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Effective Date	Drugs/Categories of Drugs	Coverage Criteria	Coverage Duration	Other Information	Non-Covered Uses
1/1/10	ADMINISTRATIVE PA	REQUIRED TO DETERMINE B VERSUS D COVERAGE	LIFETIME	REQUIRES DOCUMENTATION OF DIAGNOSIS AND APPLICABLE MEDICATION HISTORY FOR DETERMINATION OF PART D COVERAGE.	NON COVERED PART D DRUGS
1/10/10	AFINITOR	COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE EXCLUDED BY PART D. COVERED TREATMENT OF ADVANCED RCC AFTER FAILURE OF TREATMENT/DISEASE PROGRESSION WITH NEXAVAR OR SUTENT.	ONE YEAR	DOCUMENTATION OF ADVANCED RENAL CELL CARCINOMA AFTER FAILURE OF TREATMENT OR DISEASE PROGRESSION WITH NEXAVAR OR SUTENT. COVERAGE IS NOT PROVIDED IN COMBINATION WITH NEXAVAR OR SUTENT.	
1/10/10	BRANDED PPIS	COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE EXCLUDED BY PART D.	COVERED THROUGH REMAINDER OF PLAN YEAR UP TO ONE YEAR	KAPIDEX IS COVERED IF THE PATIENT HAS DEMONSTRATED FAILURE OR INTOLERANCE TO TWO PREFERRED FORMULARY PRODUCTS OF OMEPRAZOLE, AND PANTOPRAZOLE. AT LEAST ONE OF THE THERAPIES TRIED MUST BE TWICE DAILY	

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				THERAPY. NEXIUM IS COVERED AFTER A 30 DAY TRIAL OF TWO PREFERRED FORMULARY PRODUCTS OF PANTOPRAZOLE OR OMEPRAZOLE. HIGH DOSE THERAPY IS REQUIRED OF ONE DRUG TRIAL, FOR EXAMPLE 40MG OR GREATER PER DAY OF OMEPRAZOLE OR 80MG OR GREATER PER DAY OF PANTOPRAZOLE.	
1/1/10	BRANDED SEDATIVE HYPNOTICS	COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE EXCLUDED BY PART D.	COVERED THROUGH REMAINDER OF PLAN YEAR UP TO ONE YEAR	REQUIRES DOCUMENTATION OF MEDICAL NECESSITY. COVERED FOR PATIENTS WITH DOCUMENTED INTOLERANCE TO ORAL GENERIC FORMS OF ZOLPIDEM AND ZALEPLON.	
1/1/10	CYMBALTA	COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE EXCLUDED BY PART D.	COVERED THROUGH REMAINDER OF PLAN YEAR UP TO ONE YEAR	FOR MAJOR DEPRESSIVE DISORDER OR GENERALIZED ANXIETY DISORDER, REQUIRES TREATMENT FAILURE WITH ONE GENERIC	EXCLUDED FOR NON FDA OR UNSUPPORTED USE.

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				<p>ANTIDEPRESSANT, SUCH AS CITALOPRAM, PAROXETINE, VENLAFAXINE, OR BUPROPRION, AND ONE PREFERRED BRAND ANTIDEPRESSANT, SUCH AS ESCITALOPRAM. CYMBALTA IS COVERED FOR POST HERPETIC NEURALGIA OR DIABETIC NEUROPATHY. CYMBALTA IS COVERED FOR PATIENTS WITH FIBROMYALGIA.</p>	
1/1/10	ERYTHROPOESIS STIMULATING AGENTS	COVERED FOR THE TREATMENT OF ANEMIA ASSOCIATED WITH CHRONIC RENAL FAILURE, INCLUDING PATIENTS ON DIALYSIS (END-STAGE RENAL DISEASE) AND PATIENTS NOT ON DIALYSIS, TO ELEVATE OR MAINTAIN THE RBC LEVEL (AS MANIFESTED BY HEMATOCRIT OR	THREE MONTHS	DOCUMENTATION OF DIAGNOSIS, LABORATORY VALUES OF HEMOGLOBIN AND HEMATOCRIT, AND MEDICATION HISTORY, WHERE APPLICABLE. A HEMOGLOBIN LEVEL OF LESS THAN 10 MG/DL IS REQUIRED FOR INITIAL THERAPY. DOSAGE ADJUSTMENTS ARE REQUIRED TO MAINTAIN HEMOGLOBIN BETWEEN 10 MG/DL AND 12 MG/DL, WITH	ANEMIA DUE TO FOLATE, VITAMIN B12, IRON DEFICIENCIES, HEMOLYSIS, BLEEDING, OR BONE MARROW FIBROSIS. ANEMIA ASSOCIATED WITH TREATMENT OF ACUTE AND CHRONIC MYELOGENOUS LEUKEMIAS OR ERYTHROID CANCERS. ANEMIA DUE TO CANCER TREATMENT IN PATIENTS WITH UNCONTROLLED HYPERTENSION. ANEMIA

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		<p>HEMOGLOBIN DETERMINATIONS) AND TO DECREASE THE NEED FOR TRANSFUSIONS IN THESE PATIENTS. ALSO COVERED FOR ANEMIA SECONDARY TO ACTIVE CHEMOTHERAPY OF SOLID TUMORS, ANEMIA SECONDARY TO ACTIVE ZIDOVUDINE (AZT) THERAPY, ANEMIA IN MYELODYSPLASTIC DISORDERS, AND PROPHYLACTIC USE DURING MAJOR SURGERIES. ARANESP AND EPOGEN USE REQUIRES TRIAL AND FAILURE OF PROCRIT.</p>		<p>DISCONTINUATION IF HEMOGLOBIN EXCEEDS 12 MG/DL.</p>	<p>NOT ASSOCIATED WITH CANCER TREATMENT OR RENAL DISEASE UNDER INCLUSIONS. ANEMIA ASSOCIATED ONLY WITH RADIOTHERAPY. PROPHYLACTIC USE TO PREVENT CHEMOTHERAPY INDUCED ANEMIA. PROPHYLACTIC USE TO REDUCE TUMOR HYPOXIA. ERYTHROPOIETIN-TYPE RESISTANCE DURE TO NEUTRALIZING ANTIBODIES.</p>
1/1/10	GASTROINTESTINAL AGENTS	<p>COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE EXCLUDED BY PART D.COVERED FOR WOMEN 18 YEARS OR OLDER AND DIAGNOSED WITH IBS WITH CONSTIPATION.</p>	<p>COVERED THROUGH REMAINDER OF PLAN YEAR UP TO ONE YEAR</p>		

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		COVERED FOR ADULTS WITH FOR THE TREATMENT OF CHRONIC IDIOPATHIC CONSTIPATION. DOCUMENTATION OF FAILURE WITHIN THE LAST 12 MONTHS OF USE OF A FIBER LAXATIVE AND ONE OF THE FOLLOWING: A STIMULANT LAXATIVE OR AN OSMOTIC LAXATIVE. DRUG INDUCED CONSTIPATION MUST BE RULED OUT.			
1/1/10	GROWTH HORMONE	COVERED FOR THE REPLACEMENT OF ENDOGENOUS GROWTH HORMONE IN ADULTS WITH GROWTH HORMONE DEFICIENCY OF CHILDHOOD ONSET OR ADULT ONSET, COVERED IF INITIAL DIAGNOSIS BASED ON TWO GROWTH HORMONE STIMULATION TESTS AND THAT THE	COVERED THROUGH REMAINDER OF PLAN YEAR UP TO ONE YEAR	INITIAL APPROVAL FOR ONE YEAR AND RENEWAL CAN BE OBTAINED IF DOCUMENTED CLINICAL RESPONSE WITH THAT THERAPY.	NOT COVERED FOR EDEMA, ARTHRALGIAS, OR CARPAL TUNNEL SYNDROME.

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		<p>PATIENT DOES NOT HAVE EDEMA, ARTHRALGIAS, OR CARPAL TUNNEL SYNDROME. GROWTH HORMONE IS COVERED FOR ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. SEROSTIM IS COVERED FOR AIDS WASTING CACHEXIA. NORDITROPIN IS COVERED FOR NOONAN SYNDROME, TURNER SYNDROME, AND ADULT GROWTH HORMONE DEFICIENCY. NUTROPIN IS COVERED FOR TURNER SYNDROME, AND ADULT GROWTH HORMONE DEFICIENCY. OMNITROPE AND SAIZEN ARE COVERED FOR ADULT GROWTH HORMONE DEFICIENCY. ZORBTIVE IS</p>			

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		COVERED FOR THE TREATMENT OF SHORT-BOWEL SYNDROME IN PATIENTS RECEIVING SPECIALIZED NUTRITIONAL SUPPORT. SOMAVERT IS COVERED FOR ACROMEGALY. INITIAL APPROVAL FOR 1 YEAR AND RENEWAL CAN BE OBTAINED IF CLINICAL RESPONSE WITH THERAPY.			
1/1/10	HEPATITIS C TREATMENT	COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE EXCLUDED BY PART D. COVERED FOR HEPATITIS C VIRUS INFECTION. COVERED WHEN APPROPRIATE DOSES OF CONCOMITANT RIBAVARIN ARE UTILIZED FOR THE APPROPRIATE VIRAL GENOTYPE. INITIAL THERAPY WILL BE APPROVED FOR 12 WEEKS	INITIATION OF THERAPY - 12 WEEKS APPROVAL, CONTINUATION THERAPY - 24 TO 48 WEEKS APPROVAL	DOCUMENTATION OF APPROPRIATE CONCOMITANT RIBAVARIN DOSAGE MAY BE REQUIRED. CLINICAL DOCUMENTATION OF RESPONSE TO THERAPY MAY BE REQUIRED FOR REQUESTS FOR CONTINUATION OF THERAPY. DOCUMENTATION OF VIRAL GENOTYPE MAY BE REQUIRED.	

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1/1/10	HIGH RISK MEDICATIONS IN ELDERLY	COVERED FOR PATIENTS 65 YEARS OR OLDER FOR ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D IF INTOLERANCE, CONTRAINDICATIONS, OR TRIAL WITH FAILURE HAS OCCURRED WITH SAFER ALTERNATIVES, OR IF DOCUMENTATION OF SHORT TERM USE ONLY. PROPOXYPHENE AND PENTAZOCINE ARE COVERED IF PATIENT IS INTOLERANT TO OR HAS FAILED OTHER AGENTS FOR MODERATE PAIN SUCH AS ACETAMINOPHEN OR ASPIRIN WITH OR WITHOUT CODEINE OR HYDROCODONE. CHLORPROPAMIDE IS	COVERED THROUGH REMAINDER OF PLAN YEAR UP TO ONE YEAR		

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		<p>COVERED IF PATIENT HAS FAILED OR IS INTOLERANT TO SAFER ALTERNATIVES SUCH AS GLYBURIDE, GLIPIZIDE, PRECOSE, PRANDIN, OR THIAZOLIDINEDIONES. MEPERIDINE IS COVERED IF PATIENT IS INTOLERANT TO SAFER NARCOTIC ALTERNATIVES SUCH AS MORPHINE OR OXYCODONE. MEPROBAMATE IS COVERED IF PATIENT IS INTOLERANT TO OR HAS FAILED OTHER ANXIOLYTIC AGENTS SUCH AS BUSPIRONE. INDOMETHACIN IS APPROVED IF PATIENT IS INTOLERANT TO OR HAS FAILED THERAPY WITH OTHER SAFER NONSTEROIDAL ALTERNATIVES SUCH AS MELOXICAM OR CELECOXIB. DIPHENHYDRAMINE IS</p>			

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		<p>APPROVED IF PATIENT HAS FAILED OR IS INTOLERANT TO OTHER SAFER ALTERNATIVE SEDATIVE OR ANXIOLYTIC AGENTS SUCH AS ZOLPIDEM. FLUOXETINE IS COVERED FOR PATIENTS WHO HAVE A HISTORY OF USE. FOR THOSE PATIENTS INITIATING THERAPY, FLUOXETINE IS COVERED IF PATIENT HAS FAILURE OF OR INTOLERANCE TO SAFER ALTERNATIVE SSRI AGENTS SUCH AS CITALOPRAM, ESCITALOPRAM OR PAROXETINE.</p>			
1/1/10	HP ACTHAR GEL	<p>COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE EXCLUDED BY PART D. ACTH GEL MAY BE CONSIDERED MEDICALLY NECESSARY FOR USE IN DIAGNOSTIC</p>	<p>COVERED FOR REQUESTED DURATION UP TO THREE MONTHS</p>		

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		TESTING OF ADRENOCORTICAL FUNCTION, HOWEVER, COSYNTROPIN SHOULD BE USED FOR THIS TEST IN MOST CASES.			
1/1/10	INJECTABLE DIABETIC AGENTS	BYETTA IS COVERED FOR PATIENTS WHO HAVE TYPE 2 DIABETES WITH CONCURRENTLY PRESCRIBED METFORMIN, A SULFONYLUREA, A THIAZOLIDINEDIONE, A COMBINATION OF METFORMIN AND A SULFONYLUREA OR A COMBINATION OF METFORMIN AND A THIAZOLIDINEDIONE (A TRIAL OF AT LEAST TWO OF THESE THREE AGENTS IS REQUIRED) AND HAVE DEMONSTRATED A LACK OF EFFICACY OF INSULIN AND DOCUMENTATION THAT INSULIN WILL BE	LIFETIME	REQUIRES DOCUMENTATION OF DIAGNOSIS AND MEDICATION HISTORY OR INTOLERANCE(S).	NON TYPE 2 DIABETES DIAGNOSIS. NO EVIDENCE OF CONCURRENT METFORMIN OR SULFONYLUREA USE. BYETTA WILL NOT BE COVERED FOR WEIGHT LOSS IN PATIENTS WITH OR WITHOUT DIABETES.

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		DISCONTINUED. IN ADDITION TO THE ABOVE CRITERIA THE PATIENT MUST HAVE A HEMOGLOBIN A1C OF GREATER THAN 7 PER CENT. SYMLIN IS COVERED FOR PATIENTS THAT HAVE FAILED INTENSIVE TREATMENT WITH INSULIN MONOTHERAPY. SYMLIN IS COVERED FOR CONCURRENT USE WITH AN INSULIN PRODUCT. COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE COVERED BY PART D.			
1/1/10	MOZOBIL	COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE EXCLUDED BY PART D. COVERED FOR PATIENTS REQUIRING AUTOLOGOUS TRANSPLANTATION, WHEN POOR RESPONSE IS DOCUMENTED TO	COVERED FOR DURATION REQUESTED UP TO ONE MONTH.	DOCUMENTATION OF DIAGNOSIS AND THAT GRANULOCYTE COLONY STIMULATING FACTOR IS ADMINISTERED CONCOMITANTLY, AND DOCUMENTATION OF POOR RESPONSE TO APHERESIS WITH GRANULOCYTE	

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		APHERESIS WITH GRANULOCYTE COLONY STIMULATING FACTOR ALONE, AND COVERED FOR PATIENTS WITH NON-HODGKINS LYMPHOMA AND MULTIPLE MYELOMA.		COLONY STIMULATING FACTOR ALONE.	
1/1/10	NARCOTIC ANALGESICS	ACTIQ AND FENTORA ARE COVERED FOR CANCER OR CANCER RELATED DIAGNOSIS IN PATIENTS ALREADY RECEIVING LONG ACTING OPIOIDS. OXYCONTIN EXTENDED RELEASE TABLETS ARE COVERED FOR THE MANAGEMENT OF MODERATE TO SEVERE PAIN WHEN A CONTINUOUS, AROUND-THE-CLOCK ANALGESIC IS NEEDED FOR AN EXTENDED PERIOD OF TIME, AND TRIALS OF EXTENDED RELEASE MORPHINE,	COVERED THROUGH REMAINDER OF PLAN YEAR UP TO ONE YEAR	REQUIRES DOCUMENTATION OF DIAGNOSIS AND MEDICATION HISTORY OR INTOLERANCE(S).	

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		METHADONE, AND FENTANYL PATCHES IS UNSUCCESSFUL. COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE EXCLUDED BY PART D.			
1/1/10	NEUROPATHIC PAIN TREATMENT	COVERED FOR FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. LYRICA IS COVERED FOR PATIENTS WITH SEIZURES. LYRICA OR SAVELLA ARE COVERED FOR PATIENTS WITH FIBROMYALGIA.	COVERED THROUGH REMAINDER OF PLAN YEAR UP TO ONE YEAR	REQUIRES DOCUMENTATION OF DIAGNOSIS AND MEDICATION HISTORY OR INTOLERANCE(S).	EXCLUDED FOR NON FDA OR UNSUPPORTED USE.

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1/1/10	OMEPRAZOLE 40MG	COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE EXCLUDED BY PART D.	COVERED THROUGH REMAINDER OF PLAN YEAR UP TO ONE YEAR	DOCUMENTATION OF INTOLERANCE TO 2 DOSES OF 20MG OMEPRAZOLE.	
1/1/10	PROMACTA	COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE EXCLUDED BY PART D.	INITIATION OF THERAPY - 12 WEEKS APPROVAL, CONTINUATION THERAPY - 12 MONTHS APPROVAL	INITIAL COVERAGE IS PROVIDED FOR PROMACTA IN PATIENTS WHO MEET THE FOLLOWING CRITERIA: AGE 18 YEARS OR GREATER, DIAGNOSIS OF CHRONIC IMMUNE THROMBOCYTOPENIA	PROMACTA IS CONSIDERED NOT MEDICALLY NECESSARY FOR ALL OTHER CLINICAL CONDITIONS INCLUDING ACUTE THROMBOCYTOPENIA, DRUG-INDUCED THROMBOCYTOPENIA, FOR EXAMPLE INDUCED

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				<p>PURPURA DEFINED BY DIAGNOSIS BY OR IN CONSULTATION WITH A HEMATOLOGIST, PERSISTENT THROMBOCYTOPENIA DEFINED BY PLATELET COUNT LESS THAN 150,000 MCL FOR MINIMUM 2 MONTHS, AND INADEQUATE RESPONSE OR DOCUMENTED INTOLERANCE FOR THERAPY WITH CORTICOSTEROIDS, IMMUNOGLOBULINS, OR SPLENECTOMY AND CURRENT PLATELET COUNT OF LESS THAN OR EQUAL TO 50,000 MCL AND A PRESCRIBED DAILY DOSE OF 75MG OR LESS. RENEWAL OF THERAPY IS COVERED FOR PATIENTS WHO MEET THE FOLLOWING CRITERIA: RECENT PLATELET COUNT OF 30,000 TO 150,000 MCL, AND A DAILY DOSE OF 75MG OR LESS.</p>	<p>BY CHEMOTHERAPY, HEPARIN, OR QUINIDINE. PROMACTA IS CONSIDERED NOT MEDICALLY NECESSARY FOR THROMBOCYTOPENIA SECONDARY TO: CANCER, MYELODYSPLASTIC SYNDROME, HIV, HEPATITIS, SYSTEMIC LUPUS ERYTHEMATOSUS, HEMANGIOMAS, MASSIVE BLEEDING, THROMBOTIC THROMBOCYTOPENIC PURPURA, OR HEMOLYTIC UREMIC SYNDROME. ALL REQUESTS NOT MEETING CRITERIA WILL BE REVIEWED BY A PLAN PHYSICIAN FOR POTENTIAL USE.</p>

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1/1/10	PULMONARY AGENTS	LETAIRIS, REVATIO, ADCIRCA, TRACLEER AND VENTAVIS ARE COVERED FOR ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ONE YEAR OR COVERED THROUGH REMAINDER OF PLAN YEAR WHICHEVER IS GREATER		COVERAGE FOR REVATIO IS NOT PROVIDED IN SITUATIONS WHERE PATIENTS ARE RECEIVING NITRATE THERAPY.
1/1/10	RELISTOR	COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE EXCLUDED BY PART D.	THREE MONTHS	REQUIRES ADEQUATE TREATMENT CONSISTING OF 5 DAYS DURATION OF TREATMENT OF AGENTS FOR CONSTIPATION, INCLUDING ANY OF THE FOLLOWING: BULK LAXATIVES, SALINE LAXATIVES OR OSMOTIC LAXATIVES. COVERAGE MAY NOT BE PROVIDED IF THERE ARE CONTRAINDICATIONS TO METHYLNALTREXONE THERAPY.	
1/1/10	REMICADE	COVERED FOR MEMBERS WITH MODERATE TO	COVERED THROUGH REMAIN-	REQUIRES DOCUMENTATION OF DIAGNOSIS,	REMICADE IS NOT COVERED AS FIRST LINE TREATMENT OF

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		<p>SEVERELY ACTIVE CROHN'S WHO HAVE AN INADEQUATE RESPONSE TO CONVENTIONAL THERAPY. CONVENTIONAL THERAPY INCLUDES, BUT IS NOT LIMITED TO: SULFASALAZINE, MESALAMINE OR 5-ASA AGENTS, CORTICOSTEROIDS, ANTIBIOTICS, OR OTHER DRUGS THAT AFFECT THE IMMUNE SYSTEM SUCH AS AZATHIOPRINE OR 6-MERCAPTOPYRIMIDINE (6-MP). REMICADE IS ALSO COVERED FOR FIRST-LINE TREATMENT FOR MEMBERS WITH CROHN'S DISEASE ASSOCIATED WITH FISTULAS TO REDUCE THE NUMBER OF DRAINING ENTEROCUTANEOUS FISTULA(S). COVERED FOR THE TREATMENT OF</p>	<p>DER OF PLAN YEAR UP TO ONE YEAR</p>	<p>MEDICATION HISTORY AND/OR INTOLERANCE(S).</p>	<p>RHEUMATOID ARTHRITIS OR CROHN'S DISEASE (OTHER THAN FISTULIZING CROHN'S DISEASE, SEE INCLUSION CRITERIA), THEREFORE REMICADE IS NOT COVERED WHEN CONVENTIONAL, CONSERVATIVE TREATMENTS HAVE NOT BEEN ATTEMPTED FOR THESE DIAGNOSES. REMICADE IS NOT COVERED FOR DERMATOLOGIC MANIFESTATIONS OF PSORIASIS. REMICADE IS NOT COVERED FOR JUVENILE RHEUMATOID ARTHRITIS. REMICADE IS NOT COVERED FOR OTHER SPONDYLOARTHROPATHIES EXCEPT FOR ANKYLOSING SPONDYLITIS AND PSORIATIC ARTHRITIS. REMICADE IS NOT COVERED IN PATIENTS WITH ACTIVE SERIOUS INFECTIONS.</p>

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		<p>MODERATE TO SEVERELY ACTIVE RHEUMATOID ARTHRITIS FOR THE REDUCTION OF THE SIGNS AND SYMPTOMS ASSOCIATED WITH THE DISEASE FOR MEMBERS WHO HAVE AN INADEQUATE RESPONSE TO CONVENTIONAL THERAPY. CONVENTIONAL THERAPY INCLUDES BUT IS NOT LIMITED TO: NSAIDS (NON-STEROIDAL ANTI-INFLAMMATORY DRUGS), COX-2 INHIBITORS, CORTICOSTEROIDS, METHOTREXATE, OR GOLD INJECTIONS. REMICADE IS COVERED FOR ANKYLOSING SPONDYLITIS, PSORIATIC ARTHRITIS, BEHCET'S DISEASE. REMICADE IS COVERED FOR</p>			

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		MODERATELY TO SEVERELY ACTIVE ULCERATIVE COLITIS IN PATIENTS WHO HAVE HAD AN INADEQUATE RESPONSE TO CONVENTIONAL THERAPY. COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE EXCLUDED BY PART D.			
1/1/10	SANCUSO	COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE EXCLUDED BY PART D. COVERED FOR THE PREVENTION AND OR TREATMENT OF NAUSEA AND OR VOMITING ASSOCIATED WITH CHEMOTHERAPY AND OR RADIATION.	COVERED THROUGH REMAINDER OF PLAN YEAR UP TO ONE YEAR	COVERED IF TREATMENT WITH GENERIC ONDANSETRON AND ORAL GRANISETRON IS NOT EFFECTIVE OR IS NOT TOLERATED.	SANCUSO IS NOT COVERED FOR HYPEREMESIS GRAVIDARUM, NAUSEA AND VOMITING OF PREGNANCY, AND POST-OPERATIVE NAUSEA AND VOMITING.
1/1/10	SAPROPTERIN HYDROCHLORIDE	COVERED FOR PATIENTS WITH HYPERPHENYLALANINEMIA (HPA) DUE TO TETRAHYDROBIOPTE	TWO MONTHS AUTHORIZATION WILL BE	DOCUMENTATION OF DIETARY RESTRICTIONS AND DIAGNOSIS FOR APPROVAL.	EXCLUDED FOR NON FDA OR UNSUPPORTED USE.

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		RIN (BH4) RESPONSIVE PHENYLKETONURIA (PKU).	EXTENDED FOR ONE YEAR IF DOCUMENT-ED RESPONSE AFTER INITIAL THERAPY OF 2 MONTHS. DOCUMENT-ED RESPONSE INCLUDES A 30% OR GREATER REDUC-TION IN PHENYLAL ANINE FROM BASELINE.		
1/1/10	TEKTURNA/HCT	COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE EXCLUDED BY PART D.	COVERED THROUGH REMAINDER OF PLAN YEAR UP TO ONE YEAR	COVERAGE REQUIRES DOCUMENTATION OF TRIAL AND FAILURE OF ONE DRUG IN ANY TWO OF THE FOLLOWING CLASSES: DIURETICS, BETA BLOCKERS, ANGIOTESIN CONVERTING ENZYMES	

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				AND ANGIOTENSIN RECEPTOR BLOCKERS	
1/1/10	TNF ALPHA AGENTS	<p>FOLLOWING CRITERIA ARE USED IN REVIEWING ENBREL:</p> <p>1. FOR RHEUMATOID ARTHRITIS, JUVENILE RA OR PSORIATIC ARTHRITIS, ENBREL REQUIRES A THREE MONTH TRIAL ON TWO CONCURRENT NONBIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS), ONE OF WHICH MUST BE METHOTREXATE UNLESS CONTRAINDICATED.</p> <p>2. FOR MODERATE TO SEVERE PSORIASIS, A MINIMUM OF 3 MONTHS OF PREVIOUS TREATMENT WITH A TOPICAL STEROID AND 3 MONTHS TREATMENT WITH PUVA (UNLESS PUVA CONTRAINDICATED)</p>	COVERED THROUGH REMAINDER OF PLAN YEAR UP TO ONE YEAR	COVERAGE MAY ALSO REQUIRE DOCUMENTATION OF INFECTION RISKS, ESPECIALLY TUBERCULOSIS.	TNF ALPHA AGENTS ARE NOT COVERED IN PATIENTS WITH ACTIVE SERIOUS INFECTIONS. REQUIRES DOCUMENTATION OF DIAGNOSIS AND MEDICATION HISTORY OR INTOLERANCE(S).

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		<p>AND THERAPY MUST BE SUPERVISED BY A DERMATOLOGIST. 3. FOR ALKYLOSING SPONDYLITIS, REQUIRES THERAPY IS BEING SUPERVISED BY A RHEUMATOLOGIST. FOLLOWING CRITERIA ARE USED IN REVIEWING HUMIRA:</p> <p>1. FOR RHEUMATOID ARTHRITIS, JUVENILE RA OR PSORIATIC ARTHRITIS, HUMIRA REQUIRES A THREE MONTH TRIAL ON TWO CONCURRENT NONBIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS), ONE OF WHICH MUST BE METHOTREXATE UNLESS CONTRAINDICATED.</p> <p>2. FOR CROHN'S DISEASE, HUMIRA IS COVERED FOR PATIENTS AGE 18 YEARS OR OLDER, WITH A DIAGNOSIS OF</p>			

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		<p>MODERATELY TO SEVERELY ACTIVE CROHN'S DISEASE WITH A HISTORY OF INADEQUATE RESPONSE TO CONVENTIONAL THERAPY. 3. FOR ALKYLISING SPONDYLITIS, REQUIRES THERAPY IS BEING SUPERVISED BY A RHEUMATOLOGIST. 4. FOR MODERATE TO SEVERE PSORIASIS, A MINIMUM OF 3 MONTHS OF PREVIOUS TREATMENT WITH A TOPICAL STEROID AND 3 MONTHS TREATMENT WITH PUVA (UNLESS PUVA CONTRAINDICATED) AND THERAPY MUST BE SUPERVISED BY A DERMATOLOGIST. FOLLOWING CRITERIA ARE USED IN REVIEWING KINERET: 1. FOR RHEUMATOID ARTHRITIS, KINERET</p>			

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		<p>REQUIRES A THREE MONTH TRIAL ON TWO CONCURRENT DISEASE NONBIOLOGIC MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS), ONE OF WHICH MUST BE METHOTREXATE UNLESS CONTRAINDICATED AND TREATMENT FAILURE OR CONTRAINDICATION TO ENBREL AND HUMIRA. AS NEW FDA APPROVED INDICATIONS BECOME AVAILABLE PLAN WILL CONSIDER COVERAGE ACCORDINGLY. COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE EXCLUDED BY PART D.</p>			
1/1/10	WOUND CARE	COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE EXCLUDED BY PART	COVERED THROUGH REMAIN- DER OF	REQUIRES ADEQUATE TISSUE OXYGENATION AT THE SITE OF THE NEUROPATHIC	

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		D. COVERED FOR PATIENTS WITH CHRONIC NEUROPATHIC DIABETIC ULCER OF THE LOWER EXTREMITY.	PLAN YEAR UP TO ONE YEAR	DIABETIC ULCER, AND THAT THERE IS A FULL THICKNESS ULCER (FOR EXAMPLE STAGE THREE OR FOUR) EXTENDING THROUGH THE DERMIS INTO SUBCUTANEOUS TISSUE. IN ADDITION, REQUIRES THAT THE PATIENT IS PARTICIPATING IN A COMPREHENSIVE WOUND CARE TREATMENT PLAN INCLUDING SUCH MODALITIES AS DEBRIDEMENT, PRESSURE RELIEF (FOR EXAMPLE, NON WEIGHT BEARING) AND INFECTION CONTROL.	
1/1/10	XENAZINE	COVERED FOR ALL FDA APPROVED USES NOT OTHERWISE EXCLUDED BY PART D. COVERED FOR THE TREATMENT OF CHOREA ASSOCIATED WITH HUNTINGTONS DISEASE. FOR DOSES ABOVE 50MG PER	LIFETIME		COVERAGE FOR XENAZINE WILL NOT BE PROVIDED FOR PATIENTS WHO HAVE HEPATIC FUNCTION IMPAIRMENT, PATIENTS WHO ARE ACTIVELY SUICIDAL OR WHO HAVE UNTREATED OR INADEQUATELY TREATED DEPRESSION, OR

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		DAY, DOCUMENTATION OF CYP2D6 GENOTYPE OF THE PATIENT WILL BE REQUIRED.			PATIENTS TAKING MONAMINE OXIDASE INHIBITORS OR RESERPINE.