The page appears to be a document with various medical indications and criteria. However, the text is not clearly legible due to the quality of the image. It seems to discuss covered uses and exclusion criteria for medications, along with trial requirements for certain conditions. The text is fragmented and lacks clear structure, making it difficult to extract meaningful information.
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Covered Uses</th>
<th>Exchange Criteria</th>
<th>Required Medical Information</th>
<th>Age Restrictions</th>
<th>Prescriber Restrictions</th>
<th>Coverage Duration</th>
<th>Other Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIMPONI</td>
<td>MULTIPLE INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D</td>
<td>EITHER: PLAQUE PSORIASIS: LOCATIONS TO AFFECT 70% OF BODY SURFACE AREA OR PSORIATIC ARTHRITIS: AFFECTS MORE THAN 30% OF BODY OR joints AND ORAL DIABETES MELLITUS: AFFECTS MORE THAN 20% OF BODY OR joints</td>
<td>PRESCRIBED BY OR SUPERVISED BY A RHUMATOLOGIST OR ENDocrinologist.</td>
<td>6 MONTHS - 12 MONTHS RENEWAL: 12 MONTHS</td>
<td>PRESCRIBED BY OR SUPERVISED BY A RHUMATOLOGIST</td>
<td>12 MONTHS</td>
<td>OTHER INDICATIONS</td>
</tr>
</tbody>
</table>
L.A. Care Health Plan is a Coordinated Care plan with a Medicare contract and a contract with the California Medicaid program. Enrollment in L.A. Care Health Plan depends on contract renewal.

ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

Hypertension: Trial or Contraindication to a Non-Sedating Antihistamine Such as Levocetrizine, Anxiety: Trial or Contraindication to Two (2) of the Following: Propranolol, Paroxetine, Duloxetine, or Venlafaxine. Motion Sickness: Trial or Contraindication to Meclizine. Insomnia: Prescriber acknowledges that this drug is labeled as high risk medication in the Elderly for patients 65 years and older.

Medication Use: Appropriate high risk medication in the elderly for patients 65 years or older. PA not otherwise excluded from Part D.

High Risk Drugs in the Elderly - Anti-Infective

- Acyclovir, Valacyclovir, Famciclovir
- Zidovudine, Emtricitabine, Tenofovir

High Risk Drugs in the Elderly - Antihypertensives

- Thiazide Diuretics
- Beta Blockers

High Risk Drugs in the Elderly - Cardiovascular

- Guanfacine HCL
- Acetaminophen-Caffeine, Butalbital-Aspirin-Propoxyphene HCL
- Acetaminophen-Caffeine, Butalbital-Aspirin-Codine
- Butalbital-Caffeine with Codeine
- Butalbital-Caffeine, Propoxyphene HCL

High Risk Drugs in the Elderly - Central nervous system - Phenytoin

- Carbamazepine, Phenytoin, Valproate
- Carbamazepine, Phenytoin, Valproate, Lamotrigine, Topiramate

High Risk Drugs in the Elderly - Anticholinergics

- Carbamazepine, Haloperidol, Levodopa, Baclofen, Buspirone, Paroxetine

High Risk Drugs in the Elderly - Antihistamines - Hydroxyzine

- Hydroxyzine HCL, Hydroxyzine Pamoate

High Risk Drugs in the Elderly - Antihistamines - Promethazine

- Promethazine HCl, Promethazine HCl, Phenothiazine

High Risk Drugs in the Elderly - Antihistamines - Dimetadione

- Dimetadione

High Risk Drugs in the Elderly - Antihistamines - Albuterol, Atropine, Phenobarbital, Phenylpropanolamine, Theophylline

High Risk Drugs in the Elderly - Antihistamines - Decongestants

- Decongestants

High Risk Drugs in the Elderly - Decongestants

- Decongestants

Age Restrictions

65 YEARS AND OLDER: SCHIZOPHRENIA - THIS DRUG MAY BE COVERED UNDER MEDICARE

MEMBERS 65 YEARS OR OLDER WILL BE REQUIRED TO SUBMIT A DESCRIPTION OF THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

65 YEARS AND OLDER: HYPERTENSION: TRIAL OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE, ANXIETY: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING: PROPRANOLOL, PAROXETINE, DULOXETINE, OR VENLAFAXINE. MOTION SICKNESS: TRIAL OR CONTRAINDICATION TO MECLIZINE. INSOMNIA: PRESCRIBER ACKNOWLEDGES THAT THIS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.

The Elderly - High Risk Drugs in Combinations

- Barbiturates
- Anticholinergics
- Hydroxyzine
- Trihexyphenidyl
- Benztropine
- Anticholinergics
- Other otherwise excluded from Part D.

Medication Use: Appropriate high risk medication in the elderly for patients 65 years or older. PA not otherwise excluded from Part D.

Prior Authorization

Group Description

[12 MONTHS]

Required Medical Information

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.

Preparer Restrictions

No more than 90 days (total) of cumulative use will require trial of or contraindication to sulfasalazine/Antiemetic/Phenothiazine (TMP-SMX) or trimethoprim.
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Coverage Criteria</th>
<th>Exchange Criteria</th>
<th>Required Medical Information</th>
<th>Age Restrictions</th>
<th>Prescription Restrictions</th>
<th>Coverage Duration</th>
<th>Other Criteria</th>
</tr>
</thead>
</table>
| IMIQUIMOD - ALDARA | ALLE High Risk Medication for Age 0-64 years or Elder PA not required for Age 65 years or older | Approve within the current plan year | submit describing the use and setting of the drug to make the determination | 6 MONTHS | *VULNERABLE AIRCRAFT, TRIAL OR CONTRAINDICATION TO TWO OR MORE OF THE FOLLOWING: ESTRACE VAGINAL CREAM, PREMARIN VAGINAL CREAM, OR A VAGINAL GEL TOPICAL, TRIAL OR CONTRAINDICATION TO ONE OF THE FOLLOWING: ALDARA, IBRUVICAP, IBRUVICA, ITACAPRIDE, OR ESTRASE. VAGINOMUSCULAR SYMPTOMS OF MENOPAUSE. PRESCRIBER ACKNOWLEDGES THAT THIS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER. ALL OTHER FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. | 12 MONTHS | *
| IBRUVICA | ALLE High Risk Medication for Age 0-64 years or Elder PA not required for Age 65 years or older | Approve within the current plan year | submit describing the use and setting of the drug to make the determination | 6 MONTHS | *VULNERABLE AIRCRAFT, TRIAL OR CONTRAINDICATION TO TWO OR MORE OF THE FOLLOWING: ESTRACE VAGINAL CREAM, PREMARIN VAGINAL CREAM, OR A VAGINAL GEL TOPICAL, TRIAL OR CONTRAINDICATION TO ONE OF THE FOLLOWING: ALDARA, IBRUVICAP, IBRUVICA, ITACAPRIDE, OR ESTRASE. VAGINOMUSCULAR SYMPTOMS OF MENOPAUSE. PRESCRIBER ACKNOWLEDGES THAT THIS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER. ALL OTHER FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. | 12 MONTHS | *
| KELLOGE | ALLE High Risk Medication for Age 0-64 years or Elder PA not required for Age 65 years or older | Approve within the current plan year | submit describing the use and setting of the drug to make the determination | 6 MONTHS | *VULNERABLE AIRCRAFT, TRIAL OR CONTRAINDICATION TO TWO OR MORE OF THE FOLLOWING: ESTRACE VAGINAL CREAM, PREMARIN VAGINAL CREAM, OR A VAGINAL GEL TOPICAL, TRIAL OR CONTRAINDICATION TO ONE OF THE FOLLOWING: ALDARA, IBRUVICAP, IBRUVICA, ITACAPRIDE, OR ESTRASE. VAGINOMUSCULAR SYMPTOMS OF MENOPAUSE. PRESCRIBER ACKNOWLEDGES THAT THIS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER. ALL OTHER FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. | 12 MONTHS | *
**Covered Uses**

REMICADE

- ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D (OTHER THAN INFECTIONS DUE TO MOLLUSCUM CONTAGIOSUM)

TYSABRI

- ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

KALYDECO

- 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.

**Prescriber Restrictions**

GASTROENTEROLOGIST

- REQUIRED MEDICAL INFORMATION

REVLIMID

- ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

YERVOY

- ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

OTHER CRITERIA

- PATIENT IS RECEIVING PALLIATIVE CARE.

TYSABRI

- ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

KORLYM

- ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

**Coverage Duration**

- UP TO 6 MONTHS

**Exclusion Criteria**

- OTHERWISE EXCLUDED FROM PART D.

**Age Restrictions**

- 6 YEARS OF AGE OR OLDER.

**Drug Name**

- SUBMITTED DESCRIBING THE USE AND SETTING OF THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

**Prior Authorization**

- REQUIRED MEDICAL INFORMATION

**Drug Interactions**

- OTHERWISE EXCLUDED FROM PART D.

**Other Criteria**

- OTHERWISE EXCLUDED FROM PART D.

**Use in Renal Artery Aneurysm**

- PERSISTENT AORTIC OCCLUSION

**Use in Involuntary Movements**

- AZATHIOPRINE | IMMUNOSUPPRESSIVE AGENTS

**Use in Hematological Malignancies**

- ACETYL-CYSTEINE | ALBUTEROL SULFATE | METHOTREXATE | TREXALL | HYDROXYCHLOROQUINE, OR SULFASALAZINE.

**Use in Chronic Fatigue Syndrome Related to HIV**

- RIBAVIRIN | INTERFERON AGENTS

**Use in Chronic Hepatitis C**

- HEP C: DRUG MUST BE USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED.

**Use in Chronic Hepatitis B**

- HEP B: DRUG MUST BE USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED.

**Use in Rheumatoid Arthritis**

- MODALITY: A CORTICOSTEROID WITHIN THE PAST 12 MONTHS.

**Use in Crohn’s Disease**

- NO RENEWAL: HEP C: USED IN COMBINATION OR CONTRAINDICATED WITH RIBAVIRIN.

**Use in Hepatitis C**

- GENOTYPE 2 OR 3: NO RENEWAL.

**Use in Hepatitis B**

- GENOTYPE 1: 4 TO 6 MOS. ALL OTHERS: 6 MOS.

**Use in Involuntary Movements**

- OTHERWISE EXCLUDED FROM PART D.

**Use in Chronic Fatigue Syndrome Related to HIV**

- OTHERWISE EXCLUDED FROM PART D.

**Use in Hematological Malignancies**

- OTHERWISE EXCLUDED FROM PART D.
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Genus/Species</th>
<th>HCA NDC</th>
<th>Covered Uses</th>
<th>INCLUSION CRITERIA</th>
<th>EXCLUSION CRITERIA</th>
<th>REQUIRED MEDICATIONS</th>
<th>AGE RESTRICTIONS</th>
<th>PRESCRIBER RESTRICTIONS</th>
<th>COVERAGE DURATION</th>
<th>OTHER CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>RITUXAN</td>
<td>PHI4014977</td>
<td>2068341</td>
<td>LA Care can cover RITUXAN for patients with non-Hodgkin’s lymphoma (NHL) for RITUXAN and for patients with chronic lymphocytic leukemia (CLL).</td>
<td>18 YEARS OF AGE</td>
<td>ALL MEDICALLY ACCEPTED INDICATIONS NOT</td>
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<tr>
<td>JAKAFI</td>
<td>5448303352</td>
<td>1093634</td>
<td>LA Care can cover JAKAFI for patients with myelofibrosis (MF) and polycythemia vera (PV).</td>
<td>AGE RESTRICTIONS</td>
<td>ALL MEDICALLY ACCEPTED INDICATIONS NOT</td>
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<td>ISTODAX</td>
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<tr>
<td>SOVALDI</td>
<td>5448303352</td>
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<td>LA Care can cover SOVALDI for patients with hepatitis C virus (HCV) infection.</td>
<td>AGE RESTRICTIONS</td>
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<td>TRIAL OF OR CONTRAINDICATION TO VORINOSTAT</td>
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<td>OLYSIO</td>
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<td>LA Care can cover OLYSIO for patients with hepatitis C virus (HCV) infection.</td>
<td>AGE RESTRICTIONS</td>
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<td>SOFOBUVIR</td>
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<td>RUXOLITINIB</td>
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<td>ROMIDEPSIN</td>
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</tbody>
</table>
**Covered Uses**

**XENAZINE FORTEO**

**12 MONTHS.** FOR GROWTH FAILURE DUE TO (CRI): PATIENT HAS TRIAL OF OR CONTRAINDICATION TO ONE

**Coverage Duration**

**12 MONTHS**

ALL MEDICALLY ACCEPTED INDICATIONS NOT ALL FDA APPROVED INDICATIONS

**GASTROINTESTIONAL STROMAL TUMORS (GIST):** ALL FDA APPROVED INDICATIONS NOT ALL MEDICALLY ACCEPTED INDICATIONS NOT

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**ANDRODERM | ANDROGEL | AXIRON**

ALL FDA APPROVED INDICATIONS NOT ALL MEDICALLY ACCEPTED INDICATIONS NOT

**NEXAVAR**

ALL FDA APPROVED INDICATIONS NOT ALL MEDICALLY ACCEPTED INDICATIONS NOT

**Other Criteria**

**THALIDOMIDE**

THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE OTHERWISE EXCLUDED FROM PART D.

**HIV/WASTING: MEETS CRITERIA OF WEIGHT LOSS:** REQUIRED MEDICAL INFORMATION EXCLUSION CRITERIA

**THALOMID**

RENEWAL: 4 WEEKS

**NEXAVAR**

RENEWAL: 4 WEEKS

**REBIF**

RENEWAL: 4 WEEKS

**BETASERON, EXTAVIA, OR REBIF)** AND TO 12 MONTHS

**PEGINTERFERON ALFA.**

**OTHERWISE EXCLUDED FROM PART D.**

**HEP C: CONCURRENT USE OF RIBAVIRIN AND CONTRAINDICATION TO INTERFERON, WHEN USED IN COMBINATION WITH INTERFERON.**

**OR JUST INFECTION DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF INFECTIOUS DISEASES, OR IN A SPECIALTY TRAINED GROUP (E.G. HEPATOLOGIST) OR A SPECIALLY TRAINED GROUP (E.G. SPECIALIST, PHYSICIAN SPECIALIZING IN HIV/AIDS: CURRENTLY ON ANTIRETROVIRAL THERAPY.)**

**SPECIALIZED NUTRITIONAL SUPPORT.**

**BMI LESS THAN 20 KG PER METER SQUARED.**

**TOTAL BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR**

**CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS.**

**GREATER THAN 24 MONTHS OF THERAPY.**

**SHORT BOWEL: 4 WEEK REJUVENATION: MINIMUM NUMBER OF POUNDS (BMI) GAINED IN 6 MONTHS.**

**OSSEOUS INTEGRITY.**

**GREATER THAN 50% LOSS OF TOTAL BODY MASS INDEX (BMI).**

**GREATER THAN 50% LOSS OF TOTAL BODY MASS INDEX (BMI).**

**GREATER THAN 25% LOSS OF TOTAL BODY MASS INDEX (BMI).**

**GREATER THAN 25% LOSS OF TOTAL BODY MASS INDEX (BMI).**

**GREATER THAN 20% LOSS OF TOTAL BODY MASS INDEX (BMI).**

**GREATER THAN 15% LOSS OF TOTAL BODY MASS INDEX (BMI).**

**GREATER THAN 10% LOSS OF TOTAL BODY MASS INDEX (BMI).**

**GREATER THAN 5% LOSS OF TOTAL BODY MASS INDEX (BMI).**

**GREATER THAN 15% LOSS OF TOTAL BODY MASS INDEX (BMI).**

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**GREATER THAN 15% LOSS OF TOTAL BODY MASS INDEX (BMI).**

**GREATER THAN 10% LOSS OF TOTAL BODY MASS INDEX (BMI).**

**GREATER THAN 5% LOSS OF TOTAL BODY MASS INDEX (BMI).**
### Covered Uses

**BRAND TRETINON** WILL REQUIRE TRIAL BEFORE AGE RESTRICTIONS APPLY TO NEW STARTS ONLY. TRIAL OR ALL MEDICALLY ACCEPTED INDICATIONS NOT ALL FDA APPROVED INDICATIONS NOT ZELBORAF

### Required Medical Information

AVANDAMET | AVANDARYL | AVANDIA

### Prescriber Restrictions

CRITERIA APPLIES TO NEW STARTS ONLY. L.A. Care Health Plan is a Coordinated Care plan with a Medicare contract and a contract with the California Medicaid program. Enrollment in L.A. Care Health Plan depends on contract renewal.

### Exclusion Criteria

RA: INITIAL: 3 MONTHS. OTHERWISE EXCLUDED FROM PART D.

### Coverage Duration

This document may be available in a different format or language. For additional information, call customer service at 1-888-522-1298. TTY/TDD users call: 1-888-212-4460.