



CareOregon Advantage

2010 Medications Billed to the Medical Benefit
Prior Authorization Criteria

COA Plus (MCR01, MCR02, MCR03)
COA Star (STAR01, STAR02)

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Generic Name: Abatacept

Brand Name: Orencia

See criteria at:

http://www.careoregon.org/medicare/documents/2010_COA_Formulary_PA_Criteria.pdf

BOTULINUM PRODUCTS

Generic Name	OnabotulinumtoxinA AbobotulinumtoxinA RimabotulinumtoxinB
Brand Name	Botox Dysport Myobloc

See criteria at:

http://www.careoregon.org/medicare/documents/2010_COA_Formulary_PA_Criteria.pdf

Generic Name Alpha 1-Proteinase Inhibitors

Brand Name Prolastin, Aralast, Zemaira

See criteria at:

http://www.careoregon.org/medicare/documents/2010_COA_Formulary_PA_Criteria.pdf

Generic Name: Capsaicin

Brand Name: Qutenza

Created: 7/15/10

1. Does the patient have a diagnosis of postherpetic neuralgia?
If yes, continue to #2. If no, do not approve.
2. Has the patient failed ALL of the following?
 - a. Capsaicin cream
 - b. Tricyclic antidepressant (amitriptyline, nortriptyline, desipramine)
 - c. Gabapentin
 - d. LyricaIf yes, continue to #3. If no, do not approve.
3. Approve up to 4 patches x 3 months.

Generic Name: Certolizumab pegol

Brand Name: Cimzia

See criteria at:

http://www.careoregon.org/medicare/documents/2010_COA_Formulary_PA_Criteria.pdf

Generic Name: Iloprost

Brand Name: Ventavis

See criteria at:

http://www.careoregon.org/medicare/documents/2010_COA_Formulary_PA_Criteria.pdf

Generic Name: Epoprostenol

Brand Name: Flolan

Last updated: 8/31/09

Initial Criteria

1. Is the prostacyclin being requested by a pulmonologist or cardiologist?
If yes, continue to #2
If no, do not approve.
2. Is the member a current smoker?
If yes, continue to #3
If no, continue to #4.
3. Is the member enrolled in a smoking cessation program?
If yes, continue to #4.
If no, consult with provider.
4. Does the member have a diagnosis of pulmonary arterial hypertension?
If yes, continue to #5
If no, do not approve.
5. Does the member meet all of the following criteria?
 - a. Mean PAP \geq 25 mm Hg at rest
 - b. Pulmonary Capillary Wedge Pressure \leq 15 mm Hg at rest
 - c. NYHA Class III to IVIf yes, continue to #6
If no, do not approve.
6. Does the member have PAH associated with the following?
 - a. portal hypertension
 - b. sickle cell disease,
 - c. thromboembolic disease?If yes, do not approve.
If no, continue to #7.
7. Has the member tried and failed or have contraindications to treatment with a calcium channel blocker (e.g. right-heart failure): nifedipine 30-240 mg/d or diltiazem 120-900 mg/d or amlodipine?
If no, continue to #8.
If yes, continue to #9.
8. Has the member had a positive response to vasoreactivity testing such as?
 - a. \geq 25% reduction in mean PVR
 - b. Fall in mean PAP of at least 10 and \leq 40mm Hg
 - c. Increase or unchanged cardiac outputIf no, continue to #9.
If yes, do not approve.

9. Has the member tried and failed or have contraindications to treatment with bosentan (Tracleer) or ambrisentan (Letairis) such as underlying hepatic dysfunction?

If yes, continue to #10.

If no, do not approve.

10. Is the request for combination therapy with other PAH or PPH drugs, such as

a. Viagra or Revatio

b. Tracleer or Letairis

If yes, forward for review

If no, continue to #11.

with Medical Director for medical necessity.

11. Has the provider outlined specific and measurable treatment goals to assess response to a 12-16 week trial including

a. A significant increase in the 6-minute walk test, or

b. Decrease in dyspnea fatigue rating and other symptoms, or

c. Evidence of hemodynamic improvement such as a reduction in mPAP and PVR,
or

d. Improvement in NYHA class, or

e. Lack of functional or hemodynamic deterioration

If yes, approve for 4 months.

If no, request goals from provider.

Renewal Criteria

1. Does the member meet treatment goals defined above?

If yes, approve for 12 months.

If no, consult with provider.

Generic Name Infliximab

Brand Name Remicade

See criteria at:

http://www.careoregon.org/medicare/documents/2010_COA_Formulary_PA_Criteria.pdf

Generic Name: Intravenous Immune Globulin (IVIG)

Immune globulin, subcutaneous

Brand Name: Carimune NF, Flebogamma,, Gamimune N,
Gammagard S/D, Gammar IV, Gammar-P IV,
Iveegam, Octagam, Panglobulin, Polygam S/D,
Venoglobulin

Vivaglobin, Hizentra

See criteria at:

http://www.careoregon.org/medicare/documents/2010_COA_Formulary_PA_Criteria.pdf

Generic Name Linezolid

Brand Name Zyvox

See criteria at:

http://www.careoregon.org/medicare/documents/2010_COA_Formulary_PA_Criteria.pdf

Generic Name Natalizumab

Brand Name Tysabri

See criteria at:

http://www.careoregon.org/medicare/documents/2010_COA_Formulary_PA_Criteria.pdf

Generic Name Omalizumab

Brand Name Xolair

See criteria at:

http://www.careoregon.org/medicare/documents/2010_COA_Formulary_PA_Criteria.pdf

Generic Name Palivizumab

Brand Name Synagis

See criteria at:

http://www.careoregon.org/medicare/documents/2010_COA_Formulary_PA_Criteria.pdf

Generic Name Tigecycline

Brand Name Tygacil

See criteria at:

http://www.careoregon.org/medicare/documents/2010_COA_Formulary_PA_Criteria.pdf

Generic Name Treprostinil

Brand Name Remodulin

See criteria at:

http://www.careoregon.org/medicare/documents/2010_COA_Formulary_PA_Criteria.pdf

Generic Name Triptorelin pamoate

Brand Name Trelstar LA
 Trelstar Depot

See criteria at:

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