

Prior Authorization Listing

For certain drugs Advantage by Bridgeway Health Solutions HMO SNP (Bridgeway) requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Bridgeway before you fill your prescriptions. If you don't get approval, Bridgeway may not cover the drug. The prior authorization requirements are listed below to provide you with information to discuss treatment options with your physicians or health care prescribers.

The Prior Authorization Listing is subject to change and may not be comprehensive. Some of the medications on the list may also be subject to additional plan coverage rules.

Drug Product	Approval Criteria	Required Medical Criteria	Coverage Duration
ALBUTEROL NEBULIZER SOLN	Authorization required only to validate Part B versus Part D coverage.	No Part B coverage.	Ongoing if no Part B coverage.
AMEVIVE	Amevive is approved for the treatment of plaque psoriasis and all FDA-approved indications not otherwise excluded by Part D.	Trial and failure of one systemic therapy along with one topical treatment. Systemic therapy includes DMARDs or immunosuppressants including methotrexate or cyclosporine and topical treatment includes high-potency corticosteroids or calcipotriene.	Approve at six month intervals.
ARANESP	Aranesp is approved for treatment of anemia in end stage renal disease and cancer to maintain hemoglobin levels between 10 and 12 grams per deciliter and for all other FDA-approved uses not otherwise excluded by Part D.	Three months of hemoglobin monitoring and dosage titration to maintain hemoglobin levels within the range of 10 to 12.	Approve for one year.
BOTOX	Botox is approved for all FDA-approved uses not otherwise excluded by Part D.	A prior authorization request for FDA-approved and labeled indications.	Approve for six months.
CELLCEPT LIQUID AND INJECTABLE	Authorization required only to validate Part B versus Part D coverage.	Non-Medicare approved transplant.	Ongoing if non-Medicare approved transplant.

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CROMOLYN NEBULIZER	Authorization required only to validate Part B versus Part D coverage.	No Part B coverage.	Ongoing if no Part B coverage.
CYCLOSPORINE	Authorization required only to validate Part B versus Part D coverage.	No Part B coverage.	Ongoing if no Part B coverage.
EGRIFTA	Egrifta is approved for the treatment of all FDA-approved indications not otherwise excluded by Part D.	Diagnosis of severe lipodystrophy in HIV positive patients using antiretroviral drugs.	Initial approval for 3 months.
ELIDEL	Elidel is approved for the treatment of all FDA approved indications not otherwise excluded by Part D.	One trial and failure and adherent use of medium to high potency topical corticosteroids, which may include (but not limited to) betamethasone, clobetasol, desonide, desoximetasone, fluocinolone, fluocinonide, fluticasone, halobetasol, or mometasone.	Approve for one year.
FORTEO	Forteo is approved for the treatment of osteoporosis and all FDA-approved indications not otherwise excluded by Part D where patient has demonstrated a trial and failure or intolerance to oral alendronate.	Evidence of adherent trial and failure of oral alendronate.	Approve for one year.
GENGRAF	Authorization required only to validate Part B versus Part D coverage.	Non-Medicare approved transplant.	Ongoing if non-Medicare approved transplant.
INTAL NEBULIZER SOLN	Authorization required only to validate Part B versus Part D coverage.	No Part B coverage.	Ongoing if no Part B coverage.
IPRATROPIUM/ ALBUTEROL NEBULIZER SOLN	Authorization required only to validate Part B versus Part D coverage.	No Part B coverage.	Ongoing if no Part B coverage.

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KINERET	Kineret is approved for the treatment of all FDA-approved indications not otherwise excluded by Part D.	Trial and failure and adherent use of at least two oral disease-modifying anti-rheumatic drugs or immunosuppressants, unless contraindicated. Systemic therapy may include methotrexate, leflunomide, hydroxychloroquine, cyclosporine, sulfasalazine, and azathioprine.	Approve for six months.
LIDODERM PATCHES	Lidoderm Patches are approved for all FDA-approved uses not otherwise excluded by Part D.		Approve for six months.
LOTRONEX	Lotronex is approved for the treatment of all FDA-approved indications not otherwise excluded by Part D.	Female patient with severe diarrhea-predominant chronic irritable bowel syndrome of greater than 6 months duration	Approve for six months.
METAPROTERENOL NEBULIZER SOLN.	Authorization required only to validate Part B versus Part D coverage.	No Part B coverage.	Ongoing if no Part B coverage.
MYCOPHENOLATE MOFETIL	Authorization required only to validate Part B versus Part D coverage.	Non-Medicare approved transplant.	Ongoing if non-Medicare approved transplant.
NEORAL	Authorization required only to validate Part B versus Part D coverage.	Non-Medicare approved transplant.	Ongoing if non-Medicare approved transplant.
NORDITROPIN	Growth hormone is approved for the treatment of growth hormone deficiency for all FDA-approved uses not otherwise excluded by Part D.	Submission of information showing a growth hormone stimulation test reading of less than 10 µg/L in children and less than 5.1 µg/L in adults.	Approve for six months.

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NUTROPIN, NUTROPIN AQ	Growth hormone is approved for the treatment of growth hormone deficiency for all FDA-approved uses not otherwise excluded by Part D.	Submission of information showing a growth hormone stimulation test reading of less than 10 µg/L in children and less than 5.1 µg/L in adults.	Approve for six months.
ORENCIA	Orencia is approved for the treatment of all FDA approved indications not otherwise excluded by Part D.	Trial and failure and adherent use of at least two oral disease-modifying anti-rheumatic drugs or immunosuppressants, unless contraindicated. Systemic therapy may include methotrexate, leflunomide, hydroxychloroquine, cyclosporine, sulfasalazine, and azathioprine.	Approve for six months.
ORTHOCLONE OKT3	Authorization required only to validate Part B versus Part D coverage.	Non-Medicare approved transplant.	Ongoing if non-Medicare approved transplant.
PEGASYS	Pegasys is approved for the treatment of hepatitis C for treatment naïve patients with compensated liver disease and for patients diagnosed with hepatitis B. Treatment must be ordered by a gastroenterologist.	Baseline viral load and submission of 12 week lab values showing a viral load decrease of at least a 2 log from baseline.	24 weeks for genotypes 2 and 3 or 48 weeks for genotypes 1 and 4.
PEG-INTRON	Peg-Intron is approved for the treatment of hepatitis C for treatment naïve patients with compensated liver disease and for patients diagnosed with hepatitis B. Treatment must be ordered by a gastroenterologist.	Baseline viral load and submission of 12 week lab values showing a viral load decrease of at least a 2 log from baseline.	24 weeks for genotypes 2 and 3 or 48 weeks for genotypes 1 and 4.

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PROCRIT	Procrit is approved for treatment of anemia in end stage renal disease and cancer to maintain hemoglobin levels between 10 and 12 grams per deciliter and for all other FDA-approved uses not otherwise excluded by Part D.	Three months of hemoglobin monitoring and dosage titration to maintain hemoglobin levels within the range of 10 to 12.	Approve for one year.
PROGRAF	Authorization required only to validate Part B versus Part D coverage.	Non-Medicare approved transplant.	Ongoing if non-Medicare approved transplant.
PROMACTA	Promacta is approved for the treatment of all FDA-approved indications not otherwise excluded by Part D.	Platelet counts of less than 50,000 per microliter following standard treatment with corticosteroids, immunoglobulins, or after splenectomy.	Approve for six months.
PROTOPIC	Protopic is approved for the treatment of all FDA-approved indications not otherwise excluded by Part D.	One trial and failure and adherent use of medium to high potency topical corticosteroids, which may include (but not limited to) betamethasone, clobetasol, desonide, desoximetasone, fluocinolone, fluocinonide, fluticasone, halobetasol, or mometasone.	Approve for one year.
PROVIGIL	Provigil is approved for the treatment of narcolepsy, obstructive sleep apnea/hypopnea syndrome, shift work sleep disorder. and all FDA-approved indications not otherwise excluded by Part D.	Evidence supporting diagnosis of an FDA approved indication.	Approve for one year.
RANEXA	Ranexa is approved for the treatment of all FDA-approved indications not otherwise excluded by Part D.	Trial and failure of long-acting nitrate therapy.	Approve for one year.

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RAPAMUNE	Authorization required only to validate Part B versus Part D coverage.	Non-Medicare approved transplant.	Ongoing if non-Medicare approved transplant.
REGRANEX	Regranex is approved for the treatment of all FDA-approved indications not otherwise excluded by Part D.	A diagnosis of diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply.	Approve for three months initially, followed by one three month approval if ulcer has shown a decrease in size.
RESTASIS	Restasis is approved for the treatment of all FDA-approved indications not otherwise excluded by Part D.	Diagnosis of decrease tear production due to ocular inflammation associated with keratoconjunctivitis sicca.	Approve for six months.
SAIZEN	Treatment for growth hormone deficiency evidenced by growth hormone stimulation test results, bone age measurement and growth velocity as appropriate to age.	Submission of information showing a growth hormone stimulation test reading of less than 10 µg/L in children and less than 5.1 µg/L in adults.	Approve for six months.
SANDIMMUNE	Authorization required only to validate Part B versus Part D coverage.	Non-Medicare approved transplant.	Ongoing if non-Medicare approved transplant.
SEROSTIM	Serostim is approved for the treatment of all FDA-approved uses not otherwise excluded by Part D.	Diagnosis appropriate to FDA labeled indications.	Approve for six months.
SIMULECT	Authorization required only to validate Part B versus Part D coverage.	Non-Medicare approved transplant.	Ongoing if non-Medicare approved transplant.
SOMAVERT	Somavert is approved for the treatment of all FDA-approved uses not otherwise excluded by Part D.	Confirmed diagnosis of acromegaly inadequate response to surgery and/or radiation therapy and bromocriptine.	Approve for six months.

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SYMLIN	Treatment for growth hormone deficiency evidenced by growth hormone stimulation test results, bone age measurement and growth velocity as appropriate to age.	Diabetes type 1 patients: A1c reading greater than 7 and adherent use of short acting and basal insulins. Diabetes type 2 patients: A1c reading greater than 7 and evidence of prior adherent use	Approve for one year.
TACROLIMUS	Authorization required only to validate Part B versus Part D coverage.	Non-Medicare approved transplant.	Ongoing if non-Medicare approved transplant.
TEV-TROPIN	Growth hormone is approved for the treatment of growth hormone deficiency for all FDA-approved uses not otherwise excluded by Part D.	Submission of information showing a growth hormone stimulation test reading of less than 10 µg/L in children and less than 5.1 µg/L in adults.	Approve for six months.
THYMOGLOBULIN	Authorization required only to validate Part B versus Part D coverage.	Non-Medicare approved transplant.	Ongoing if non-Medicare approved transplant.
XENAZINE	Xenazine is approved for the treatment of all FDA-approved indications not otherwise excluded by Part D.	Diagnosis of chorea associated with Huntington disease.	Approve for one year.
XOLAIR	Xolair is approved for the treatment of all FDA-approved indications not otherwise excluded by Part D.	Prescription history evidence of adherence to inhaled corticosteroids along with long-acting beta agonists for at least 3 months prior to request. Submission of IgE serum levels between 30 and 700 IU per milliliter.	Approve for six months.
XOPENEX NEBULIZER SOLN	Authorization required only to validate Part B versus Part D coverage.	No Part B coverage.	Ongoing if no Part B coverage.
ZORTRESS	Authorization required only to validate Part B versus Part D coverage.	Non-Medicare approved transplant.	Ongoing if non-Medicare approved transplant

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You can find out if your drug has any additional requirements or limits by looking in the Bridgeway Comprehensive Formulary. For a complete listing of drugs covered by Bridgeway, please visit our web site at <http://advantage.bridgewayhs.com> or call 1-866-475-3129, from 8:00AM to 8:00PM, 7 days a week. TTY/TDD users should call 1-877-613-2076.

This information is available for free in other languages. Please contact Member Services at 1-866-475-3129 for additional information.

Este documento está disponible en formatos e idiomas diferentes, incluso en español. Comuníquese con Servicios para los Miembros para solicitar información en otros formatos o idiomas.

Bridgeway is a Coordinated Care plan with a Medicare Advantage contract and a contract with the Arizona Medicaid program.

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