Blue Care Network commercial (HMO) requirements for drugs covered under the medical benefit

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REV: May 17, 2018

Drug Information			Authorization Criteria									Quantity Limit	
Procedure Code	Generic Name	Brand Name	Authorization required?	Age	Diagnosis	Physician Specialty	Genetic Testing	Laboratory Results	Treatment History	Site of Care	Clinical documentation Required	Authorization Summary	Quantity Limit	Quantity Limit Summary
J0129	ABATACEPT	Orencia®	X	X	X	X			X	X		· Diagnosis of rheumatoid arthritis - Prescribing physician is a rheumatologist - Previous treatment failure with one DMARD for 3 months - Previous treatment failure with Remicade®/ Renflexis™/ Inflectra™ OR Simponi Aria® - Should not be used in combination with another TNF antagonist **OR** · Diagnosis of juvenile idiopathic arthritis in patients 6 years and older - Prescribing physician is a rheumatologist· - Previous treatment failure with one DMARD for 3 months - Previous treatment failure with Humira® OR Remicade® **OR** · Diagnosis of psoriatic arthritis in patients 18 years and older - Prescribing physician is a rheumatologist or dermatologist - Previous treatment failure with one DMARD for 3 months - Previous treatment failure with Remicade®/ Renflexis™/ Inflectra™ - Should not be used in combination with another TNF antagonist · Any additional pertinent medical information	X	· Rheumatoid arthritis - Induction (doses given at 0, 2, and 4 weeks): < 60 kg: 500 mg 60 - 100 kg: 750 mg > 100 kg: 1,000 mg - Maintenance (doses given monthly): < 60 kg: 500 mg 60 - 100 kg: 750 mg > 100 kg: 1,000 mg · Juvenile arthritis - Induction (doses given at 0, 2, and 4 weeks): < 75 kg: 10 mg/kg 75 - 100 kg: 750 mg > 100 kg: 1,000 mg - Maintenance (doses given monthly): < 75 kg: 10 mg/kg 75 - 100 kg: 750 mg > 100kg: 1,000 mg
J0586	ABOBOTULINUMTOXINA	Dysport®	X		X				X			· Diagnosis the medication is being used to treat · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		
J9354	ADO-TRASTUZUMAB EMTANSINE	Kadcyla™	X		X				X		**X**	· Diagnosis of HER2-positive metastatic breast cancer · Previous treatment failure with trastuzumab AND a taxane (separately or in combination) · Any additional pertinent medical information		
J0178	AFLIBERCEPT	Eylea™	X		X	X			X			· Diagnosis of neovascular (wet) age-related macular degeneration (AMD) **OR** · Diagnosis of macular edema due to retinal vein occlusion (RVO) **OR** · Diagnosis of diabetic macular edema (DME) **OR** · Diagnosis of diabetic retinopathy (DR) in patients with DME · Prescribing physician is a ophthalmologist · Previous treatment failure with Avastin (bevacizumab) · Any additional pertinent medical information	X	· Diabetic macular edema (DME) & macular edema following retinal vein occlusion (RVO) - 2 mg every 4 weeks x 5 doses, then every 8 weeks thereafter · Wet age-related macular degeneration (AMD) - 2 mg every 4 weeks
J0180	AGALSIDASE BETA	Fabrazyme®	X		X	X	X	X		X		· Diagnosis of Fabry disease - Male diagnosis: deficient activity of enzyme α-galactosidase in plasma and/or leukocytes AND GLA mutation - Female diagnosis: GLA mutation · Evidence of symptomatic manifestations of disease · Diagnosis made by or in consultation with a geneticist or metabolic specialist · Any additional pertinent medical information		
J0202	ALEMTUZUMAB	Lemtrada™	X	X	X	X		X	X			· Diagnosis of a relapsing form of multiple sclerosis with evidence of disease activity demonstrated by: - Clinical documentation within the past 12 months **OR** - New lesion on an MRI within the past 6 months · Confirmation of varicella zoster virus (VZV) vaccination status · Confirmation that anti-viral prophylaxis for herpetic infections will be initiated upon starting Lemtrada therapy · Patient is greater than or equal to 18 years of age · Prescribing physician is a neurologist · Previous treatment failure with all of the following therapies: - One preferred oral agent - One preferred self-injectable agent - Ocrevus™ · Any additional pertinent medical information		
J0221	ALGLUCOSIDASE ALFA	Lumizyme®	X		X	X	X	X		X		· Diagnosis of infantile-onset or late-onset (non-infantile) Pompe disease without evidence of cardiac hypertrophy · Diagnosis confirmed by the absence of acid alpha glucosidase (GAA) activity confirmed by GAA mutation testing or GAA activity testing in fibroblasts or muscle · Diagnosis supported by a series of screening tests (e.g., chest X-ray, electrocardiogram [ECG], electromyogram [EMG], creatine kinase [CK], among other laboratory tests) · Diagnosis made by or in consultation with a geneticist or metabolic specialist · Any additional pertinent medical information		

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J0256	ALPHA 1 PROTEINASE INHIBITOR	Aralast®, Prolastin®-C/Liquid, Zemaira®	X	X	X			X	X	X		· Diagnosis of alpha-1 antitrypsin deficiency (AATD) · Diagnosis confirmed by alpha-1 antitrypsin serum levels · Patient is a non-smoker · Evidence of symptomatic emphysema · Evidence of deteriorating pulmonary function demonstrated by FEV1 decline · Patient is greater than or equal to 18 years of age · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		
J0257	ALPHA 1 PROTEINASE INHIBITOR	Glassia™	X	X	X			X	X	X		· Diagnosis of alpha-1 antitrypsin deficiency (AATD) · Diagnosis confirmed by alpha-1 antitrypsin serum levels · Patient is a non-smoker · Evidence of symptomatic emphysema · Evidence of deteriorating pulmonary function demonstrated by FEV1 decline · Patient is greater than or equal to 18 years of age · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · May be self-administered after appropriate training · Any additional pertinent medical information		
J7186	ANTIHEMOPHILIC FACTOR VIII/VWB COMPLEX (HUMAN)	Alphanate®											X	· Hemophilia A - Body weight (kg) x desired factor VIII rise (IU/dL or % of normal) x 0.5 (IU/kg per IU/dL) OR IU/dL (or # normal) twice daily for 1-10 days · Von Willebrand disease - Adults: Pre-operative dose of 60 IU VWF:RCo/kg body weight; subsequent doses of 40-60 IU; VWF:RCo/kg body weight at 8-12-hour intervals post-operatively, if needed - Pediatric: Pre-operative dose of 75 IU VWF:RCo/kg body weight; subsequent doses of 50-75 IU; VWF:RCo/kg at 8-12 hours post-operative as clinically needed
J9022/ J9999	ATEZOLIZUMAB	Tecentriq™	X	X	X	X		X	X			· Patient is greater than or equal to 18 years of age · Prescribing physician is an oncologist · No prior therapy with a PD-1 inhibitor · Used a monotherapy · Any additional pertinent medical information **AND** · One of the following diagnoses: · Diagnosis of locally advanced or metastatic urothelial carcinoma · Patient not eligible for cisplatin containing chemotherapy OR · Disease progression experienced with: - Platinum-containing chemotherapy OR - Within 12 months of neoadjuvant or adjvuant treatment with platinum-containing chemotherapy **OR** - Diagnosis of metastatic non-small cell lung cancer (NSCLC) - Previous treatment failure with: - Platinum-based chemotherapy **AND** - EGFR or ALK inhibitors if EGFR or ALK mutation positive, respectively		

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J9999 / J9023	AVELUMAB	Bavencio®	X	X	X	X			X			· Prescribing physician is an oncologist · No prior therapy with a PD-1 inhibitor · Used a monotherapy AND · One of the following diagnoses: · Diagnosis of locally advanced or metastatic urothelial carcinoma · Patient is greater than or equal to 18 years of age · Disease progression experienced with: - Platinum containing chemotherapy OR - Within 12 months of neoadjuvant or adjvuant treatment with platinum containing chemotherapy OR · Diagnosis of metastatic Merkel cell carcinoma · Patient is greater than or equal to 12 years of age · Any additional pertinent medical information		
J3490	AXICABTAGENE CILOLEUCEL	Yescarta™	X		X	X		X	X		**X**	· Prescribed by an oncologist · Patient is age 18 years or older · Documentation of CD 19 tumor expression · Received prior therapy with Anti-CD20 monoclonal antibody unless investigator determines otherwise · Received an anthracycline containing chemotherapy regimen · Have not received prior treatment with Yescarta or any other gene therapy or are being considered for other gene therapy · Documentation showing response to Yescarta treatment must be provided within 3 months of treatment AND · Treatment of relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, primary mediastinal large B-cell lymphoma (PMBCL), high grade B-cell lymphoma, and DLBCL arising from follicular lymphoma (FL) OR · For patients with transformed FL, must have received prior chemotherapy for FL and subsequently have chemorefractory disease after transformation to DLBCL		
J0490	BELIMUMAB	Benlysta®	X		X			X	X	X		· Diagnosis of systemic lupus erythematosus (SLE) · Seropositive laboratory results at two independent time points · Disease activity > 6 as indicated by the Safety of Estrogens in Lupus: National Assessment modification (SELENA-SLEDAI) score · No evidence that severe lupus nephritis, active nephritis, or central nervous system lupus · Previous treatment failure with TWO or more of the following for at least 12 weeks of therapy: - Chloroquine, hydroxychloroquine, methotrexate, azathioprine, cyclophosphamide AND/OR mycophenolate mofetil · Any additional pertinent medical information		
J9032	BELINOSTAT	Beleodaq®	X		X	X			X			· Diagnosis of relapsed or refractory peripheral T-cell lymphoma (PTCL) · Prescribing physician is an oncologist · Previous treatment failure with at least one prior therapy · Any additional pertinent medical information		
J9033	BENDAMUSTINE	Treanda®											X	· Chronic lymphocytic leukemia (CLL) - 100 mg/m2 per dose given for 2 days of a 28-day cycle - Up to 6 cycles administered · Non-Hodgkin's lymphoma (NHL) - 120 mg/m2 for 2 days of a 21-day cycle - Up to 8 cycles administered
J3490/ J3590	BENRALIZUMAB	Fasenra™	X	X	X	X		X	X			Used as add-on maintenance treatment for the diagnosis of severe eosinophillic asthma confirmed by: - Blood eosinophilis > 300 cells/mcL in the past 12 months AND - Repeated hospital/ED visits AND - Regular use of oral and high dose inhaled corticosteroids AND · Confirmation Fesanra will not be used in combination with another biologic for asthma · Patient is greater than or equal to 12 years of age · Prescriber physician is an allergist, immunologist, or pulmonologist · Trial and failure of all preferred products · Any additional pertinent medical information		

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J9035	BEVACIZUMAB	Avastin®											X	· Colorectal cancer: - 5 mg/kg to 10 mg/kg (dose depends on chemotherapy regimen) · Non-small cell lung cancer (NSCLC) & cervical cancer - 15 mg/kg per dose · Renal cell carcinoma (RCC)/gliobastoma - 10 mg/kg per dose; 20 mg/kg per month · Breast cancer - 10 mg/kg per dose; 20 mg/kg per month
J3590 / J0565	BEZLOTOXUMAB	Zinplava®	X	X	X	X		X	X			· Diagnosis of clostridium dificile infection (CDI) and a positive stool test · Patient at high risk of CDI recurrence including: - Patients 65 years of age and older - History of CDI in the past 6 months - Immunocompromised state - Severe CDI at presentation - Clostridium dificile ribotype 027 · Prescribed by or in consultation with a gastroenterologist or infectious disease specialist · Patient 18 years of old or greater · Used in conjunction with standard of care antibacterial agents (i.e. metronidazole or vancomycin) · Any additional pertinent medical information		
J9039	BLINATUMOMAB	Blincyto™	X		X		X		X			· Diagnosis of B-cell precursor acute lymphoblastic leukemia (ALL) confirmed by Philadelphia (Ph) chromosome negative genetic testing · Documentation of relapsed or refractory disease · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		
J9041	BORTEZOMIB	Velcade®											X	· Mantle cell lymphoma (MCL) & multiple myeloma (MM) - 1.3 mg/m2 per dose
J9042	BRENTUXIMAB VEDOTIN	Adcetris™											X	· Hodgkin's lymphoma & systemic anaplastic large-cell lymphoma - 1.8 mg/kg per dose
J0570	BUPRENORPHINE IMPLANT	Probuphine®	X		X	X			X			· Diagnosis of opioid dependence with documented use of validated screening tools (for example, DSM-IV, DAST-10, SIP, CINA, COW, etc) · Prescriber must be part of REMS program and specialize in either pain or addiction · Patient must have achieved and sustained prolonged clinical stability on low-to-moderate doses of a transmucosal buprenorphine-containing product: - For example: doses of no more than 8 mg per day of Subutex or Suboxone sublingual tablet or generic equivalent - Patient must be on this dose for at least 3 months without any need for supplemental dosing or adjustments - Patient must not be tapered down to this dose for the sole purpose of transitioning to Probuphine · Must be used in conjunction with a complete treatment program which includes both counseling and psychosocial support - Patient must show they understand the program and agree to be compliant · Must not be used in combination with other buprenorphine or opioid agents · Patient must signed informed consent · Any additional pertinent medical information		
J3590	BUROSUMAB-TWZA	Crysvita®	X	X	X	X		X	X	X		· 18-65 years old · Prescribed by Endocrinologist · Treatment for the underlying cause of X-linked hypophosphatemia (XLH) · Serum Pi < 2.5 mg/dL · Measurable bone/joint pain (≥4 BPI-Q3 Worst Pain) · Trial and failure of preferred products		
J0597	C-1 ESTERASE	Berinert®	X		X	X		X	X	X		· Diagnosis of Type I or Type II hereditary angioedema (HAE) · Laboratory results confirming diagnosis (Include all of the following: C1q, C4, and C1 INH levels) · Diagnosed by an immunologist, allergist, or hematologist · Previous treatment failure with attenuated androgens (i.e., danazol, stanozolol, and oxandrolone) for the indication of short-term prophylaxis · Any additional pertinent medical information		

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J0598	C-1 ESTERASE	Cinryze™	X	X	X	X		X	X			· Diagnosis of Type I or Type II hereditary angioedema (HAE) · Laboratory results confirming diagnosis (Include all of the following: C1q, C4, and C1INH levels) · Documented history of at least 2 HAE attacks per month OR history of attacks that are considered severe with swelling of face, throat or gastrointestinal tract · Patient is greater than or equal to 9 years of age · Diagnosed by an immunologist, allergist, or hematologist · Previous treatment failure with attenuated androgens (i.e., danazol, stanozolol, and oxandrolone) for the indication of long-term prophylaxis · Any additional pertinent medical information		
J0596	C1 INHIBITOR RECOMBINANT	Ruconest™	X	X	X	X		X	X	X		· Diagnosis of Type I or Type II hereditary angioedema (HAE) · Documentation supporting absence of laryngeal spasms · Laboratory results confirming diagnosis (Include all of the following: C1q, C4, and C1INH levels) · Patient is greater than or equal to 13 years of age · Diagnosed by an immunologist, allergist, or hematologist · Previous treatment failure with attenuated androgens (i.e., danazol, stanozolol, and oxandrolone) for the indication of short-term prophylaxis · Any additional pertinent medical information		
J9043	CABAZITAXEL	Jevtana®	X		X				X			· Diagnosis of hormone-refractory metastatic prostate cancer previously treated with a docetaxel containing regimen - Given in combination with prednisone - Neutrophil count > 1,500 cells/mm3 · Any additional pertinent medical information		
J0638	CANAKINUMAB	Ilaris®	X		X	X	X	X	X	X	**X**	· Diagnosis of systemic juvenile idiopathic arthritis - Documented active disease while on treatment - Previous treatment failure with all of the following: · Oral non-biologic DMARD, Enbrel, Remicade AND Actemra **OR** · Diagnosis of cryopyrin-associated periodic syndrome (CAPS) - Diagnosis confirmed by evidence of a genetic mutation, such as the cold-induced auto-inflammatory syndrome 1 (CIAS1 or NLRP-3) - Evidence patient is experiencing classic CAPS symptoms (meeting criteria for either Familial Cold Auto-inflammatory Syndrome [FCAS] or Muckle-Wells Syndrome [MWS]) - Clinical documentation supporting significant functional impairment leading to limitations in daily living **OR** · Diagnosis of Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS) in adults and pediatric patients **OR** · Diagnosis of hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD) in adult and pediatric patients **OR** · Diagnosis of Familial Mediterranean Fever (FMF) in adult and pediatric patients who have experienced treatment failure to colchicine. · Any additional pertinent medical information		
J9047	CARFILZOMIB	Kyprolis™	X		X	X			X			· Diagnosis of relapsing or refractory multiple myeloma · Prescribing physician is an oncologist or hematologist · If being used as monotherapy, must have previous treatment failure with at least one other line of therapy such as: - Bortezomib-based regimen - Lenalidomide or thalidomide-based regimen **OR** · If used in combination with dexamethasone OR lenalidomide PLUS dexamethasone, must have previous treatment failure with one to three prior lines of therapy such as: - Bortezomib based regimen - Lenalidomide or thalidomide based regimen · Any additional pertinent medical information		

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J3590	CERLIPONASE ALFA	Brineura™	X	X	X	X	X	X	X			· Diagnosis of late infantile neuronal ceroid lipofuscinosis type 2 (CLN2) · Patient must be age 3 years and older · Prescribing physician is a neurologist, geneticist, or metabolic specialist · Diagnosis must be confirmed by deficiency in tripeptidyl peptidase 1 enzyme OR genetic mutation in CLN2 gene . Patient must be ambulatory at start of treatment . Receiving standard of care regimen for CLN2 (e.g. seizure management, nutritional support, physical therapy) · Any additional pertinent medical information		
J0717	CERTOLIZUMAB PEGOL	Cimzia®	X		X	X			X	X		· Diagnosis of: · Crohns disease - Previous treatment failure with corticosteroid or immunomodulatory agent · Diagnosis of: · Rheumatoid arthritis (RA) · Psoriatic arthritis OR - Previous treatment failure with one non biological DMARD · Diagnosis of: · Ankylosing spondolitis · Any additional pertinent medical information		
J9055	CETUXIMAB	Erbitux®											X	· Head/neck cancer and colorectal cancer - 400 mg/m2, then 250 mg/m2 weekly
J9999	CHEMOTHERAPY DRUG	NOC	X	X	X	X			X		**X**	· Diagnosis the drug is being used to treat · Age of the member · Specialty of the prescribing physician · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		
J0775	COLLAGENASE CLOSTRIDIUM HISTOLYTICUM	Xiaflex®	X	X	X	X			X			· Diagnosis of Depuytren's contracture · Evidence of a finger flexion contracture with a palpable cord involving the metacarpophalangeal (MP) or proximal interphalangeal (PIP) joint is present · Administering physician is a surgeon with experience / training in hand surgeries **OR** · Diagnosis of Peyronie's disease · Evidence of palpable plaque and curvature deformity of ≥ 30 degrees at the start of therapy · Diagnosis made by or in consultation with a urologist · Previous treatment failure with one of the following therapies: intralesional verapamil, pentoxifylline or verapamil gel. **AND** · Patient is greater than or equal to 18 years of age · Facility enrolled to receive Xiaflex through Xiaflex Risk Evaluation and Mitigation (REMS) program · Any additional pertinent medical information		
J7999	COMPOUNDED DRUG	NOC	X	X	X	X			X			· Diagnosis the drug is being used to treat · Age of the member · Specialty of the prescribing physician · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		
J9999	COPANLISIB	Aliqopa™	X		X						**X**	· FDA-approved indications and dosing		
J0800	CORTICOTROPIN	Acthar Gel®	X	X	X							· Diagnosis of infantile spasms · Patient is less than 2 years of age · Any additional pertinent medical information		

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J9145	DARATUMUMAB	Darzalex™	X		X	X			X			· Diagnosis of multiple myeloma · Used as monotherapy when: - Treatment failure with at least 3 prior lines of therapy including a proteasome inhibitor AND and immunomodulatory agent **OR** - Treatment failure with both a proteasome inhibitor AND immumodulatory agent · Used in combination with lenalidomide plus dexamethasone OR bortezomib plus dexamethasone for patients who have received one prior therapy **OR** · Used in combination with pomalidomide and dexamethasone, for the treatment of patients who have received two prior therapies including lenalidomide and a PI · Prescribed by or in consultation with an oncologist or hematologist · Any additional pertinent medical information		
J0897	DENOSUMAB	Prolia®	X		X			X	X			· Diagnosis of one of the following: - Osteoporosis confirmed by a BMD T-score at or below -2.5 at the lumbar spine or total hip - Men at high risk for fracture receiving androgen-deprivation therapy for nonmetastatic prostate cancer - Women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for nonmetastatic breast cancer **AND** · Previous treatment failure with at least one bisphosphonate (either oral or intravenous formulations) · Any additional pertinent medical information		
J0897	DENOSUMAB	Xgeva®	X		X			X	X			· Diagnosis of bone metastases from solid tumors · Treatment failure with at least one intravenous bisphosphonate · Any additional pertinent medical information **OR** · Diagnosis of giant cell tumor of the bone in adults and skeletally mature adolescents · Documentation of confirmed giant cell tumor of bone and radiologic evidence of measurable disease (i.e., CT scan or MRI) · Documentation supporting bone is unresectable or surgical resection is likely to result in severe morbidity · Any additional pertinent medical information **OR** · Diagnosis of hypercalcemia of malignancy (HCM) · Lab results supporting the corrected serum calcium (CSC) ≥ 12 mg/dL (3.0 mmol/L) · Treatment failure with at least one intravenous bisphosphonate · Any additional pertinent medical information		
J9171	DOCETAXEL	Taxotere®											X	· Breast cancer - Locally advanced/metastatic: 100 mg/m2 per dose every 3 weeks - Adjuvant: 75 mg/m2 every per dose every 3 weeks up to 6 cycles · Non-small cell lung cancer (NSCLC)/prostate cancer/gastric adenocarcinoma/ head and neck cancer - 75 mg/m2 per dose every 3 weeks
J9999	DURVALUMAB	Imfinzi™	X	X	X	X			X		**X**	· Prescribing physician is an oncologist · No prior therapy with a PD-1 inhibitor · Used a monotherapy · Patient is greater than or equal to 18 years of age · Diagnosis of locally advanced or metastatic urothelial carcinoma · Disease progression experienced with: - Platinum containing chemotherapy OR - Within 12 months of neoadjuvant or adjvuant treatment with platinum containing chemotherapy		
J3490	DRUGS UNCLASSIFIED	NOC	X	X	X	X			X	X	**X**	· Diagnosis the medication is being used to treat · Age of the member · Specialty of the prescribing physician · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		

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J1290	ECALLANTIDE	Kalbitor®	X		X	X		X	X	X		· Diagnosis of Type I or Type II hereditary angioedema (HAE) · Laboratory results confirming diagnosis ((Include all of the following: C1q, C4, and C1 INH levels) · Diagnosed by an immunologist, allergist, or hematologist · Previous treatment failure with attenuated androgens (i.e., danazol, stanozolol, and oxandrolone) for the indication of short-term prophylaxis · Any additional pertinent medical information		
J1300	ECULIZUMAB	Soliris®	X		X	X		X	X	X	X	· Documentation supporting a meningococcal vaccination will be provided to the member at least 2 weeks prior to Soliris treatment **AND** · Diagnosis of atypical hemolytic uremic syndrome (aHUS) **OR** · Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) · Supporting documentation to confirm the member's platelets > 30,000 ng/mL prior to Soliris therapy in addition to one of the following: - Patient had at least one transfusion in the 24 months preceding Soliris **OR** - Member has documented history of major adverse thrombotic vascular events from thromboembolism **OR** · Diagnosis of refractory, anti-AChR antibody positive myasthenia gravis · Prescribed by a neurologist · Chart notes indicating positive anti-AChR antibody AND one of the following tests - Positive edrophonium test **OR** clinical response to oral cholinesterase inhibitors **OR** electrophysiological evidence of abnormal neuromuscular transmission · No history of thymectomy within past 12 months **OR** thymoma **OR** neoplasms of the thymus · Profound muscle weakness throughout the body · Trial and failure of corticosteroids and at least 2 or more oral immunosuppressive agents · Trial and failure of 3 of the following: cyclophosphamide, rituximab, chronic intravenous immunoglobulin (IVIG), chronic plasma exchange (PLEX) · Any additional pertinent medical information		
J3490	EDARAVONE	Radicava™	X		X	X		X	X		X	· Diagnosis of amyotrophic lateral sclerosis (ALS) - Prescribing physician is a neurologist - Eligible for start of treatment within 2 years of diagnosis OR - After 2 years of diagnosis, with a percent predicted forced vital capacity (FVC) value of ≥ 80 %. - Documentation of a baseline metrics from the ALSFRS-R (Revised ALS Functional Rating Scale) - Receiving treatment with Riluzole · Any additional pertinent medical information		
J1322	ELOSULFASE ALFA	Vimizim™	X	X	X	X	X	X		X		· Diagnosis of mucopolysaccharidosis type IVA (MPS IVA [Morquio A Syndrome]) · Confirmed by serum assays of an enzyme deficiency of N-acetylgalactosamine-6-sulfatase AND urinary glucosaminoglycan (GAG) keratin sulfate · Patient is greater than or equal to 5 years of age · Diagnosis made by or in consultation with a geneticist or metabolic specialist · Any additional pertinent medical information		
J9176	ELOTUZUMAB	Empliciti™	X		X	X			X			· Diagnosis of multiple myeloma · Treatment failure with one to three prior lines of therapy (at least 1 must be a Category 1 treatment based on NCCN guidelines unless all are contraindicated) · Prescribed by or in consultation with an oncologist or hematologist · Used in combination with lenalidomide and dexamethasone · Any additional pertinent medical information		

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J1428	ETEPLIRSEN	Exondys 51™	X	X	X	X		X	X		**X**	Coverage of Exondys 51™ is considered investigational/experimental for all indications and will not be provided.		
J9179	ERIBULIN MESYLATE	Halaven®											X	· Breast cancer - 1.4 mg/m2 per dose, 2 doses given per 21-day cycle
J7187	FACTOR VIII COMPLEX/VON WILLEBRAND FACTOR	Humate-P®											X	· Hemophilia A - 15 to 50 IU/kg once to twice daily · Von Willebrand disease (perioperative management & treatment of spontaneous and trauma-induced bleeding) - Bleed treatment: 40 to 80 IU VWF:RCo per kg body weight every 8-12 hours
J7193	FACTOR IX (ANTIHEMOPHILIC FACTOR, PURIFIED, NON-RECOMBINANT)	AlphaNine® SD, MonoNine®											X	· Hemophilia B - Body weight (kg) x desired increase in plasma factor IX(%) x 1.0 IU/kg twice daily for 1-10 days
J7195	FACTOR IX (ANTIHEMOPHILIC FACTOR, RECOMBINANT)	BeneFIX®											X	· Hemophilia B · Treatment/prophylaxis/perioperative management: Body weight (kg) x desired factor IX increase (IU or % of normal) x reciprocal of observed recovery (IU/kg per IU/dL)
J7190	FACTOR VIII (ANTIHEMOPHILIC FACTOR [HUMAN])	Koate® DVI, Monoclate-P®, Hemofil M®											X	· Hemophilia A - **Koate:** · Body weight (kg) x 5 increase / 2, every 8 to 12 hours - **Monoclate**: · 30-100% correction; surgery dosing is 100% 1 hr before, then 1/2 dose 5 hrs after, then 30% correction for 10-14 days - **Hemofil M**: · Body weight (kg) x desired increase in plasma factor IX (%) x 1.0 IU/dL every 8-24 hours for 1-3 or more days
J7192	FACTOR VIII (NOT OTHERWISE SPECIFIED)	Advate®, Helixate® FS, Kogenate® FS, Recombinate™											X	· Hemophilia A - **Advate:** · Prophylaxis: 40 IU/kg per dose; 640 IU/kg per month every other day · Treatment: Body weight (kg) x desired Factor VIII risk (IU/dL or % of normal) x 0.5 (IU/kg per IU/dL) - **Helixate and Kogenate:** · Prophylaxis: 25 units/kg per dose every other day · Perioperative/control: Body weight (kg) x desired factor VIII rise (IU/dL or % of normal) x 0.5 (IU/kg per IU/dL); frequency determined by bleeding episode - **Recombinate:** · Treatment/prophylaxis/perioperative management: Body weight (kg) x desired factor VIII rise (IU/dL or % of normal) x 0.5 (IU/kg per IU/dL) every 8-24 hours
J7185	FACTOR VIII	Xyntha®											X	· Hemophilia A - Body weight (kg) x desired factor IX ris (IU/dL or % of normal) x 0.5 (IU/kg per IU/dL) every 8-24 hours until resolved
J7200	FACTOR IX (ANTIHEMOPHILIC FACTOR [RECOMBINANT])	Rixubis™											X	Prophylaxis · 60 IU/kg per dose OR 480 IU/kg per month given twice weekly Treatment/perioperative management · Initial dose = body weight (kg) X desired factor IX increased X reciprocal of observed recovery

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J1458	GALSULFASE	Naglazyme®	X		X	X	X	X		X		· Diagnosis of mucopolysaccharidosis (MPS) syndrome VI · Diagnosis confirmed by serum assays of an enzyme deficiency of N-acetylgalactosamine-6-sulfatase AND urinary glucosaminoglycan (GAG) dermatan sulfate · Diagnosis made by or in consultation with a geneticist or metabolic specialist · Any additional pertinent medical information		
J9201	GEMCITABINE	Gemzar®											X	· Breast cancer - 1,250 mg/m2 given 2 days of each 21-day cycle · Non-small cell lung cancer (NSCLC) - 1,000 mg/m2 given on 3 days of each 28-day cycle - 1,250 mg/m2 given for 2 days of each 21-day cycle · Ovarian cancer - 1,000 mg/m2 given weekly for 7 weeks, then weekly every 3 weeks of each 21-day cycle · Pancreatic cancer: - 1,000 mg/m2 given weekly for 7 weeks, then weekly for 3 weeks of each 28-day cycle
J1602	GOLIMUMAB	Simponi® Aria™	X		X	X				X		· Diagnosis of rheumatoid arthritis OR ankylosing spondylitis · Prescribing physician is a rheumatologist OR · Diagnosis of psoriatic arthritis · Prescribing physician is a dermatologist or rheumatologist AND · Any additional pertinent medical information	X	· Rheumatoid arthritis - 2 mg/kg at week 0 and 4, then every 8 weeks thereafter
J9226	HISTRELIN ACETATE	Supprelin® LA Implant											X	· Central precocious puberty - 50 mg per dose once every 12 months in males < 9 years of age and females < 8 years of age
J1726	HYDROXYPROGESTERONE CAPROATE	Makena®	X		X			X				· Administered by a healthcare professional · Ultrasound confirmed gestational age between 16w0d and 20w6d at treatment initiation · Singleton pregnancy · Previous history of spontaneous preterm delivery (<37 weeks gestation) in singleton pregnancy. · No known fetal anomalies incompatible with life · Any additional pertinent medical information	X	250 mg weekly starting at 16 weeks. 0 days gestation to 36 weeks, 6 days gestation for maximum of 21 doses
J1744	ICATIBANT	Firazyr™	X		X	X		X	X	X		· Diagnosis of Type I or Type II hereditary angioedema (HAE) · Laboratory results confirming diagnosis (Include all of the following: C1q, C4, and C1 INH levels) · Diagnosed by an immunologist, allergist, or hematologist · Previous treatment failure with attenuated androgens (i.e., danazol, stanozolol, and oxandrolone) for the indication of short-term prophylaxis · Any additional pertinent medical information		
J1743	IDURSULFASE	Elaprase®	X		X	X	X	X		X		· Diagnosis of mucopolysaccharidosis II (MPS II [Hunter's Syndrome]) · Diagnosis confirmed by serum assays of an enzyme deficiency of iduronate sulfatase AND urinary glucosaminoglycan (GAG), dermatan sulfate or heparin sulfate · Diagnosis made by or in consultation with a geneticist or metabolic specialist · Any additional pertinent medical information		
J1786	IMIGLUCERASE	Cerezyme®	X		X	X	X	X	X	X		· Diagnosis of Type 1 Gaucher disease confirmed by: - Two pathogenic mutations of glucocerebrosidase gene **OR** - Assay of glucocerebrosidase activity in WBCs or skin fibroblasts · Evidence of symptomatic manifestations of disease · Diagnosis made by or in consultation with a geneticist or metabolic specialist · Any additional pertinent medical information		

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J1555	IMMUNE GLOBULIN	Cuvitru™	X		X			X	X	X	**X**	· Diagnosis of a primary humoral immunodeficiency disease (i.e., X-linked agammaglobulinemia, hypogammaglobulinemia, common variable immunodeficiency (CVID), immunoglobulin subclass deficiency, combined immunodeficiency syndromes) · Pertinent laboratory results to confirm diagnosis (for example, baseline IgG level plus laboratory findings to support diagnosis) · Names of medications previously used to treat this condition, including: · Dosages · Dates of therapy · Response to therapy · Any additional pertinent medical information		
J1575	IMMUNE GLOBULIN	Hyqvia®	X		X			X	X	X	**X**	· Diagnosis of a primary humoral immunodeficiency disease (i.e., X-linked agammaglobulinemia, hypogammaglobulinemia, common variable immunodeficiency (CVID), immunoglobulin subclass deficiency, combined immunodeficiency syndromes) · Pertinent laboratory results to confirm diagnosis (for example, baseline IgG level plus laboratory findings to support diagnosis) · Names of medications previously used to treat this condition, including: · Dosages · Dates of therapy · Response to therapy · Any additional pertinent medical information		
J1556	IMMUNE GLOBULIN	Bivigam™ /Gammagard® S/D less IgA	X		X			X	X	X	**X**	· Diagnosis the medication is being used to treat · Pertinent lab results to confirm diagnosis · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		
J1572	IMMUNE GLOBULIN	Flebogamma®	X		X			X	X	X	**X**	· Diagnosis the medication is being used to treat - Pertinent lab results to confirm diagnosis · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		
J1569	IMMUNE GLOBULIN	Gammagard®	X		X			X	X	X	**X**	· Diagnosis the medication is being used to treat - Pertinent lab results to confirm diagnosis · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		
J1557	IMMUNE GLOBULIN	Gammaplex®	X		X			X	X	X	**X**	· Diagnosis the medication is being used to treat - Pertinent lab results to confirm diagnosis · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		
J1561	IMMUNE GLOBULIN	Gamunex®-C/ Gammaked™	X		X			X	X	X	**X**	· Diagnosis the medication is being used to treat - Pertinent lab results to confirm diagnosis · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		

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J1559	IMMUNE GLOBULIN	Hizentra®	X		X			X	X	X	**X**	· Diagnosis the medication is being used to treat - Pertinent lab results to confirm diagnosis · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		
90283	IMMUNE GLOBULIN	Immune Globulin (IgIV)	X		X			X	X	X	**X**	· Diagnosis the medication is being used to treat - Pertinent lab results to confirm diagnosis · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		
90284	IMMUNE GLOBULIN	Immune globulin (SCIg)	X		X			X	X	X	**X**	· Diagnosis the medication is being used to treat - Pertinent lab results to confirm diagnosis · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		
J1566	IMMUNE GLOBULIN	Carimune® NF	X		X			X	X	X	**X**	· Diagnosis the medication is being used to treat - Pertinent lab results to confirm diagnosis · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		
J1568	IMMUNE GLOBULIN	Octagam®	X		X			X	X	X	**X**			
J1459	IMMUNE GLOBULIN	Privigen®	X		X			X	X	X	**X**	· Diagnosis the medication is being used to treat - Pertinent lab results to confirm diagnosis · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		
J0588	INCOBOTULINUMTOXIN A	Xeomin®	X		X				X			· Diagnosis the medication is being used to treat · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		
J1745	INFLIXIMAB	Remicade®	X	X	X	X			X	X		· Diagnosis the medication is being used to treat · Any additional pertinent medical information	X	· Ankylosing spondylitis -10mg/kg every 6 weeks · Crohn's disease (pediatric) · Psoriasis / psoriatic arthritis · Ulcerative colitis -10mg/kg every 8 weeks · Rheumatoid Arthritis - 10 mg/kg every 4 weeks · Crohn's Disease (adult) - 10 mg/kg every 8 weeks

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Q5102	INFLIXIMAB -ABDA	Renflexis™	X	X	X	X			X	X		· Diagnosis the medication is being used to treat · Any additional pertinent medical information		· Same as Remicade
Q5102	INFLIXIMAB -DYYB	Inflectra™	X	X	X	X			X	X		· Diagnosis the medication is being used to treat · Any additional pertinent medical information	X	· Same as Remicade
J9999	INOTUZUMAB OZOGAMICIN	Besponsa™	X		X						**X**	· FDA-approved indications and dosing		
J9214	INTERFERON ALFA-2b	Intron®-A											X	· AIDS-related Kaposi's Sarcoma - 30 million IU/m2 per dose 3 times weekly · Chronic hepatitis B - 10 million IU/dose given daily or 3 times weekly - Maximum of 140 million IU per month · Chronic hepatitis B (pediatrics) - 3 million IU/m2 per dose given 3 times weekly up to 16-24 weeks - Maximum of 36 million IU/m2 per month · Chronic Hepatitis C - 3 million IU 3 times weekly - Maximum of 36 million IU per month · Congylomata Acuminata - 1 million IU per lesion 3 times weekly x 3 weeks - Given in a maximum of 5 lesions · Follicular lymphoma - 5 million IU 3 times weekly x 18 months - Maximum of 60 million IU per month · Hairy Cell Leukemia - 2 million IU/m2 3 times weekly - Maximum of 24 million IU/m2 per month · Malignant melanoma - Induction: 20 million IU/m2 for 5 consecutive days per week for 4 weeks (maximum of 400 million IU/m2 per month) - Maintenance: 10 million IU/m2 3 times weekly for 48 weeks (maximum of 120 million IU/m2 per month)
J9228	IPILIMUMAB	Yervoy™	X	X	X	X					**X**	· Diagnosis of unresectable or metastatic melanoma · Monotherapy: pediatric patients greater than or equal to 12 years of age · Combination therapy with Yervoy: adults greater than or equal to 18 years of age **OR** · Diagnosis of cutaneous melanoma **AND** · Prescribed by or in consultation with an oncologist · Any additional pertinent medical information		

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J9205	IRINOTECAN LIPOSOMAL	Onivyde™	X		X	X			X			· Diagnosis of metastatic adenocarcinoma of the pancreas · Disease progression after BOTH of the following treatments: - Gemcitabine-based therapy - Higher-rated NCCN category recommendation for 2nd line therapy · Prescribed by or in consultation with an oncologist · Used in combination with fluorouracil and leucovorin · Any additional pertinent medical information		
J9207	IXABEPILONE	Ixempra®											X	· Breast cancer - 40 mg/m2 every three weeks
J1931	LARONIDASE	Aldurazyme®	X		X	X		X		X		· Diagnosis of Hurler mucopolysaccharidosis (MPS) I with moderate to severe symptoms **OR** · Diagnosis of Hurler-Scheie (MPS) I with moderate to severe symptoms **AND** · Diagnosis confirmed by serum assays showing an enzyme deficiency of alpha-L-iduronidase AND urinary glucosaminoglycan (GAG), dermatan sulfate or heparin sulfate · Diagnosis made by or in consultation with a geneticist or metabolic specialist · Any additional pertinent medical information		
J9217	LEUPROLIDE ACETATE	Eligard®											X	· Prostate cancer - 7.5 mg given monthly in males - Maximum of 7.5 mg per month
J1950	LEUPROLIDE ACETATE	Lupron Depot®											X	Lupron Depot (pediatrics) · Central precocious puberty · Males < 9 years of age and females < 8 years of age - 1 month regimen: 7.5 mg, 11.25 mg and 15 mg (given monthly) - 3 month regimen: 11.25 mg and 30 mg (given every 3 months) Lupron Depot · Endometriosis (females) - 3.75 mg monthly for 6 months - 11.25 mg every 3 months for 6 months - 1 additional treatment of both regimens is allowed · Fibroids (females) - 3.75 mg monthly for 3 months - 11.25 mg once in 3 months - 1 additional treatment of both regimens is allowed · Prostate cancer (males) - 1 month regimen: 7.5 mg - 3 month regimen: 22.5 mg - 4 month regimen: 30 mg - 6 month regimen: 45 mg

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J0641	LEVOLEUCOVORIN	Fusilev®	X	X	X	X						· Diagnosis of one of the following conditions: · Rescue after high-dose methotrexate therapy in osteosarcoma **OR** · Diminishing toxicity and counteracting effects of impaired methotrexate elimination and of inadvertent overdose of folic acid antagonists **OR** · Use in combination with 5-fluorouracil in the palliative treatment of patients with advanced metastatic colorectal cancer **AND** · FDA-identified leucovorin shortage and an absence of alternative appropriate therapies · Patient is greater than or equal to 6 years of age · Prescribing physician is an oncologist · Any additional pertinent medical information		
J9999, A9699, C9399	LUTETIUM LU 177 DOTATATE	Lutathera®	X		X				X		**X**	· FDA-approved indications · Trial and failure of preferred therapies		
J2182	MEPOLIZUMAB	Nucala®	X	X	X	X		X	X	X		· Used as add-on maintenance treatment for the diagnosis of severe eosinophillic asthma confirmed by: - Blood eosinophils ≥ 150 cells/mcL at initiation of treatment **OR** - Blood eosinophilis ≥ 300 cells/mcL in the past 12 months **AND** - Repeated hospital/ED visits **AND** - Regular use of oral and high dose inhaled corticosteroids **AND** · Confirmation Nucala will not be used in combination with another biologic for asthma · Patient is greater than or equal to 12 years of age · Prescriber physician is an allergist, immunologist, or pulmonologist · Any additional pertinent medical information		
J2323	NATALIZUMAB	Tysabri®											X	· Multiple sclerosis / crohn's disease - 300 mg given every 4 weeks - Maximum of 300 mg per month
J9295	NECITUMUMAB	Portrazza™	X	X	X	X			X			· Diagnosis of metastatic squamous non-small cell lung cancer (NSCLC) · Prior treatment failure with TWO category 1 or 2A NCCN-recommended treatment regimens for first-line therapy · Prescribed by or in consultation with an oncologist · Patients greater than 18 years of age but less than 70 year of age · Must be used in combination with cisplatin and gemcitabine therapy · Any additional pertinent medical information		

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J9299	NIVOLUMAB	Opdivo®	X	X	X	X		X	X		X	· Patient is greater than or equal to 18 years of age · Prescribing physician is an oncologist · No prior therapy with other PD-1 inhibitor · Used as monotherapy · Any additional pertinent medical information **AND** · One of the following diagnoses: - Diagnosis of unresectable or metastatic melanoma - As monotherapy OR - In combination with Yervoy. Requests for combination therapy are evaluated on a case-by-case basis and are determined following appropriate genetic testing and assessment of risks and benefits **OR** - Diagnosis of metastatic non-small cell lung cancer (NSCLC) - Previous treatment failure with: - Platinum-based chemotherapy **AND** - EGFR or ALK inhibitors if EGFR or ALK mutation positive, respectively **OR** - Diagnosis of clear-cell renal cell carcinoma (RCC) - Previous treatment failure with: - At least 1 anti-angiogenic agent (i.e., Sutent, Votrient, and Nexavar) **OR** - Diagnosis of classical Hodgkin lymphoma (cHL): - Previous treatment failure with: - Autologous hematopoietic stem cell transplantation (HSCT) AND - Trial and failure of Adcetris (brentuximab vedotin) OR - Disease progression after 3 lines of systemic therapy (includes autologous HSCT as 1 line of therapy) OR - Diagnosis of head and neck squamous cell carcinoma (HNSCC) who have demonstrated disease progression on or after platinum-containing chemotherapy OR - Diagnosis of metastatic urothelial carcinoma who have disease progression on or after platinum-containing chemotherapy - Diagnosis of clear-cell renal cell carcinoma (RCC) - Previous treatment failure with: - At least 1 anti-angiogenic agent (i.e., Sutent, Votrient, and Nexavar) OR · Diagnosis of metastatic microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer - Greater than or equal to 12 year of age - Documentation of disease progression following FOLFOXIRI in previous 12 months OR · Diagnosis of hepatocellular carcinoma (HCC) - Documentation of disease progression following sorafenib - Use as monotherapy		
J3490 / J2326	NUSINERSEN	Spinraza ™	X	X	X	X	X	X			X	· Diagnosis of type 1, 2, or 3 spinal muscular atrophy confirmed by genetic testing - Treated by a neurologist specializing in pediatric neuromuscular disorders - Patients age 14 years and younger - Patient must not be fully ventilator dependent - Submission of baseline (before treatment), age appropriate exam to establish baseline motor function and ability must be included (examples: Hammersmith Infant Neurological Exam (HINE), Hammersmith Functional Motor Scale Expanded (HFMSE), Upper Limb Module (ULM) Test, Six-Minute Walk Test (6MWT) or Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)). · Renewal request requires record of response to therapy which is defined as a significant improvement in a repeat assessment of motor function and ability · Any additional pertinent medical information		

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J9301	OBINUTUZUMAB	Gazyva™	X	X	X				X			· Diagnosis of treatment naïve, chronic lymphocytic leukemia (CLL) and are receiving concurrent chlorambucil therapy **OR** · Diagnosis of follicular lymphoma in patients who have relapsed or are refractory to a rituximab-containing regimen - If treatment naive, must receive concurrent chemotherapy (bendamustine, CHOP or CVP) · Patient is greater than or equal to 18 years of age · Any additional pertinent medical information		
J3590 / J2350	OCRELIZUMAB	Ocrevus™	X	X	X	X		X	X			· Diagnosis of primary progressive multiple sclerosis (PPMS) - Documented evidence of disease progression for at least one year - One brain lesion OR positive cerebrospinal fluid (CSF) OR two spinal lesions. · Diagnosis of relapsing form of multiple sclerosis - Documented evidence of new and/or newly enlarged MRI lesions in the previous year - Clinical relapse or progression despite treatment - Treatment failure to at least one injectable agent (examples: Avonex®, Betaseron®, Copaxone®, Extavia®, or Rebif®) - Treatment failure to at least one oral agent (examples: Gilenya®, or Tecfidera®) · Any additional pertinent medical information		
J9302	OFATUMUMAB	Arzerra®											X	· Chronic lymphocytic leukemia (CLL) - Cycle 1: 300 mg on day 1, 1,000 mg on day 8 - Subsequent cycles: 1,000 mg on day 1, of each cycle for 3 cycles - Maximum of 12 cycles (each cycles is 28 days)
J2357	OMALIZUMAB	Xolair®	X	X	X	X		X	X	X	**X**	· Diagnosis of uncontrolled, moderate to severe allergic asthma supported by ALL of the following: - Positive skin test or in-vitro reactivity to a perennial aeroallergen - Confirmation of chronic, combination therapy with a systemic or high-dose inhaled corticosteroids with long-acting inhaled beta-2 agonists or leukotriene modifiers for at least three months to maintain adequate control - IgE level > 30 IU/mL but < 700 IU/mL for patients 12 years of age and older - IgE level > 30 but < 1300 IU/mL for patients 6 to < 12 years of age - Evidence of reversible disease with bronchodilators · Patient is greater than or equal to 6 years of age · Confirmation Xolair will not be used in combination with another biologic for asthma **OR** · Diagnosis of idiopathic urticaria supported by all of the following criteria: - Documentation of diagnosis per American Academy of Allergy Asthma and Immunology (AAAI) guidelines: 1) Must have occurrence of almost daily hives and itching for at least 6 weeks. - Previous treatment failure with at least 2 months of all three steps below: 1) Maximally tolerated doses of 2nd generation antihistamine AND 2) Maximal tolerated dose of a first generation antihistamine at bedtime OR an H2 receptor antagonist OR another second generation antihistamine OR Leukotriene receptor antagonist therapy AND 3) Trial and failure of hydroxyzine or doxepin · Patient is greater than or equal to 12 years of age · Other diagnoses have been ruled out **AND** · Diagnosis made by or in consultation with an allergist, immunologist, or pulmonologist · Any additional pertinent medical information		

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J0585	ONABOTULINUMTOXINA	Botox®	X		X				X			· Diagnosis the medication is being used to treat · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information	X	· 400 units every 12 weeks - Axillary hyperhidrosis - Blepharospasm - Cervical dystonia - Chronic migraine - Detrusor overactivity associated with a neurologic condition - Overactive bladder - Strabismus - Upper and lower limb spasticity - Pelvic floor spasm
J9263	OXALIPLATIN	Eloxatin®											X	· Colon cancer / colorectal cancer - 85 mg/m2 every 2 weeks
J9264	PACLITAXEL	Abraxane®											X	Breast Cancer · 260 mg/m2 per dose every 3 weeks Non-small cell lung cancer (NSCLC) · 100 mg/m2 per dose on day 1, 8, 15 of each 21-day cycle Pancreatic cancer · 125 mg/m2 per dose on day 1, 8, 15 of each 28-day cycle
J9303	PANITUMUMAB	Vectibix®											X	· Colorectal cancer: - 6 mg/kg every 2 weeks
J2504	PEGADEMASE BOVINE	Adagen®	X		X	X		X	X	X		· Diagnosis of adenosine deaminase (ADA) deficiency in a patient with severe combined immunodeficiency disease (SCID) · Diagnosis confirmed by evidence of combined immunodeficiency AND an absence of thymus and other lymphoid tissues · Evidence the patient has previously failed or is an unsuitable candidate for bone marrow transplantation · No evidence of severe thrombocytopenia · Diagnosis made by or in consultation with an immune specialist · Any additional pertinent medical information		
J9266	PEGASPARGASE	Oncaspar®											X	· Acute lymphoblastic leukemia (ALL) - 2,500 IU/m2 given no more frequently then every 14 days - Maximum of 5,000 IU/m2 per month
J2507	PEGLOTICASE	Krystexxa™	X	X	X			X	X	X (effective 7/1/2018)		· Diagnosis of active gout supported by all of the following: - Three gouty flares or more in the previous 18 months - Presence of one or more tophi - Chronic gouty arthritis -Serum uric acid level greater than 8mg/dL · Patient is greater than or equal to 18 years of age · Previous treatment failure with maximally tolerated doses of: 1) Allopurinol (800mg) AND 2) Febuxostat (80mg) · Any additional pertinent medical information · Site of Care requirement is effective 7/1/2018		

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J9271	PEMBROLIZUMAB	Keytruda®	X	X	X	X		X	X		**X**	· Prescribing physician is an oncologist · Used as monotherapy · No prior therapy with other PD-1 inhibitor therapy · Any additional pertinent medical information AND · Diagnosis of metastatic melanoma in patients greater than or equal to 18 OR · Diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) in patients greater than or equal to 18 - Used as first line therapy when positive for PD-L1 on an FDA-approved companion diagnostic test (tumor proportion score greater than or equal to 50%) AND - No EGFR or ALK genomic tumor aberrations and no prior systemic chemotherapy for metastatic NSCLC OR - For second line treatment if tumor proportion score (TPS) is greater than or equal to 1% after progression on or after platinum-containing chemotherapy or FDA-approved therapy for EGFR or ALK mutation OR · Diagnosis of head and neck squamous cell carcinoma (HNSCC) in patients greater than or equal to 18 yrs and who have demonstrated disease progression on or after platinum-containing chemotherapy OR · Diagnosis of refractory classical hodgkin lymphoma (cHL) or cHL in patients 2 years and older that has relapsed after 3 or more prior lines of therapy -No allogeneic hematopoietic stem cell transplant (HSCT) transplant within the past 5 years OR · Diagnosis of locally advanced or metastatic urothelial carcinoma - Not eligible for cisplatin containing chemotherapy OR - Disease progression experienced with: - Platinum-containing chemotherapy OR - Within 12 months of neoadjuvant or adjvuant treatment with platinum-containing chemotherapy OR · Diagnosis of Microsatellite Instability-High Cancer(MSI-H) - Patient must be 2 years of age or older - Unresectable or metastatic MSI-H or mismatch repair deficient (dMMR) solid tumors that have progressed following prior treatment and have no alternative treatment options OR - MSI-H or mismatch repair deficient colorectal cancer that has progressed following treatment with FOLFOXIRI - PCR based assay showing microsatellite markers instability OR Immunohistochemistry results showing deficiency in mismatch repair genes · Diagnosis of recurrent locally advanced or metastatic gastric or gastroesophageal junction adenocarcinoma · Tumor expresses PD-L1 Combined Positive Score (CPS) greater than or equal to 1 as determined by an FDA-approved test · Demonstrates disease progression on or after two or more prior lines of therapy including a fluoropyrimidine and platinum containing chemotherapy doublet regimen, and if appropriate, an epidemral growth factor receptor 2 (HER2) targeted therapy		
J9305	PEMETREXED	Alimta®											X	· Non-small cell lung cancer (NSCLC) / mesothelioma - 500 mg/m2 given once every 21-day cycle
J9306	PERTUZUMAB	Perjeta™	X		X		X		X		**X**	· Diagnosis of one of the following: - HER2-positive metastatic breast cancer **OR** - HER2-positive, locally advanced, inflammatory or early stage breast cancer **AND** · Confirmation of HER2 overexpression defined as 3+ IHC by Dako HerceptestTM or FISH amplification ration ≥ 2.0 by Dako HER2 FISH PharmDxTM test kit or equivalent · Confirmation patient has not received prior anti-HER2 chemotherapy for metastatic disease · Any additional pertinent medical information		

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J9308	RAMUCIRUMAB	Cyramza™	X		X	X			X			· Diagnosis of gastric cancer or gastroesophageal junction adenocarcinoma · Used as monotherapy OR in combination with paclitaxel · Previous treatment failure with fluoropyrimidine or platinum-containing chemotherapy **OR** · Diagnosis of metastatic non-small cell lung cancer (NSCLC) · Used in combination with docetaxel · Previous treatment failure with all of the following therapies: 1) First-line platinum-based chemotherapy 2) FDA-approved therapy, if EGFR or ALK genomic tumor aberration is present **OR** · Diagnosis of metastatic colorectal cancer (mCRC) · Used in combination with FOLFIRI (irinotecan, folinic acid, and 5-fluorouracil) · Previous treatment failure with bevacizumab, oxaliplatin, and a fluoropyrimidine **AND** · Prescribing physician is an oncologist · Any additional pertinent medical information		
J2778	RANIBIZUMAB	Lucentis®	X		X	X			X			· Diagnosis of neovascular (wet) age-related macular degeneration (AMD) **OR** · Diagnosis of macular edema due to retinal vein occlusion (RVO) **OR** · Diagnosis of diabetic macular edema (DME) **OR** · Diagnosis of diabetic retinopathy (DR) in patients with DME **OR** · Diagnosis of myopic choroidal neovascularization (mCNV) **AND** · Prescribing physician is a ophthalmologist · Previous treatment failure with Avastin (bevacizumab) · Any additional pertinent medical information	X	· Diabetic macular edema (DME) - 0.3 mg every 4 weeks - Maximum of 0.3 mg per month · Wet age-related macular degeneration (AMD) and macular edema following retinal vein occlusion (RVO) - 0.5 mg every 4 weeks - Maximum of 0.5 mg per month
J2786	RESLIZUMAB	Cinqair®	X	X	X	X		X	X	X		· Used as add-on maintenance treatment for the diagnosis of severe eosinophillic asthma confirmed by: - Blood eosinophils ≥ 400 cells/mcL at initiation of treatment AND - Repeated hospital/ED visits AND - Regular use of oral and high dose inhaled corticosteroids **AND** · Confirmation Cinqair will not be used in combination with another biologic for asthma · Patient is greater than or equal to 18 years of age · Prescriber physician is an allergist, immunologist, or pulmonologist · Any additional pertinent medical information		

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J0587	RIMABOTULINUMTOXINB	Myobloc®	X		X				X			· Diagnosis the medication is being used to treat · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		
J9310	RITUXIMAB	Rituxan®											X	· Chronic Lymphocytic Leukemia (CLL) - 1st cycle: 375 mg/m2 500 mg/m2, then 500 mg/m2 cycle 2-6 every 28 days · Non-Hodgkin's Lymphoma (NHL) - 375 mg/m2 per dose · Rheumatoid arthritis (RA) - 1,000 mg per dose every 2 weeks for 2 doses, repeated every 24 weeks - Maximum of 2,000 mg per month · Wegener's granulomatosis / microscopic polyangiitis - 375 mg/m2 weekly for 4 weeks - Maximum of 1,500 mg/m2 per month
J2796	ROMIPLOSTIM	Nplate®	X	X	X	X		X	X			· Diagnosis of chronic immune thrombocytopenia purpura (ITP) · Persistent thrombocytopenia defined by: - Current platelet count < 20,000 mcL **OR** - Current platelet count < 30,000 mcL AND symptoms of active bleeding · Previous treatment failure with: 1) Corticosteroids, immunoglobulins, or splenectomy **AND** 2) Promacta · Patient is greater than or equal to 18 years of age · Diagnosis made by or in consultation with a hematologist · Any additional pertinent medical information		
90378	RSV MAB	Synagis®	X	X	X						**X**	· Indication of respiratory syncytial virus (RSV) prophylaxis · Coverage is based on the recommendations from the American Academy of Pediatrics (AAP) Policy Statement · Any additional pertinent medical information	X	· Respiratory Syncytial Virus (RSV) prophylaxis - 15 mg/kg monthly in members < 24 months of age - Given through RSV season
J2840	SEBELIPASE ALFA	Kanuma™	X		X	X	X	X		X		· Diagnosis of lysosomal acid lipase deficiency (LAL-d) confirmed by blood test measuring LAL activity OR genetic testing · Symptomatic manifestation of the disease are present (i.e., elevated liver enzymes, microvesicular steatosis, elevated low-density lipoprotein, low high-density lipoprotein, or coronary artery disease · Diagnosis made by or in consultation with a geneticist or metabolic specialist · Any additional pertinent medical information		
Q2043	SIPULEUCEL-T AUTO CD54+	Provenge®	X		X			X				· Diagnosis of hormone-refractory metastatic prostate cancer · Documentation confirming spread of disease (i.e., CT or bone scan) · Baseline testosterone levels · Clinical documentation confirming little to no cancer-related pain · Evidence confirming narcotic pain medication has not been used · Any additional pertinent medical information		

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J3060	TALIGLUCERACE ALFA	Elelyso®	X		X	X	X	X	X	X		· Diagnosis of Type 1 Gaucher disease confirmed by one of the following: - Two pathogenic mutations of glucocerebrosidase gene **OR** - Assay of glucocerebrosidase activity in WBCs or skin fibroblasts **AND** · Evidence of symptomatic manifestations of disease · Diagnosis made by or in consultation with a geneticist or metabolic specialist · Any additional pertinent medical information		
J9330	TEMSIROLIMUS	Torisel®											X	· Renal cell carcinoma (RCC) - 25 mg weekly - Maximum of 100 mg per month
S0189	TESTOSTERONE PELLET	Testopel®	X		X			X	X			· Diagnosis of androgen deficiency syndrome in a male patient confirmed by two morning testosterone levels in the past year below the testing laboratory's lower limit of normal range (free testosterone levels may be required) · Evidence of at least TWO specific signs and/or symptoms of testosterone deficiency (i.e., incomplete/delayed sexual development, breast discomfort, gynecomastia, loss of body hair, etc.) · Confirmation that other causes of low testosterone have been ruled out · Previous treatment failure with a preferred injectable agent (such as generic depo-testosterone or generic Delatestryl) OR · Patients with breast cancer who are in need of adjunctive palliative treatment · Any additional pertinent medical information		
J3145	TESTOSTERONE UNDECANOATE	Aveed®	X		X			X	X			· Diagnosis of androgen deficiency syndrome in a male patient confirmed by two morning testosterone levels in the past year below the testing laboratory's lower limit of normal range (free testosterone levels may be required) · Evidence of at least TWO specific signs and/or symptoms of testosterone deficiency (i.e., incomplete/delayed sexual development, breast discomfort, gynecomastia, loss of body hair, etc.) · Confirmation that other causes of low testosterone have been ruled out Previous treatment failure with a preferred injectable agent (such as generic depo-testosterone or generic Delatestryl) OR · Patients with breast cancer who are in need of adjunctive palliative treatment · Any additional pertinent medical information		
J3590	TILDRAKIZUMAB-ASMN	Ilumya™	X	X	X	X			X	X		· Diagnosis of moderate to severe plaque psoriasis · Patient is 18 years of age or older · The prescribing physician is a dermatologist · Treatment with a minimum of 3 months of topical steroids was ineffective · Treatment with phototherapy or photochemotherapy was ineffective, contraindicated, or not tolerated · Treatment with at least one generic oral systemic agent for plaque psoriasis was ineffective or not tolerated, unless contraindicated. Examples of systemic agents include, but are not limited to, cyclosporine, methotrexate, and acitretin · Trial and failure of preferred drug(s) as required by BCBSM · Patients may not use Ilumya in combination with other biologics (eg. Enbrel, Stelara)		
J3490 / Q2040	TISAGENLECLEUCEL-T	Kymriah™	X		X	X		X	X		**X**	· Prescribed by an oncologist · Age 1-25 years at time of initial request · Documentation of CD 19 tumor expression · Bone marrow (BM) relapse after allogenic SCT · Ineligible for allogeneic stem cell transplant (SCT) · Have not received prior treatment with Kymriah or any other gene therapy or are being considered for other gene therapy · Documentation showing patient's response to Kymriah treatment must be provided within 3 months of treatment AND Diagnosis of B-cell precursor acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse · Primary refractory as defined by not achieving a complete response after 2 cycles of a standard chemotherapy regimen or chemorefractory as defined by not achieving a complete response after 1 cycle of standard chemotherapy for relapsed leukemia OR Diagnosis of Philadelphia (Ph) chromosome positive (Ph+) ALL · Trial and failure to at least 2 lines of tyrosine kinase inhibitor (TKI) therapy		

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J3262	TOCILIZUMAB	Actemra®	X		X	X			X	X		· Diagnosis of Rheumatoid arthritis (RA) · Prescribing physician is a rheumatologist · Previous treatment failure with: 1) Remicade/ Renflexis/ Inflectra OR Simponi Aria · Diagnosis of Systemic juvenile idiopathic arthritis (SJIA) OR Polyarticular Juvenile idiopathic arthritis (PJIA) · Prescribing physician is a rheumatologist · Previous treatment failure with: 1) Remicade OR Simponi Aria · Diagnosis of severe or life threatening Cytokine release syndrome (CRS) associated with chimeric antigen receptor (CAR) T cell therapy · Prescribed by or in consultation with an oncologist · Any additional pertinent medical information	X	· Rheumatoid arthritis (RA) - 8 mg/kg every 4 weeks · Polyarticular juvenile idiopathic arthritis (pJIA) <30 kg: 10 mg/kg every 4 weeks ≥ 30 kg: 8 mg/kg every 4 weeks · Systemic juvenile idiopathic arthritis (sJIA) < 30 kg: 12 mg/kg every 2 weeks ≥ 30 kg: 8 mg/kg every 2 weeks
J9352	TRABECTEDIN	Yondelis®	X		X	X			X			· Diagnosis of unresectable or metastatic liposarcoma or leiomyosarcoma · Trial and failure of an anthracycline-containing regimen · Prescribed by or in consultation with an oncologist · Any additional pertinent medical information		
J9355	TRASTUZUMAB	Herceptin®											X	· Breast cancer - Adjuvant: 4 mg/kg, then 2 mg/kg weekly OR 9 mg/kg, then 6 mg/kg every 3 weeks for a total of 52 doses - Metastatic: 4 mg/kg, then 2 mg/kg weekly · Gastric cancer - 8 mg/kg, followed by 6 mg/kg every 3 weeks
J3590	UNCLASSIFIED BIOLOGICS	NOC	X	X	X	X			X	X	**X**	· Diagnosis the drug is being used to treat · Age of the member · Specialty of the prescribing physician · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		
C9399	UNCLASSIFIED DRUGS OR BIOLOGICALS	NOC												
J3357	USTEKINUMAB	Stelara®	X		X	X			X	X (effective 7/1/2018)		· Diagnosis of psoriasis · Chart notes involving at least 10% of the body surface area or causes significant functional disability · Previous treatment failure with phototherapy or photochemotherapy **OR** · Diagnosis of psoriatic arthritis · Any additional pertinent medical information · Site of Care requirement is effective 7/1/2018	X	· Psoriasis ≤ 100kg: 45 mg at week 0, 4, then every 12 weeks thereafter > 100kg: 90 mg at week 0, 4, then every 12 weeks thereafter · Psoriatic arthritis - 45 mg at week 0, 4, then every 12 weeks thereafter

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J3358	USTEKINUMAB	Stelara®	X		X	X			X	X (effective 7/1/2018)		· Diagnosis of Crohn's disease · Start of therapy with an appropriate dose of intravenous Stelara based on body weight · Site of Care requirement is effective 7/1/2018	X	· Crohn's disease - 90 mg every 8 weeks
J3380	VEDOLIZUMAB	Entyvio®	X		X	X			X	X		· Diagnosis of moderate to severe, active ulcerative colitis **OR** · Diagnosis of moderate to severe, active crohn's disease **AND** · Prescribed by or in consultation with a gastroenterologist · Previous treatment failure with all the following therapies: - Conventional therapy (i.e., corticosteroids, immunomodulators) **AND** - TWO preferred biologic therapies (i.e., Remicade/ Renflexis/ Inflectra and Humira) · Any additional pertinent medical information	X	· Crohn's disease and Ulcerative colitis - 300mg every 8 weeks
J3385	VELAGLUCERASE ALFA	Vpriv®	X		X	X	X	X	X	X		· Diagnosis of Type 1 Gaucher disease - Two pathogenic mutations of glucocerebrosidase gene **OR** - Assay of glucocerebrosidase activity in WBCs or skin fibroblasts **AND** · Evidence of symptomatic manifestations of disease · Diagnosis made by or in consultation with a geneticist or metabolic specialist · Names of medications previously used to treat this condition, including dosages, dates of therapy and response · Any additional pertinent medical information		
J3490 / J3590	VESTRONIDASE ALFA-VJBK	Mepsevii™	X		X	X		X	X	X		· Diagnosis of mucopolysaccharidosis VII (MPS VII, Sly syndrom based on leukocyte or fibroblast glucuronidase enzyme assay or genetic testing · Prescribed by or in consultation with a geneticist or metabolic specialist · Baseline disease status must be documented · Elevated urinary glycosaminoglycan (uGAG) excretion at a minimum of 3-fold over the mean normal for age · Clinical signs of lysosomal storage disease		
J3490	VORETIGENE NEPARVOVEC	Luxturna™	X	X	X	X	X	X			**X**	· Diagnosis of confirmed biallelic RPE65 mutation associated retinal dystrophy · Prescribed and administered by an opthalmologist · Documentation of biallelic RPE65 gene mutation · Visual acuity of 20/60 or worse in both eyes OR a binocular visual field less than 20 degrees in any meridian · Retinal thickness of greater than 100 microns within the posterior pole		