KAISER PERMANENTE®

2021 Prior Authorization Criteria

ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD) **Drug Products Affected:** Methamphetamine	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

AIDS RELATED WEIGHT LOSS **Drug Products Affected:** Dronabinol, Serostim, Syndros	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

ANTICONVULSANTS **Drug Products Affected:** Epidiolex	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

ANTI-INFECTIVES **Drug Products Affected:** Arikayce	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

ANTINEOPLASTICS **Drug Products Affected:** Targretin	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

BENIGN PROSTATIC HYPERPLASIA **Drug Products Affected:** Tadalafil 2.5 mg, 5 mg tablets	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Stand Alone Erectile Dysfunction
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

BONE DISORDERS **Drug Products Affected:** Xgeva	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

CARISOPRODOL PRODUCTS **Drug Products Affected:** Aspirin/Carisoprodol; Aspirin/Carisoprodol/Codeine Phosphate, Carisoprodol	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

COSMETIC INDICATION **Drug Products Affected: Altreno,** Avita, Fabior, Retin-A, Retin-A Micro, Tazorac, Tazarotene, Tretinoin, Tretinoin Microsphere	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Treatment for cosmetic purposes.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

CYSTIC FIBROSIS **Drug Products Affected:** Kalydeco	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

EOSINOPHILIC PHENOTYPE **Drug Products Affected:** Dupixent, Fasenra, Nucala	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

FERTILITY TREATMENT **Drug Products Affected:** Clomiphene, Crinone, Chorionic gonadotropin injection, Novarel, Pregnyl	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

HEPATITIS DRUGS **Drug Products Affected:** Daklinza, Epclusa, Harvoni, Ledipasvir/sofosbuvir, Mavyret, Sofosbuvir/Velpatasvir, Sovaldi, Viekira Pak, Viekira XR, Vosevi, Zepatier	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Genotype must be documented
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

HYPERCHOLESTEROLEMIA **Drug Products Affected:** Juxtapid, Kynamro, Repatha	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

HYPERPHOSPHATEMIA **Drug Products Affected:** Auryxia	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

LIDOCAINE PATCH **Drug Products Affected:** Lidocaine Patch	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

MULTIPLE SCLEROSIS **Drug Products Affected:** Aubagio	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

NUVIGIL/PROVIGIL **Drug Products Affected:** Armodafinil, Modafinil	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

PAIN TREATMENT **Drug Products Affected:** Demerol injection, Meperidine injection	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

PLAQUE PSORIASIS/PSORIATIC ARTHRITIS **Drug Products Affected:** Ilumya, Otezla, Stelara	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

PULMONARY ARTERIAL HYPERTENSION **Drug Products Affected**: Adempas, Alyq, Sildenafil 20mg tablets, Tadalafil 20mg tablets	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

PULMONARY FIBROSIS **Drug Products Affected:** Esbriet	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

PSEUDOBULBAR AFFECT **Drug Products Affected:** Nuedexta	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

RHEUMATOID ARTHRITIS **Drug Products Affected:** Cimzia, Enbrel	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

SHORT BOWEL SYNDROME **Drug Products Affected:** Gattex	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

SKELETAL MUSCLE RELAXANTS **Drug Products Affected:** Cyclobenzaprine, Fexmid	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

SOMATROPIN PRODUCTS **Drug Products Affected:** Genotropin, Humatrope, Norditropin, Nutropin, Omnitrope, Saizen, Saizenprep, Zomacton, Zorbtive	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

TASIMELTEON **Drug Products Affected:** Hetlioz	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

TRANSMUCOSAL IMMEDIATE RELEASE FENTANYL (TIRF) **Drug Products Affected:** **Actiq** (generics only) – fentanyl citrate, oral transmucosal lozenge **Fentora** (and generics) – fentanyl citrate, buccal tablet **Abstral –** fentanyl citrate, sublingual tablets **Lazanda –** fentanyl, nasal spray **Subsys –** fentanyl, sublingual metered spray	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Diagnosis of Non-Cancer related pain
Required Medical Information	Diagnosis of Cancer pain. Documentation of tolerance to around-the-clock opioid therapy for their underlying persistent pain.
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of Oncologist or Hospice/Palliative Care Specialist.
Coverage Duration	Through the End of the Plan Contract Year
Other Criteria	N/A

XOLAIR **Drug Products Affected:** Xolair	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the End of the Plan Contract Year
Other Criteria	N/A

You must reside in the Kaiser Permanente Medicare health plan service area in which you enroll.

Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, call Member Services at **1-800-476-2167** (TTY **711**),8 a.m. to 8 p.m., seven days a week.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to 2500 South Havana, Aurora, CO 80014 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

KAISER PERMANENTE®

Multi-language Interpreter Services

English

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-800-476-2167** (TTY: **711**).

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-476-2167** (TTY: **711**).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-476-2167**（TTY：**711**）。

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-476-2167** (TTY: **711**).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-476-2167** (TTY: **711**).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-800-476-2167 (TTY: **711**)번으로 전화해 주십시오.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-476-2167** (телетайп: **711**).

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-476-2167**（TTY:**711**）まで、お電話にてご連絡ください。

Amharic

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-476-2167 (መስማት ለተሳናቸው: **711**).

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-476-2167** (TTY: **711**).

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French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-476-2167** (ATS : **711**).

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-476-2167** (TTY: **711**) تماس بگیرید.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-674-008-7612** (رقم هاتف الصم والبكم: -**117**).

Yoruba

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-476-2167** (TTY: **711**).

Cushite-Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-476-2167** (TTY: **711**).

Nepali

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् **1-800-476-2167** (टिटिवाइ: **711**)।