



L.A. Care
HEALTH PLAN®

L. A. Care Health Plan Medicare Advantage HMO
Drugs Requiring Prior Authorization Effective 03/01/2010

Medicare Part D								
Prior Authorization Group Description	Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
5HT3 ANTI-NAUSEA AGENT BVD DETERMINATION	GRANISETRON HCL GRANISOL ONDANSETRON HCL ONDANSETRON ODT	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.						
APREPITANT BVD DETERMINATION	EMEND	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.						
BECAPLERMIN	REGRANEX	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D	NON-DIABETIC. KNOWN NEOPLASM AT APPLICATION SITE. PRESSURE OR VENOUS STASIS ULCERS. ULCER DOES NOT EXTEND THROUGH DERMIS.			VASCULAR SURGEON, PODIATRIST, ENDOCRINOLOGIST OR PHYSICIAN PRACTICING IN A SPECIALTY WOUND CLINIC ONLY	3 MONTHS	
BENZYL ALCOHOL	ULESFIA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			6 MONTHS AND OLDER		1 MONTH	UP TO 2724 GRAMS
CALCINEURIN INHIBITORS	ELIDEL PROTOPIC	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D	NOT TRIED/FAILED OR INTOLERABLE ADVERSE EFFECTS TO TOPICAL CORTICOSTEROIDS		PROTOPIC 0.03%: PATIENT AGE GREATER THAN OR EQUAL TO 2 YEARS OLD. PROTOPIC 0.1%: PATIENT AGE GREATER THAN OR EQUAL TO 15 YEARS OLD		12 MONTHS	
CYCLOSPORINE OPTHALMIC	RESTASIS	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		KERATOCONJUNCTIVITIS SICCA (KCS) OR DRY EYE DISEASE		OPHTHALMOLOGIST, OPTOMETRIST, RHEUMATOLOGIST	12 MONTHS	
DARBEPOETIN	ARANESP	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D	ANEMIA ASSOCIATED WITH CHRONIC RENAL FAILURE: HEMOGLOBIN GREATER THAN OR EQUAL TO 12G/DL. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CHEMOTHERAPY: HEMOGLOBIN GREATER THAN OR EQUAL TO 10G/DL				RENAL FAILURE:12 MONTHS CANCER CHEMOTHERPY:COURSE OF TREATMENT BASED ON CHEMOTHERAPY CYCLE.	
ELTROMBOPAG	PROMACTA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D	INITIAL: ADEQUATE RESPONSE TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR SUFFICIENT RESPONSE TO SPLENECTOMY. RENEWAL: NO CLINICAL RESPONSE AS DEFINED BY AN INCREASE IN PLATELET COUNT OF GREATER THAN OR EQUAL TO 50 X10 ⁹ /L AT THE MAX DOSE OF 75MG PER DAY FOR 4 WEEKS				INITIAL:1 MONTH RENEWAL: NO RESPONSE AFTER INITIAL:1 MONTH AT MAX DOSE. IF RESPONSE: 12 MONTHS.	

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EPOETIN ALFA	EPOGEN PROCRIT	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	CHRONIC RENAL FAILURE: HEMOGLOBIN EQUAL TO OR GREATER THAN 10 G/DL IF NOT UNDERGOING DIALYSIS OR GREATER THAN OR EQUAL TO 12 IF ON DIALYSIS. PATIENTS WITH ANEMIA RELATED TO AZT THERAPY: HEMOGLOBIN EQUAL TO OR GREATER THAN 12 G/DL. ANEMIA DUE TO CONCOMITANTLY ADMINISTERED CHEMOTHERAPY: HEMOGLOBIN EQUAL TO OR GREATER THAN 10 G/DL. PATIENTS SCHEDULED FOR ELECTIVE, NONCARDIAC SURGERY, NONVASCULAR SURGERY: HEMOGLOBULIN GREATER THAN 13 G/DL				ANEMIA FROM CHRONIC RENAL FAILURE/AZT/CHEMOTHERAPY:12 MONTHS, ANEMIA FROM ELECTIVE SURGERY: 21 DAYS	
FENTANYL TRANSDERMAL PATCH	FENTANYL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	PATIENT ABLE TO TAKE OR HAS NOT FAILED ORAL LONG-ACTING OPIOID NARCOTIC ANALGESICS.	PATIENT IS RECEIVING DAILY, AROUND-THE-CLOCK PAIN MEDICATION FOR AT LEAST ONE WEEK			12 MONTHS	
FENTANYL TRANSMUCOSAL AGENTS	FENTANYL CITRATE FENTORA ONSOLIS	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		CANCER: ON A MAINTENANCE DOSE OF CONTROLLED- RELEASE PAIN MEDICATION, AND EITHER A TRIAL AND FAILURE OF 1 IMMEDIATE-RELEASE ORAL PAIN AGENT OR DIFFICULTY SWALLOWING TABLETS/CAPSULES			6 MONTHS	
FONDAPARINUX	ARIXTRA	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ACUTE DVT/PE TREATMENT: IS STABILIZED ON WARFARIN AND HAS ESTABLISHED AN ORAL ANTICOAGULANT EFFECT WITH A THERAPEUTIC INR BETWEEN 2 TO 3.				HIP REPLACEMENT/FRACTURE SURGERY UP TO 33 DAYS KNEE/ABDOMINAL SURGERY/DVT/PE TREATMENT UP TO 14 DAYS	
HEPATITIS A VACCINE (INACTIVATED) BVD DETERMINATION	HAVRIX VAQTA	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.						
HEPATITIS B VACCINE BVD DETERMINATION	ENGERIX-B RECOMBIVAX HB	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.						
IMQUIMOD	ALDARA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	PERIANAL GENITAL WARTS: PATIENT HAS NOT TRIED/FAILED CONDYLOX. NON-HYPERKERATOTIC, NON-HYPERTROPHIC ACTINIC KERATOSES ON THE FACE OR SCALP: HAS NOT TRIED/FAILED OR CONTRAINDICATION TO TOPICAL 5-FLUOROURACIL. SUPERFICIAL BASAL CELL CARCINOMA: GREATER THAN 2CM IN SIZE AND ON THE FACE		EXTERNAL GENITAL OR PERIANAL WARTS: GREATER THAN OR EQUAL TO 12 YEARS OF AGE. ACTINIC KERATOSIS: GREATER THAN OR EQUAL TO 18 YEARS OF AGE	ACTINIC KERATOSIS: DERMATOLOGIST ONLY. SUPERFICIAL BASAL CELL CARCINOMA: DERMATOLOGIST OR ONCOLOGIST ONLY.	4 MONTHS	CRITERIA APPLIES TO NEW STARTS ONLY
IMMUNE GLOBULIN BVD DETERMINATION	CARIMUNE NF NANOFILTERED FLEBOGAMMA DIF GAMASTAN S-D GAMMAGARD LIQUID GAMUNEX OCTAGAM POLYGAM S-D VIVAGLOBIN	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.						
IMMUNOSUPPRESSANT BVD DETERMINATION	AZATHIOPRINE AZATHIOPRINE SODIUM CELLCEPT CYCLOSPORINE CYCLOSPORINE MODIFIED GENGRAF MYCOPHENOLATE MOPETIL MYFORTIC ORTHOCLONE OKT-3 PROGRAF RAPAMUNE SIMULECT TACROLIMUS ANHYDROUS TORISEL ZENAPAX	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.						
INFUSIBLE DRUG BVD DETERMINATION	ABELCET ACYCLOVIR SODIUM ADRIAMYCIN AMBISOME AMPHOTEC AMPHOTERICIN B BLEOMYCIN SULFATE CLADRIBINE CYCLOPHOSPHAMIDE CYTARABINE CYTOVENE DOXIL FLUOROURACIL FOSCARNET SODIUM HERCEPTIN IFOSFAMIDE IFOSFAMIDE-MESNA METHOTREXATE MITOMYCIN REMICADE REMODULIN VINBLASTINE SULFATE VINCRISTINE SULFATE	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.						

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LOW MOLECULAR WEIGHT HEPARIN AGENTS	INNOHEP	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ALL LMWH: CURRENTLY ON WARFARIN AND SCHEDULED FOR MINOR SURGERY OR MAJOR SURGERY AND HAS A THERAPEUTIC INR (GREATER THAN 2 FOR AT LEAST 2 DAYS).	ALL AGENTS: PREGNANCY TEST, INR.			CANCER: LIFETIME HIP REPLACEMENT/FRACTURE SURGERY UP TO 30 DAYS OTHER FDA INDICATIONS UP TO 17 DAYS	
MEASLES VIRUS LIVE VACCINE BVD DETERMINATION	ATTENUVAX VACCINE WITH DILUENT	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.						
METHYLNALTREXONE	RELISTOR	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NOT ON PALLIATIVE CARE OR LIFE EXPECTANCY OF GREATER THAN 6 MONTHS	CONSTIPATION DUE TO OPIOIDS			UP TO 6 MONTHS	
MODAFINIL	PROVIGIL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CHRONIC FATIGUE SYNDROME RELATED TO MULTIPLE SCLEROSIS.	OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME: NO TRIAL OF CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP). NARCOLEPSY: NO TRIAL/FAILURE OF OR CONTRAINDICATION TO AMPHETAMINE, DEXTROAMPHETAMINE AND/OR METHYLPHENIDATE.				12 MONTHS	
OFATUMUMAB	ARZERRA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D	CHRONIC LYMPHOCYTIC LEUKEMIA: NO FAILED TREATMENT WITH FLUDARABINE AND ALEMTUZUMAB				6 MONTHS	
OMALIZUMAB	XOLAIR	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		INITIAL: PATIENT MEETS THE CRITERIA OF MODERATE TO SEVERE ASTHMA. POSITIVE SKIN PRICK OR RAST TEST, NON-SMOKER, FEV1 LESS THAN 80%, DEMONSTRATED INADEQUATELY CONTROLLED SYMPTOMS ON INHALED CORTICOSTEROIDS AND SECOND ASTHMA CONTROLLER, BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30 IU/ML. RENEWAL: PATIENT REDUCED EXACERBATIONS BY AT LEAST 25% FROM BASELINE, REDUCTION IN ORAL OR INHALED CORTICOSTEROID USE FROM BASELINE.	PATIENT 12 YEARS OF AGE OR OLDER	SPECIALIST IN ALLERGY OR PULMONARY MEDICINE ONLY	12 MONTHS	
PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION	ADCIRCA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		PULMONARY ARTERIAL HYPERTENSION: WHO CLASS I-IV SYMPTOMS		CARDIOLOGIST OR PULMONOLOGIST	12 MONTHS	2 TABLETS PER DAY PER MONTH
QUININE SULFATE	QUALAQUIN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
RABIES VACCINE BVD DETERMINATION	IMOVAX RABIES VACCINE RABAVERT	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.						
RANOLAZINE	RANEXA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	PATIENT HAS NOT TRIED/FAILED OR HAVE CONTRAINDICATION TO 1 ANTI-ANGINA AGENT (BETA-BLOCKER, AMLODIPINE, NIFEDIPINE, ISOSORBIDE, OR LONG ACTING NITROGLYCERIN).
SAPROPTERIN	KUVAN	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D	INITIAL: HAS NOT TRIED DIETARY MODIFICATIONS RENEWAL: PATIENT HAS NOT ACHIEVED AT LEAST 20% REDUCTION IN BLOOD PHENYLALANINE WITH INITIAL TREATMENT			ENDOCRINOLOGIST ONLY	INITIAL USE: 4 WEEKS. CONTINUED USE: 6 MONTHS	

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SOMATROPIN	GENOTROPIN HUMATROPE NORDITROPIN NORDIFLEX NUTROPIN NUTROPIN AQ OMNITROPE SAIZEN SEROSTIM TEV-TROPIN ZORBTIVE	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ATHLETIC ENHANCEMENT OR ANTI-AGING PURPOSE. GROWTH FAILURE DUE TO CHRONIC RENAL INSUFFICIENCY(CRI) IF PATIENT HAS HAD A RENAL TRANSPLANT	FOR GROWTH FAILURE DUE TO (CRI): PATIENT HAS NOT UNDERGONE A RENAL TRANSPLANT, PATIENT'S HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER, LACK OF RESPONSE FROM PREVIOUS YEAR, PATIENT HAS REACHED 50TH PERCENTILE FOR TARGET HEIGHT FOLLOWING GROWTH HORMONE THERAPY. FOR HIV/WASTING: THE PATIENT ON ANTIRETROVIRAL THERAPY, MEETS SPECIFIED CRITERIA OF WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, 7.5% OVER 6 MONTHS, 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN) OR 23% (WOMEN) OF TOTAL BODY WT. AND A BODY MASS INDEX (BMI) LESS THAN 27KG/M2, OR BMI LESS THAN 20KG/M2. IF CURRENTLY ON GROWTH HORMONE, PATIENT HAS SHOWN CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT OR IF NOT ON GROWTH HORMONE, PATIENT HAS HAD INADEQUATE RESPONSE TO PREVIOUS THERAPY. FOR SHORT-BOWEL SYNDROME: CURRENTLY ON SPECIALIZED NUTRITIONAL SUPPORT			HIV/AIDS: 3 MONTHS. SHORT BOWEL: 4 WEEK ONCE. ALL OTHER DIAGNOSES: 12 MONTHS.	
TESTOSTERONE AGENTS	ANDRODERM ANDROGEL TESTOSTERONE CYPIONATE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	FEMALE, UNLESS DIAGNOSED WITH METASTATIC BREAST CANCER.	MALE HYPOGONADISM CONFIRMED BY EITHER: 1) LABORATORY CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL OF LESS THAN 250NG/DL (8.7NMOL/L) OBTAINED WITHIN 90 DAYS, OR 2) LABORATORY CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL BETWEEN 250NG/DL AND 350NG/DL (12NMOL/L) TOGETHER WITH A FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 50NG/L (174 PMOL/L) OR 3) MALE DELAYED PUBERTY NOT SECONDARY TO PATHOLOGY.			12 MONTHS	
TETANUS TOXOID VACCINE BVD DETERMINATION	TETANUS TOXOID ADSORBED	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.						
TOTAL PARENTERAL NUTRITION AGENT BVD DETERMINATION	AMINOSYN AMINOSYN II AMINOSYN II 3.5% M- DEXTROSE 5% AMINOSYN II 3.5%-DEXTROSE 25% AMINOSYN II 3.5%-DEXTROSE 5% AMINOSYN II 4.25% M-DEXT 10% AMINOSYN II 4.25%-DEXTROSE 25% AMINOSYN II 5% IN 25% DEXTROSE AMINOSYN II IN DEXTROSE AMINOSYN II W/ELEC IN DEX W/CA AMINOSYN M AMINOSYN W/ELECTROLYTES AMINOSYN-HBC AMINOSYN- HF AMINOSYN-PF CLINIMIX CLINIMIX E CLINISOL DEXTROSE 10%-1/4NS DEXTROSE IN WATER DEXTROSE WITH SODIUM CHLORIDE FREAMINE HBC FREAMINE III FREAMINE III WITH ELECTROLYTES HEPATAMINE HEPATASOL INTRALIPID LIPOSYN II LIPOSYN III NEPHRAMINE NOVAMINE PREMASOL PROCALAMINE PROSOL QUICK MIX WITH LYTRES RENAMIN TRAVASOL TRAVASOL W/ELECTROLYTES TRAVASOL WITH DEXTROSE TRAVASOL WITH ELECTROLYTES TROPHAMINE	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.						