

## 2019 Prior Authorization Criteria

<b>ACTHAR</b>	
<b>Drug Products Affected:</b> H.P. Acthar gel	
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Through the end of the Plan Contract Year
<b>Other Criteria</b>	N/A

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

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

<b>BOTULINUM TOXINS</b>	
<b>Drug Products Affected:</b> Botox, Dysport, Xeomin	
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Through the end of the Plan Contract Year
<b>Other Criteria</b>	N/A

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**SKELETAL MUSCLE RELAXANTS****Drug Products Affected:** Amrix, Cyclobenzaprine, Flexmid

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Through the end of the Plan Contract Year
<b>Other Criteria</b>	N/A

**SOMATROPIN PRODUCTS****Drug Products Affected:** Genotropin, Humatrope, Norditropin, Nutropin, Omnitrope, Saizen, Tev-Tropin, Zomacton, Zorbtive

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Through the end of the Plan Contract Year
<b>Other Criteria</b>	N/A

**TASIMELTEON****Drug Products Affected:** Hetlioz

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Through the end of the Plan Contract Year
<b>Other Criteria</b>	N/A



<b>TRANSMUCOSAL IMMEDIATE RELEASE FENTANYL (TIRF)</b>	
<b>Drug Products Affected:</b>	
<b>Actiq</b> (and generics) – fentanyl citrate, oral transmucosal lozenge	
<b>Fentora</b> (and generics) – fentanyl citrate, buccal tablet	
<b>Abstral</b> – fentanyl citrate, sublingual tablets	
<b>Lazanda</b> – fentanyl, nasal spray	
<b>Subsys</b> – fentanyl, sublingual metered spray	
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Diagnosis of Non-Cancer related pain
<b>Required Medical Information</b>	Diagnosis of Cancer pain. Documentation of tolerance to around-the-clock opioid therapy for their underlying persistent pain.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Patient under care of Oncologist or Hospice/Palliative Care Specialist.
<b>Coverage Duration</b>	Through the End of the Plan Contract Year
<b>Other Criteria</b>	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 **1-877-221-8221 (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 500 NE Multnomah St., Suite 100, Portland OR 97232 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>**.

# Multi-language Interpreter Services

## English

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-221-8221** (TTY: **711**).

## Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-221-8221** (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 **1-877-221-8221** (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 **1-877-221-8221** (TTY: **711**).

## Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-221-8221** (TTY: **711**).

## Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-221-8221** (TTY: **711**)번으로 전화해 주십시오.

## Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-221-8221** (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。**1-877-221-8221** (TTY: **711**) まで、お電話にてご連絡ください。

## Punjabi

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।  
**1-877-221-8221**

## Cambodian

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតលុយ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ **1-877-221-8221** (TTY: **711**)។

## Thai

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-877-221-8221** (TTY:711).

## Farsi

**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-877-221-8221** (TTY: 711) تماس بگیرید.

## Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-221-8221** (رقم هاتف الصم والبكم: -711).

## Amharic

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ **1-877-221-8221** (መስማት ለተሳናቸው: 711)።

## German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-221-8221** (TTY: 711).

## French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-221-8221** (ATS : 711).

## Cushite-Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-877-221-8221** (TTY: 711).

## Lao

ໂບດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຮ **1-877-221-8221** (TTY: 711).

## Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-877-221-8221** (телетайп: 711).

## Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-877-221-8221** (TTY: 711).