contraindication to all of the following groups: ? Corticosteroids: Budesonide (Entocort? EC), Prednisone, Hydrocortisone, Methylprednisolone ? Aminosalicylates: Sulfasalazine, Mesalamine (Asacol?, Rowasa?, Canasa?, Pentasa?), Olsalazine (Dipentum?), balsalazide (Colazal?) ? Immunomodulators: Azathioprine, 6-mercaptopurine, Cyclosporine, Sirolimus (Prograf?), Methotrexate ? Antibiotics: Metronidazole or Fluoroquinolones

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

INCRELEX

Drugs

Increlex

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Individuals who have active or suspected neoplasia

Required Medical Information

The individual has a basal IGF-1 standard deviation score of less than or equal to 3.0 SD scores below normal (based on age and sex related reference ranges). The individual has normal or elevated growth hormone (GH) (based on a GH stimulation testing) or (for children with GH gene deletion) measured titers of GH-neutralizing antibodies The individual has open epiphyses (bone growth plates) (bone age less than 14 years for girls and less than 16 years for boys)

Age Restriction

Deny if age less than 2 years

Prescriber Restriction

Deny if not prescribed by an endocrinologist or pediatric endocrinologist

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

The individual has a height standard deviation score of less than or equal to 3.0 SD scores below normal (growing at or below the third percentile for age and sex).

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

INTUNIV

Drugs

Intuniv ER

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure or contraindication/intolerance/allergy to any two of the following medications: A methylphenidate containing product, A mixed amphetamine salts containing product (eg, amphetamine-dextroamphetamine [Adderall or Adderall XR]), Atomoxetine hydrochloride (Strattera), A dextroamphetamine containing product, Methamphetamine hydrochloride (Desoxyn), A dexmethylphenidate containing product OR Documentation of a history of or a potential for drug abuse among the individual or a member of the individual's household

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

INVEGA

Drugs

Invega, Invega Sustenna

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

For diagnosis of Schizophrenia: Documentation trial and failure or contraindication to at least ONE of the following: Abilify?, Risperidal?, Seroquel?, Zyprexa?

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

IRESSA

Drugs

IRESSA

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Individuals who were documented as previously benefiting from gefitinib (Iressa?) therapy prior to September 15, 2005 and have registered through the Iressa Access Program to continue therapy will be approved

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

JANUVIA

Drugs

Janumet, Januvia

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of Trial and failure or contraindication with both Actos and Metformin

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

KEPPRA XR

Drugs

Keppra XR

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a 30 day trial or contraindication to a Levetiracetam immediate release containing product

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

KINERET

Drugs

Kineret

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

? Concurrent therapy with tumor necrosis factor antagonists OR ? Active infections or sepsis OR ? Patient has been evaluated (i.e. tuberculin skin test) and has active tuberculosis

Required Medical Information

N/A

Age Restriction

Deny if age less than 18 years

Prescriber Restriction

Deny if not prescribed by Rheumatologist.

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Patient had at least a 30 day trial and failure with ONE of the following disease-modifying anti-rheumatic drugs (DMARDs) OR contraindication to all of the following DMARDs: ? Methotrexate ? Hydroxychloroquine ? Leflunomide ? Azathioprine ? Sulfasalazine ? Adalimumab (Humira?) ? Etanercept (Enbrel?)

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

LATUDA

Drugs

Latuda

Covered Uses

All medically accepted indications not otherwise excluded from Part DAll medically accepted indications not otherwise excluded from Part D. Documentation of a diagnosis of schizophrenia

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of trial and failure with one of the following agents: Aripirazole (Abilify), Risperidone (Risperidal), Quetiame fumarate, Olanzapine OR Documentation of continuous therapy with Lurasidone (Latuda)

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

LIVALO

Drugs

Livalo

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of trial and failure or contraindication/intolerance/allergy to ONE of the following agents: Lovastatin-containing product, Pravastatin-containing product, Simvastatin-containing product AND ? Documentation of trial and failure or contraindication/intolerance/allergy to rosuvastatin calcium (Crestor?)

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

LYRICA

Drugs

Lyrica

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

For Diagnosis of add-on therapy for partial onset epileptic seizures in adults: documentation of trial and failure or contraindication/intolerance/allergy to Gabapentin OR Diagnosis of post herpetic neuralgia with trial and failure or contraindication/intolerance/allergy to Gabapentin OR Documentation of non diabetic neuropathic pain with a trial and failure or contraindication/intolerance/allergy to Gabapentin and ONE medication of the following five (5) groups: oAn opiod containing productoTramadoloA tricyclic antidepressantoLidoderm Patch or a form of topical lidocaineoCarbamazepine

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

MAGNACET

Drugs

Magnacet

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

For non cancer pain and hospice patients authorization will be for 6 months.

Other Criteria

INITIAL REQUESTS: Documentation of the trial and failure/intolerance to an oxycodone/acetaminophen-containing product with 325 mg of acetaminophen AND Documentation of the reason why an oxycodone/acetaminophen-containing product with greater than 400 mg of acetaminophen would not be appropriate SUBSEQUENT REQUESTS: Documentation to support the efficacy associated with the current regimen (eg pain scores, clinical response)

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

MOBIC

Drugs

Mobic

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of trial/failure/contraindication to generic meloxicam

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

NASACORT AQ

Drugs

Nasacort AQ

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure or contraindication to a generic nasal corticosteroid (flunisolide or fluticasone propionate) OR Documentation of a trial and failure or contraindication to Mometasone (Nasonex)

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

NEUMEGA

Drugs

Neumega

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Patient has experienced severe thrombocytopenia (e.g., platelet count less than equal to 20,000/mcL) from previous chemotherapy OR for patient is considered to be at high risk for the development of severe thrombocytopenia.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

NEXAVAR

Drugs

Nexavar

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

NOXAFIL

Drugs

Noxafil

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

Deny if age is less than 13 years

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of trial and failure of voriconazole (Vfend?) for use in prophylaxis of invasive Aspergillus and Candida infections due to a severe immunocompromised OR Documentation of trial and failure with both itraconazole or fluconazole for a diagnosis of oropharyngeal candidiasis

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

NUCYNTA

Drugs

Nucynta

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure of or contraindication/intolerance/allergy to TWO of the following agents: o Oxycodone IR o Hydromorphone o Morphine sulfate IR

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

NUEDEXTA

Drugs

Nuedexta

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

NUVIGIL

Drugs

Nuvigil

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME (OSAHS): Documentation that (Armodafinil) Nuvigil will be used concurrently with continuous positive airway pressure (CPAP)
FOR SHIFT WORK SLEEP DISORDER (SWSD): Polysomnography and the multiple sleep latency test (MSLT) demonstrate loss of a normal sleep-wake pattern

Age Restriction

N/A

Prescriber Restriction

For NARCOLEPSY: Recommendation of (Armodafinil) Nuvigil by a neurologist or sleep specialist
FOR SHIFT WORK SLEEP DISORDER (SWSD: Recommendation of Armodafinil (Nuvigil) by a neurologist or sleep specialist OR Polysomnography and the multiple sleep latency test (MSLT) demonstrate loss of a normal sleep-wake pattern

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

FOR NARCOLEPSY: Documentation of a diagnosis of Narcolepsy. FOR OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME (OSAHS): Documentation of a diagnosis of obstructive sleep apnea/hypopnea syndrome (OSAHS). FOR SHIFT WORK SLEEP DISORDER (SWSD): Documentation that the Member has No medical or mental disorder accounts for the symptoms AND The symptoms do not meet criteria for any other sleep disorder producing insomnia or excessive sleepiness (e.g. time-zone change [jet lag] syndrome)

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

ONSOLIS

Drugs

Onsolis

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

Deny if age is less than 18 years

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

FOR INITIAL AUTHORIZATION REQUESTS ? Documentation of a trial and failure of generic oral transmucosal fentanyl citrate for at least one week or longer AND ? Documentation of registration through the FOCUS distribution program AND ? Documentation of tolerance to current opioid therapy (ie, adherence to ONE of the following regimens for one week or longer): o At least 25mcg of transdermal fentanyl hourly o At least 30mg of oxycodone daily o At least 60mg of oral morphine daily o At least 8 mg of oral hydromorphone daily o An equianalgesic dose of another opioid FOR RE-AUTHORIZATION REQUESTS ? Documentation to support the efficacy associated with the current regimen (eg pain scores, clinical response)

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

ORACEA

Drugs

Oracea

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of trial and failure or contraindication/intolerance/allergy to topical Metronidazole
AND one other formulation of oral doxycycline

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

Part B/D Drugs

Drugs

0.45 % NaCl-potassium chloride, Abelcet, acetylcysteine, albuterol sulfate, Aldurazyme, allopurinol sodium, Aloprim, Aloxi, AmBisome, A-Methapred, aminophylline, Aminosyn 10 %, Aminosyn 3.5 %, Aminosyn 5 % (sulfite-free), Aminosyn 7 %, Aminosyn 8.5 %, Aminosyn 8.5 %-Electrolytes, Aminosyn II 10 %, Aminosyn II 15%, Aminosyn II 3.5 %/Dextrose 5 %, Aminosyn II 3.5 %-Dextrose 25%, Aminosyn II 3.5% M/Dextrose 5%, Aminosyn II 3.5%-Lytes-Ca-D25W, Aminosyn II 4.25%/Dextrose 20%, Aminosyn II 4.25%-Dextrose 10%, Aminosyn II 4.25%-Dextrose 25%, Aminosyn II 4.25%-Lytes-Ca-D25, Aminosyn II 5%/Dextrose 25%, Aminosyn II 7 %, Aminosyn II 8.5 %, Aminosyn II 8.5 %-Electrolytes, Aminosyn M 3.5 %, Aminosyn-HBC 7%, Aminosyn-HF 8 %, Aminosyn-PF 10 %, Aminosyn-PF 7 % (Sulfite-Free), ammonium chloride, Amphotec, amphotericin b, Antizol, Anzemet, Aralast NP, Aranesp (polysorbate), Aredia, Arranon, Atgam, AVASTIN, Azasan, azathioprine, azathioprine sodium, Boniva, budesonide, Busulfex, Calcijex, calcitonin (salmon), calcitriol, Camptosar, Cancidas, Carimune NF Nanofiltered, Carnitor, cefotetan, cefoxitin, cefoxitin in dextrose, iso-osm, ceftriaxone, CellCept, CellCept Intravenous, Ceredase, Cerezyme, Cerubidine, chloramphenicol sod succinate, chlorothiazide sodium, Cipro in D5W, ciprofloxacin, Claforan, Cleocin in D5W, clindamycin phosphate, Clinimix 2.75%/D5 Sulfite Free, Clinimix 4.25%/D5 Sulfite Free, Clinimix 4.25/D10 Sulfite Free, Clinimix 4.25/D20 Sulfite Free, Clinimix 4.25/D25 Sulfite Free, Clinimix 5%/D15 Sulfite Free, Clinimix 5%/D20 Sulfite Free, Clinimix 5%/D25 Sulfite Free, Clinimix E 2.75/D10 SulfiteFree, Clinimix E 2.75/D5 SulfiteFree, Clinimix E 4.25/D25 SulfiteFree, Clinimix E 4.25/D5 SulfiteFree, Clinimix E 5%/D15 Sulfite Free, Clinimix E 5%/D20 Sulfite Free, Clinimix E 5%/D25 Sulfite Free, CLOLAR, Cosmegen, Coumadin, cromolyn, CUBICIN, cyclophosphamide, cyclosporine, cyclosporine modified, Cytovene, D10 %-0.45 % sodium chloride, D10-0.2 % NaCl & Potassium Cl, D2.5 %-0.45 % sodium chloride, D5-1/2 NS & potassium chloride, D5-1/3 NS & potassium chloride, D5-1/4 NS & potassium chloride, D5-LR with potassium chloride, D5-NS with potassium chloride, D5W with potassium chloride, Dacogen, DaunoXome, Depacon, Depo-Medrol, dexrazoxane, Diflucan in NaCl (iso-osm), diltiazem HCl, Diuril IV, Doribax, Doxil, doxycycline hyclate, dronabinol, ELAPRASE, electrolyte-48 in D5W, Ellence, Eloxatin, Emend, EMLA, Engerix-B (PF), Epogen, Erbitux, Erythrocin, Ethylol, Etopophos, Fabrazyme, famotidine(PF) in sal (iso-os), Fludara, Folutyn, fomepizole, Fortaz in D5W, FORTICAL, foscarnet, Freamine III 3 %-Electrolytes, Freamine III 8.5 %, GamaSTAN S/D, Gammagard Liquid, Gammaplex, Gamunex, ganciclovir sodium, gemcitabine, Gemzar, Gengraf, gentamicin in NaCl (iso-osm), gentamicin sulfate (PF), Glassia, granisetron, Halaven, Hectorol, heparin (porcine), heparin (porcine) in D5W, heparin (porcine) in NS (PF), heparin (porcine)-0.45% NaCl, heparin, porcine (PF), Hepatamine 8%, Hepatasol 8 %, Hizentra, Hycamtin, Idamycin PFS, idarubicin, ifosfamide-mesna, Imuran, Intralipid, Ionosol-B in D5W, Ionosol-MB in D5W, Ionosol-T in D5W, ipratropium bromide, ipratropium-albuterol, irinotecan, Isolyte-H in D5W, Isolyte-M in D5W, Isolyte-P in D5W, Isolyte-S, Isolyte-S in D5W, Istodax, Kepivance, Keppra, labetalol, Leustatin, levocarnitine, levocarnitine (with sucrose), lidocaine HCl, lidocaine-prilocaine, liothyronine, Liposyn II, Liposyn III, Lopressor, magnesium sulfate, magnesium sulfate in D5W, Merrem, Mesnex, methotrexate sodium, methylodopate, methylprednisolone, methylprednisolone acetate, methylprednisolone sodium succ, metoprolol tartrate, Miacalcin, Mycamine, mycophenolate mofetil, Myfortic, Myozyme, nafcillin in D2.4W, Nebupent, Neoral, Nephramine 5.4 %, Nexium IV, nifedipine, Nipent, nitroglycerin, Normosol-M in D5W, Normosol-R in D5W, Novantrone, NS with potassium chloride, ondansetron, ondansetron HCl, Orenicia, Orthoclone OKT3, oxacillin in dextrose, iso-osm, pamidronate, penicillin G pot in dextrose, Pepcid, Perforomist, Photofrin, piperacillin, Plasma-Lyte 148, Plasma-Lyte 148 in D5W, Plasma-Lyte 56, Plasma-Lyte A,

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

Plasma-Lyte R, Plasma-Lyte-56 in D5W, potassium chloride, prednisolone sodium phosphate, prednisone, Prednisone Intensol, Premasol 10 %, Premasol 6 %, Primaxin IV, Privigen, Procalamine 3%, Procrit, Prograf, Prolastin, Prolastin C, propranolol, Prosol 20%, Pulmicort, Pulmozyme, Rapamune, Reclast, Recombivax HB (PF), Revatio, Rheumatrex, Rifadin, ringers, Rocaltrol, Sandimmune, Simulect, sodium bicarbonate, sodium chloride 5 %, Sodium Edecrin, sodium lactate, Solu-Medrol, Solu-Medrol (PF), sotalol, Synera, Synercid, tacrolimus, Taxotere, TAZICEF, Teflaro, Thymoglobulin, Timentin, Tobi, tobramycin in NS, topotecan, torsemide, TPN Electrolytes, Travasol 10 %, TrophAmine 10 %, Trophamine 6%, Twinrix (PF), TYSABRI, valproate sodium, vancomycin, Vectibix, Vfend IV, Vistide, Vivaglobin, Xgeva, Zantac in 1/2 NS, Zemaira, Zemplar, Zinacef, Zinacef in dextrose (iso-osm), Zinacef in Sterile Water, Zinecard, Zithromax, Zofran, Zortress, Zosyn, Zosyn in dextrose (iso-osm), Zuplenz

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 Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

N/A

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

PRADAXA

Drugs

Pradaxa

Covered Uses

All medically accepted indications not otherwise excluded from Part DAll medically accepted indications not otherwise excluded from Part D. Documentation of use to reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

PRANDIMET

Drugs

Prandimet

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a minimum 30 day trial of concurrent use of repaglinide (Prandin) and a metformin-containing product

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

PREVACID SOLUTABS

Drugs

Prevacid SoluTab

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

PRISTIQ

Drugs

Pristiq

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

Proton Pump Inhibitors

Drugs

Aciphex, Dexilant, Prevacid, Protonix, Zegerid

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of any of the indications specified for the drug AND ? A documented trial and failure or contraindication/intolerance/allergy to a preferred generic proton pump inhibitor (PPI) AND ? A documented trial and failure or contraindication/intolerance/allergy to a preferred brand proton pump inhibitor (PPI)

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

PROVIGIL

Drugs

Provigil

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

For Diagnosis of narcolepsy, idiopathic hypersomnia, or obstructive sleep apnea/hypopnea syndrome: a report of a sleep study supporting requested diagnosis For shift work sleep disorder: Polysomnography and the multiple sleep latency test (MSLT) demonstrate loss of a normal sleep wake pattern

Age Restriction

N/A

Prescriber Restriction

For narcolepsy, idiopathic hypersomnia, or obstructive sleep apnea/hypopnea syndrome: recommendation of modafinil (Provigil?) by a neurologist or sleep specialist For fatigue associated with multiple sclerosis: recommendation of modafinil (Provigil?) by a neurologist

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Diagnosis of narcolepsy, idiopathic hypersomnia, or obstructive sleep apnea/hypopnea syndrome OR Diagnosis of shift work sleep disorder when all of the following inclusion criteria are met: o Patient has a primary complaint of insomnia or excessive sleepiness temporally associated with a work period that occurs during the habitual sleep phase o No medical or mental disorder accounts for the symptoms o The symptoms do not meet criteria for any other sleep disorder producing insomnia or excessive sleepiness (e.g. time-zone change [jet lag] syndrome. OR Diagnosis of fatigue associated with multiple sclerosis

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

PYLERA

Drugs

Pylera

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

QUALAQUIN

Drugs

Qualaquin

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

RANEXA

Drugs

Ranexa

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of insufficient response, intolerance, or contraindication to at least one formulary anti-anginal product

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

REMICADE

Drugs

Remicade

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Coverage is not provided for use of Remicade in combination with other biologics e.g., Enbrel, Kineret or Humira, etc

Required Medical Information

Coverage is provided in situations where the patient has been evaluated and screened for the presence of latent TB infection prior to initiating treatment with Remicade.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

Coverage is provided for mild ulcerative colitis when the patient has had an inadequate response to at least one conventional treatment (for example: sulfasalazine, olsalazine, mesalamine, etc.), and for ankylosing spondylitis when the patient has experienced inadequate symptom relief from at least one other treatment such as NSAIDs, COX2 inhibitors, or methotrexate, unless the patient is unable to receive treatment with these drugs.

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

REVELA

Drugs

Renvela

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure/contraindication/intolerance/allergy to calcium acetate

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

REQUIP XL

Drugs

Requip XL

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a minimum 30 day therapy of Ropinirole immediate release containing product

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

REVATIO

Drugs

Revatio

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a diagnosis of pulmonary arterial hypertension AND no history of concomitant nitrate prescription

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

REVLIMID

Drugs

REVLIMID

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

Deny if age is less than 18 years

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Lenalidomide (Revlimid?) is approved for individuals who are registered with the RevAssist(SM) Program

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

RHINOCORT

Drugs

Rhinocort Aqua

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure or contraindication to a generic nasal corticosteroid (flunisolide or fluticasone propionate) OR Documentation of a trial and failure or contraindication to Mometasone (Nasonex)

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

RITUXAN

Drugs

Rituxan

Covered Uses

All FDA approved indications not otherwise excluded from Part D. Additional coverage for off-label use is provided for relapsed or refractory Waldenstroms macroglobulinemia.

Exclusion Criteria

Coverage is not provided for use of Rituxan in combination with other biologics e.g., Humira, Kineret or Remicade, etc.

Required Medical Information

N/A

Age Restriction

For rheumatoid arthritis: 18 years of age or older

Prescriber Restriction

N/A

Coverage Duration

1 month for rheumatoid arthritis, 12 months for other indications

Other Criteria

For rheumatoid arthritis: inadequate response to at least one TNF inhibitor or been intolerant to treatment with at least two TNF inhibiting drugs.

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

ROZEREM

Drugs

Rozerem

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure of a zolpidem tartrate immediate-release-containing product for a minimum of 14 days OR Documentation of abuse potential

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

RYZOLT

Drugs

Ryzolt

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

Deny if patient is less than 16 years old

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure of or intolerance to generic tramadol extended release

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

SABRIL

Drugs

Sabril

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

SAMSCA

Drugs

Samsca

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a diagnosis of clinically significant hypervolemic or euvolemic hyponatremia [serum sodium less than 125meq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction]

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

SANCTURA

Drugs

Sanctura, Sanctura XR

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of Trial and failure or contraindication with two of the following agents: Vesicare, Toviaz, Detrol LA

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

SAPHRIS

Drugs

Saphris

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

? Documentation of a trial and failure of, or contraindication to, at least ONE of the following medications: o Aripiprazole (Abilify) o Risperidone (Risperdal) o Quetiapine fumarate (Seroquel) o An olanzapine-containing product

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

SAVELLA

Drugs

Savella

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

SIMPONI

Drugs

Simponi

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

? Concurrent therapy with Anakinra (Kineret?) or tumor necrosis factor antagonists OR ? Active infections or sepsis OR ? Patient has been evaluated (i.e. tuberculin skin test) and has active tuberculosis

Required Medical Information

N/A

Age Restriction

Deny if patient is less than 18 years

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Patient had a trial and failure/contraindication/intolerance/allergy to Adalimumab (Humira) AND Etanercept (Enbrel)

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

SLEEP AGENTS

Drugs

Ambien CR, Silenor

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Ambien CR and Lunesta: Diagnosis of insomnia or chronic insomnia AND Documentation of a trial and failure/contraindication/intolerance to an immediate release zolpidem-containing product
Rozerem: Diagnosis of insomnia or chronic insomnia AND Documentation of abuse potential to any drug

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

SPRYCEL

Drugs

Sprycel

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

SUBOXONE

Drugs

Suboxone

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

Deny if age less than 16 years

Prescriber Restriction

Documentation (special identification number must be provided) that prescriber has received a Drug Addiction Treatment Act (DATA) 2000 waiver OR Documentation that prescriber has applied for the DATA 2000 waiver

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

SUBUTEX

Drugs

Subutex

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

Deny if age less than 16 years

Prescriber Restriction

Documentation (special identification number must be provided) that prescriber has received a Drug Addiction Treatment Act (DATA) 2000 waiver OR Documentation that prescriber has applied for the DATA 2000 waiver

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

SUTENT

Drugs

Sutent

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

SYMLIN

Drugs

Symlin, SymlinPen 120, SymlinPen 60

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

TACLONEX

Drugs

Taclonex, Taclonex Scalp

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

Deny if age is less than 18 years

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of the trial and failure of/intolerance to concurrent use of calcipotriene (Dovonex?) and a topical betamethasone product

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

TARCEVA

Drugs

Tarceva

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

TASIGNA

Drugs

Tasigna

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

TEKAMLO HYBRID

Drugs

Tekamlo

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure of or intolerance to valsartan (Diovan/Diovan HCT) and generic Losartan/Losartan HCT.

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

TEKTURNA/TEKTURNA HCT HYBRID

Drugs

Tekturna, Tekturna HCT

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documented trial and failure or contraindication/intolerance/allergy to an Angiotensin Converting Enzyme (ACE) inhibitor or an amlodipine-containing product AND Documented trial and failure or contraindication/intolerance/allergy to Diovan/Diovan HCT or generic Losartan/Losartan HCT.

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

THALOMID

Drugs

Thalomid

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

TOVIAZ ER

Drugs

Toviaz

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure or contraindication with an oxybutynin-containing product and Enablex

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

TRAVATAN

Drugs

Travatan Z

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of Trial and failure or contraindication with Lumigan and Latanoprost containing product

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

TREXIMET

Drugs

Treximet

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

Deny if age is less than 12 years old

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure of concurrent therapy with Imitrex and a naproxen containing product

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

TRIBENZOR

Drugs

Tribenzor

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure to one of the following: Olmesartan/olmesartan HCT (Benicar/Benicar HCT) [Benicar/Benicar HCT requires prior authorization], A losartan/losartan-HCTZ-containing product, An amlodipine-containing product, An angiotensin converting enzyme (ACE) inhibitor-containing product

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

TWYNSTA

Drugs

Twynsta

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of at least a 30-day trial and failure or contraindication to Azor(Amlodipine besylate/Olmesartan) OR Documentation of at least a 30-day trial of concurrent therapy of Micardis/Micardis HCT (Telmisartan/Telmisartan HCT) and an amlodipine-containing product

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

TYKERB

Drugs

Tykerb

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

ULTRAM ER

Drugs

Ultram ER

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of trial and failure or intolerance to generic tramadol extended release

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

VALTURNA HYBRID

Drugs

Valturna

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documented diagnosis of hypertension AND Documentation of trial and failure of or contraindication/intolerance/allergy to an ACE inhibitor AND Documentation of trial and failure of or contraindication/intolerance/allergy to Diovan/Diovan HCT or Losartan/Losartan HCT.

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

VANDETANIB

Drugs

vandetanib

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of symptomatic or progressive medullary thyroid cancer in patients with unresectable locally advanced or metastatic disease OR documentation of continuous therapy with Vandetanib.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

Prior authorization will be approved till the end of the contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

VECTICAL

Drugs

Vectical

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

Deny if age is less than 18 years

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of trial and failure or contraindication or intolerance to calcipotriene (Dovonex)

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

VERAMYST

Drugs

Veramyst

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure or contraindication to a generic nasal corticosteroid (flunisolide or fluticasone propionate) OR Documentation of a trial and failure or contraindication to Mometasone (Nasonex)

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

VICTOZA

Drugs

Victoza

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure to one of the following: a metformin-containing product, a thiazolidinedione, a sulfonylurea OR Documentation of contraindication to all of the following: a metformin-containing product, a thiazolidinedione, a sulfonylurea.

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

VIMOVO

Drugs

Vimovo

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of concurrent therapy with Esomeprazole magnesium (Nexium) (requires prior authorization) and Naproxen for at least 30 days

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

VIMPAT

Drugs

Vimpat

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

Deny if age is less than 17 years

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

VOLTAREN GEL

Drugs

Voltaren

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of the trial and failure or contraindication/intolerance to a meloxicam-containing product and one additional oral non-steroidal anti-inflammatory drug (NSAID).

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

VOTRIENT

Drugs

Votrient

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

VPRIV

Drugs
VPRIV

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

VYVANSE

Drugs

Vyvanse

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure or contraindication/intolerance/allergy to any TWO of the following medications: A methylphenidate containing product A mixed amphetamine salts containing product (eg, amphetamine-dextroamphetamine [Adderall or Adderall XR]) Atomoxetine hydrochloride (Strattera?) A dextroamphetamine containing product Methamphetamine hydrochloride (Desoxyn?) A dexmethylphenidate containing product OR Documentation of a history of or a potential for drug abuse among the individual or a member of the individual's household

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

XENAZINE

Drugs

Xenazine

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

XOLAIR

Drugs

Xolair

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Requires a positive skin test or in vitro reactivity to a perennial aeroallergen

Age Restriction

Deny if age is less than 12 years

Prescriber Restriction

Deny if prescriber is not an allergist or pulmonologist

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documented trial and failure with at least one inhaled corticosteroid

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

XYZAL

Drugs

Xyzal

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

? Documented diagnosis of allergic rhinitis or urticaria AND ? Documentation of a two week trial and failure of, or contraindication to a fexofenadine-containing product

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

ZEGERID ORAL SUSPENSION

Drugs

Zegerid

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation that the individual is under 12 years of age or documentation of the inability to swallow capsules/tablets (eg, dysphagia, gastrointestinal [GI] tubes) AND Documented trial and failure/intolerance/allergy with esomeprazole (Nexium) for delayed-release oral suspension

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

ZIPSOR

Drugs

Zipsor

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of trial and failure or contraindication/intolerance to a meloxicam-containing product and one additional oral non-steroidal anti-inflammatory drug (NSAID).

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

ZMAX

Drugs

Zmax Adult-Pediatric

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of contraindication or intolerance to at least one generic formulation of azithromycin.

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

ZOLINZA

Drugs

Zolinza

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of diagnosis of T-Cell Lymphoma with cutaneous manifestations AND Documentation of trial and failure or contraindication to at least 2 systemic therapies

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

ZOLPIMIST

Drugs

Zolpimist

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of a trial and failure/contraindication/intolerance to an immediate-release zolpidem-containing tablet

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

ZOMIG

Drugs

Zomig, Zomig ZMT

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

PA will be approved through the remainder of contract year

Other Criteria

Documentation of trial/failure or contraindication to a sumatriptan containing product and Rizatriptan (Maxalt/Maxalt-MLT)

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

ZYTIGA

Drugs

Zytiga

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of metastatic castration-resistant prostate cancer in patients who have received prior chemotherapy containing docetaxel OR Documentation of continuous therapy with Zytiga.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

Prior authorization will be approved till the end of the contract year

Other Criteria

N/A

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

ZYVOX

Drugs

Zyvox

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

Deny if not prescribed by an infectious disease (ID) specialist or prescribed with ID consultation (telephone consultation is acceptable) including name of the ID specialist and date of the consultation within the last 60 days

Coverage Duration

28 days

Other Criteria

Documentation of a current diagnosis of vancomycin-resistant *Enterococcus faecium* (VRE) infection, methicillin-resistant *Staphylococcus aureus* (MRSA) or methicillin-resistant *Staphylococcus epidermis* (MRSE) infection or noscomial pneumonia caused by *Staphylococcus aureus* (methicillin-susceptible or resistant strains) or *Streptococcus pneumonia* (including multi-drug resistant strains [MDRSP]) OR Documentation of a current bacterial infection with trial and failure of at least one drug from two of the following groups within the last 60 days: 1. At least one of the penicillins or cephalosporins 2. At least one of the macrolides or a ketolide 3. At least one of the fluoroquinolones 4. Trimethoprim and sulfamethoxazole 5. At least one of the tetracyclines 6. Clindamycin

Keystone 65 Preferred and Personal Choice 65 Prior Authorization Criteria
(Effective 01/01/2012)

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