

CuraScript - Specialty Prior Authorization Criteria

The drugs in the table below are examples of prior authorization clinical criteria. This table is not all inclusive of approved and excluded uses.

| Drug Name | Primary Indications* | Potential for Abuse | Drug usage guidelines/criteria |
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| abobotulinumtoxinA for injection (Dysport™) | Indicated for the treatment of cervical dystonia | Potential for cosmetic use | Cover numerous non-cosmetic indications with supportive evidence. |
| alpha-1 proteinase inhibitor, intravenous injection (Prolastin®, Prolastin®-C, Aralast NP™, Zemaira™, Glassia®) | Treatment of alpha ₁ -antitrypsin deficiency and emphysema. | Significant cost impact and potential for inappropriate use | Cover for patients with various phenotypes with an alpha ₁ -antitrypsin deficiency. |
| ambrisentan tablets (Letairis®) and bosentan tablets (Tracleer®) | Treatment of pulmonary arterial hypertension (PAH). | Some potential for inappropriate use. | Covered for select patients with PAH meeting clinical criteria who have had appropriate medical work-up. |
| certolizumab pegol for subcutaneous injection (Cimzia®) | Indicated for Crohn's disease in adults and for treatment of adults with moderately to severely active rheumatoid arthritis (RA). | Significant cost impact and potential for inappropriate use | Cover for select patients with Crohn's disease and select patients with RA. |
| epoetin alfa intravenous or subcutaneous injection (Procrit®, Epogen®), and darbepoetin alfa intravenous or subcutaneous injection (Aranesp®) | Numerous indications where an increase in red blood cell production is medically necessary. | Significant cost impact and potential for inappropriate use | Cover for patients with anemia associated with chronic renal failure, cancer chemotherapy and other indications with supportive evidence. |
| epoprostenol injection (Flolan®, Veletri®, generic) [included in Flolan-Remodulin PA] | Treatment of pulmonary arterial hypertension (PAH) | Significant cost impact and potential for inappropriate use. | Covered for select patients with PAH meeting clinical criteria who have had appropriate medical work-up. Covered for other uses with supportive evidence |
| growth promoting agents: somatropin injection, (Genotropin®, Humatrope®, Norditropin®, Omnitrope™, Nutropin®/AQ, Saizen®, Serostim®, Tev-Tropin®, Zorbtive™) and mecasermin injection (Increlex™) | Somatropin (growth hormone) is indicated for the treatment of growth failure in children with acquired growth hormone deficiency, non-growth hormone deficient short stature, in adults diagnosed with growth hormone deficiency and other conditions listed in the product information. Mecasermin is indicated | Significant cost impact and potential for inappropriate use | Cover only for indications that are FDA approved. |

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| | for growth failure in children with severe primary insulin-like growth factor-1 deficiency. | | |
| iloprost inhalation solution (Ventavis [®]) and treprostinil inhalation solution (Tyvaso [™]) | Treatment of pulmonary arterial hypertension (PAH). | Significant cost impact and potential for inappropriate use. | Covered for select patients with PAH meeting clinical criteria who have had appropriate medical work-up. |
| incobotulinumtoxinA for injection (Xeomin [®]) | Indicated for cervical dystonia and blepharospasm. | Potential for cosmetic use | Cover numerous non-cosmetic indications with supportive evidence. |
| onabotulinumtoxinA for injection (Botox [®]) | Indicated for the treatment of blepharospasm and strabismus associated with dystonia, cervical dystonia, axillary hyperhidrosis, upper limb spasticity, and prophylaxis of headaches in patients with chronic migraine. | Potential for cosmetic use | Cover numerous non-cosmetic indications with supportive evidence. |
| rimabotulinumtoxinB injection (Myobloc [®]) | Indicated for the treatment of cervical dystonia | Potential for cosmetic use | Cover numerous non-cosmetic indications with supportive evidence. |
| tadalafil tablets (Adcirca) and sildenafil tablets (Revatio [®]) | Treatment of pulmonary arterial hypertension (PAH) | Potential for inappropriate use | Covered for select patients meeting clinical criteria who have had appropriate medical work-up. |
| tesamorelin injection (Egrifta [™]) | Indicated for the reduction of excess abdominal fat in HIV-infected patients with lipodystrophy. | | Covered for FDA-approved indication. |
| treprostinil injection (Remodulin [®]) [included in Flolan-Remodulin PA] | Treatment of pulmonary arterial hypertension (PAH) | Significant cost impact and potential for inappropriate use. | Covered for select patients with PAH meeting clinical criteria who have had appropriate medical work-up. Covered for another use with supportive evidence. |
| abatacept, for intravenous injection (Orencia [®]) | Indicated in adults with moderate-to-severe rheumatoid arthritis (RA) and in children with juvenile idiopathic arthritis (JIA) | Significant cost impact and potential for inappropriate use | Covered for select patients with RA and JIA. |
| adalimumab, subcutaneous injection (Humira [®]) | Indicated in the treatment of adults with moderately-to-severely active rheumatoid | Significant cost impact and potential inappropriate use | Cover for select adults with RA, psoriatic arthritis, ankylosing spondylitis, plaque psoriasis and Crohn's disease; in |

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| | arthritis (RA), psoriatic arthritis, ankylosing spondylitis, plaque psoriasis, and Crohn's disease, and in children with juvenile idiopathic arthritis (JIA). | | children with JIA; and in other uses with supportive evidence. |
| alefacept, for subcutaneous or intramuscular injection (Amevive®) | Indicated for treatment of adults with moderate-to-severe chronic plaque psoriasis. | Significant cost impact and potential of inappropriate use | Covered for patients with chronic plaque psoriasis |
| anakinra, for subcutaneous injection (Kineret®) | Indicated in the treatment of adults with moderately-to-severely active rheumatoid arthritis (RA) who have failed one or more disease-modifying antirheumatic drugs. | Significant cost impact and potential for inappropriate use | Cover for select adults with RA and in other uses with supportive evidence. |
| etanercept, for subcutaneous injection (Enbrel®) | Indicated in the treatment of adults with moderately-to-severely active rheumatoid arthritis (RA), psoriatic arthritis, ankylosing spondylitis, and plaque psoriasis, and in children with juvenile idiopathic arthritis (JIA). | Significant cost impact and potential for inappropriate use | Cover for select adults with RA, psoriatic arthritis, ankylosing spondylitis, and plaque psoriasis; in children with JIA; and in other uses with supportive evidence. |
| golimumab, for subcutaneous injection (Simponi®) | Indicated for treatment of adults with moderately to severely active rheumatoid arthritis (RA) in combination with methotrexate (MTX) and in adults with active psoriatic arthritis (PsA) or ankylosing spondylitis (AS) either alone or in combination with MTX or other non-biologic disease modifying antirheumatic drugs (DMARDs). | Significant cost impact and potential for inappropriate use | Cover for select patients with RA, PsA, and AS. |
| infliximab, for intravenous injection (Remicade®) | Indicated for adults with moderate to severe rheumatoid arthritis (RA) in combination with MTX, and in adults with psoriatic arthritis, ankylosing spondylitis, Crohn's disease, fistulizing Crohn's | Significant cost impact and potential for inappropriate use | Covered for select patients with RA, psoriatic arthritis, ankylosing spondylitis, Crohn's disease, fistulizing Crohn's disease, plaque psoriasis, and ulcerative colitis and in other uses with supportive evidence. |

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| | disease, plaque psoriasis, and ulcerative colitis and in children with Crohn's disease. | | |
| omalizumab, for subcutaneous injection (Xolair®) | Indicated for adults and adolescents (aged ≥ 12 years) with moderate-to-severe persistent asthma who have a positive skin test or <i>in vitro</i> reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids. | Significant cost impact and potential for inappropriate use | Cover for select patients with asthma and seasonal and perennial allergic rhinitis as supported. Cover for other uses with supportive evidence. |
| rituximab, intravenous injection (Rituxan®) | Indicated for the treatment of non-Hodgkin's lymphoma, chronic lymphocytic leukemia, and in adults with moderate to severe active rheumatoid arthritis (RA) who have had an inadequate response to one or more tumor necrosis factor (TNF) antagonists. | Significant cost impact and potential for inappropriate use | Cover for select patients with RA. This policy mainly addresses the use of rituximab in RA. |
| teriparatide, subcutaneous injection (Forteo®) | Treatment of women with postmenopausal osteoporosis; increase bone mass in men with primary or hypogonadal osteoporosis; treatment of men and women with glucocorticoid-induced osteoporosis. | Potential for inappropriate use for the prevention of osteoporosis. | Cover for select patients in the treatment of osteoporosis who are at high risk for fracture-and in hypoparathyroidism. |
| ustekinumab injection (Stelara™) | Indicated for Plaque psoriasis in adults | Significant cost impact and potential for inappropriate use | Cover for select patients with plaque psoriasis. |
| Bisphosphonates, intravenous (Reclast®, Boniva®) | Reclast is indicated for the treatment of osteoporosis in postmenopausal women (PMO); for the prevention of PMO; the treatment of Paget's disease of bone in men and women; for the treatment to increase | Significant cost impact and potential for inappropriate use | Cover for select patients with postmenopausal osteoporosis and other indications listed in the policy. |

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| | bone mass in men with osteoporosis; and for the treatment and prevention of glucocorticoid-induced osteoporosis (GIO) in patients expected to be on glucocorticoids for at least 12 months. Boniva IV is indicated for treatment of PMO. | | |
| glatiramer acetate, subcutaneous injection (Copaxone®) | Indicated for the treatment of multiple sclerosis (MS). | Significant cost impact with potential for inappropriate use | Cover for patients with MS. |
| hyaluronic acid derivatives, intraarticular (Euflexxa®, Hyalgan®, Synvisc®, Synvisc® One, Supartz®, Orthovisc®) | Indicated for the treatment of pain related to knee osteoarthritis (OA) in patients who have failed to respond adequately to conservative non-pharmacologic therapy and to simple analgesics. | Cost impact and potential for inappropriate use | Cover for select patients with knee OA and who have failed other therapies. |
| immune globulin intravenous (IVIG) | All IVIG products are Food and Drug Administration-approved for replacement therapy in patients with primary immunodeficiencies. Individual products are labeled for use in other conditions. | Significant cost impact and potential for inappropriate use | Many covered indications have been identified with specific criteria. |
| immune globulin subcutaneous injections (Gamunex-C®) | Indicated for the treatment of patients with primary immune deficiency. | Cost impact and potential for inappropriate use | Cover in select patients with primary immune deficiency and other uses with supportive evidence. |
| interferon beta-1a, injection (Rebif® [subcutaneous]), (Avonex® [intramuscular]) | Indicated for the treatment of multiple sclerosis (MS). | Significant cost impact with potential for inappropriate use | Cover for patients with MS. |
| interferon beta-1b, subcutaneous injection (Betaseron®, Extavia®) | Indicated for the treatment of multiple sclerosis (MS). | Significant cost impact with potential for inappropriate use | Cover for patients with MS. |
| leuprolide acetate, intramuscular injection (Lupron Depot®/Ped®) subcutaneous injection (Eligard®) | Indicated for conditions that benefit from the suppression of ovarian and testicular steroidogenesis | Cost impact and potential for inappropriate use | Cover selected dosage forms and for patients with select medical indications as listed in the policy. |
| fentanyl buccal soluble film | Indicated for the | Significant cost | Cover for select patients with |

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| (Onsolis [®]), | management of breakthrough cancer pain in patients with malignancies who are already receiving and who are tolerant to opioid therapy for their underlying persistent cancer pain | impact and potential for inappropriate use | breakthrough chronic cancer and non-cancer pain. |
| palivizumab (Synagis [®]) | Indicated for prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV) in pediatric patients at high risk of RSV disease. | Potential inappropriate use as a <i>treatment</i> option for RSV disease | Coverage for <i>prevention</i> of RSV disease for the duration of the RSV season in pediatric patients at high risk of RSV disease. |
| pegfilgrastim, subcutaneous injection (Neulasta [®]) | Indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia. | Significant cost impact. | Covered for cancer patients receiving chemotherapy. |
| pegvisomant injection (Somavert [®]) | Treatment of acromegaly in patients with an inadequate response to other therapies such as surgery, radiation therapy, and/or medical therapies, or if these therapies are not appropriate. | Significant cost impact. | Cover for patients with acromegaly. |
| tocilizumab for injection (Actemra [®]) | Indicated for adults with moderate to severe active rheumatoid arthritis (RA) who have had an inadequate response to one or more tumor necrosis factor (TNF) antagonists. | Significant cost impact and potential for inappropriate use | Covered for select patients with RA, and in other uses with supportive evidence. |
| pegylated interferons: peginterferon alfa-2b, for subcutaneous injection (PEG-Intron [®]) and peginterferon alfa-2a, subcutaneous injection (Pegasys [®]) | Indicated for the treatment of adults with chronic hepatitis C virus (HCV) infection. Peginterferon alfa-2a is indicated in adults with chronic hepatitis B infection. | Significant cost impact and potential for inappropriate use | Treatment of select patients with chronic HCV. |

* = FDA-Approved Indications