

2019 Prior Authorization Criteria

ACTHAR	
Drug Products Affected: H.P. Acthar gel	
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

ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD)	
Drug Products Affected: Desoxyn, 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, Marinol, 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

BOTULINUM TOXINS	
Drug Products Affected: Botox, Dysport, Xeomin	
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, Soma	
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: Atralin, Avita, Retin-A, Retin-A Micro, Tazorac, Tretin-X, Tretinoin	
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

DICLOFENAC PATCH	
Drug Products Affected: Flector	
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: Cialis 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

FERTILITY TREATMENT	
Drug Products Affected: 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, Eplclusa, Harvoni, Mavyret, Olysio, Sovaldi, Technivie, 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, Praluent, 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

LIDOCAINE PATCH	
Drug Products Affected: Lidoderm	
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, Nuvigil, Provigil	
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: 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 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

PULMONARY ARTERIAL HYPERTENSION	
Drug Products Affected: Adcirca, Adempas, Opsumit, Revatio, Remodulin, Sildenafil 20mg tablets, Tadalafil	
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:** Amrix, Cyclobenzaprine, Flexmid

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, Tev-Tropin, Zomacton, Zorbive

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 (and generics) – 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

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

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

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 **1-800-805-2739 (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 711 Kapiolani Blvd, Honolulu, HI 96813 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 is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

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 **1-800-805-2739** (TTY: **711**).

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-805-2739** (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 **1-800-805-2739** (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 **1-800-805-2739** (TTY: **711**).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-805-2739** (TTY: **711**).

Korean

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

1-800-805-2739 (TTY: **711**)번으로 전화해 주십시오.

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。**1-800-805-2739** (TTY:**711**) まで、お電話にてご連絡ください。

Lao

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຮ **1-800-805-2739** (TTY: **711**).

Ilocano

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti **1-800-805-2739** (TTY: **711**).

Samoan

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se togoti, mo oe, Telefoni mai: **1-800-805-2739** (TTY: **711**).

Marshallese

LALE: Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jermal in jipañ ilo kajin ñe am ejjeļok wōñāān. Kaalok **1-800-805-2739** (TTY: **711**)

Trukese

MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori **1-800-805-2739** (TTY: **711**).

Hawaiian

E NĀNĀ MAI: Inā ho‘opuka ‘oe i ka ‘ōlelo ho‘okomo ‘ōlelo, loa‘a ke kōkua manuahi iā ‘oe. E kelepona iā **1-800-805-2739** (TTY: **711**).

Pohnpeian

Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie Lokaiahn Pohnpei komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call **1-800-805-2739** (TTY: **711**).

Bisayan

ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa **1-800-805-2739** (TTY: **711**).

Tongan

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai **1-800-805-2739** (TTY: **711**).