

# ABOBOTULINUMTOXINA

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## Products Affected

- DYSPORE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Cosmetic uses
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Conservative treatments, for example, physical therapy, oral medications, etc, have been tried or considered, have failed and/or are contraindicated
<b>Age Restrictions</b>	Must be 2 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	Maximum billing unit(s) equals 1500 units

# AFLIBERCEPT

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## Products Affected

- EYLEA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	The patient has tried and failed or is intolerant to less expensive, clinically appropriate alternatives, the patient does not have an active ocular or periocular infection, and the patient does not have an active intraocular inflammation. Renewable if the patient continues to meet the criteria for medical necessity.
<b>Age Restrictions</b>	The patient is 18 years of age or older
<b>Prescriber Restrictions</b>	Ophthalmologist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

# ALGLUCOSIDASE ALFA

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## Products Affected

- LUMIZYME

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For the initial authorization, the following supporting documentation must be submitted: Subjective findings (complaints), Objective findings (exams, lab results), Physical examination, Complications (for example, bony changes or kidney failure), Quality of life issues (for example, severe, unremitting pain or extreme fatigue), Identified licensed practitioner who will administer infusion therapy, coordinate care, and their Plan: Include the treatment plan including the genetic evaluation and counseling information for the patient and family members and Goal: Include specific information about the desired outcome
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with a neurologist, geneticist or other physician with specialty in treating Pompe disease
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	The recommended dose is 20 mg/kg every two weeks

# ANTINEOPLASTIC

## Products Affected

- ADCETRIS
- ADRIAMYCIN
- ADRUCIL
- AVASTIN 100 MG/4 ML VIAL P/F,SUV
- CAMPTOSAR
- *carboplatin*
- *cisplatin*
- *cyclophosphamide*
- *dacarbazine*
- *docetaxel*
- *doxorubicin*
- *etoposide*
- *fluorouracil*
- *fulvestrant*
- *gemcitabine*
- HERCEPTIN
- HERZUMA
- *irinotecan*
- KADCYLA
- KANJINTI
- KEYTRUDA
- MVASI
- OGIVRI
- ONTRUZANT
- OPDIVO
- *oxaliplatin*
- *paclitaxel*
- *paclitaxel protein-bound*
- PARAPLATIN
- *pemetrexed*
- PERJETA
- POLIVY
- TRAZIMERA
- *vinblastine*
- *vincristine*
- YERVOY
- ZEPZELCA
- ZIRABEV

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must meet "1" of the following requirements: i. Confirmed diagnosis of FDA labeled indication, OR ii. Confirmed NCCN recommended regimen of category 2B or above AND b. Request for off-labeled use and/or non-preferred NCCN regimen requires clinical review by IEHP pharmacist
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Specialist (e.g., Oncologist, Hematologist, Dermatologist, etc.)
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	Reauthorization Criteria: a. Must meet the following requirement: i. Review by Clinical Pharmacist

# BORTEZOMIB

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## Products Affected

- *bortezomib*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. For chemotherapy-related indications, refer to PA ANTINEOPLASTIC
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Specialist (e.g., Oncologist, Hematologist, Dermatologist, etc.)
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

# CAR-T

## Products Affected

- ABECMA
- BREYANZI
- KYMRIAH
- TECARTUS
- YESCARTA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	See CAR-T Policy, requires clinical pharmacist review
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

# DENOSUMAB

## Products Affected

- PROLIA
- XGEVA

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. For Prolia: 60 mg subcutaneously every six months indicated for postmenopausal women with osteoporosis at high risk of fracture, to increase bone mass in men with osteoporosis at high risk for fracture, to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer, to increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer, and the recommended dose of denosumab. For Xgeva: The recommended dose for the prevention of skeletal related events in patients with bone metastases from solid tumors is 120 mg subcutaneously every four weeks in the upper arm, upper thigh or abdomen, for giant cell tumor of bone that is 120 mg subcutaneously every four weeks with additional 120 mg doses on days eight and 15 of the first month of therapy administered in the upper arm, upper thigh, or abdomen, for hypercalcemia of malignancy is 120 mg administered every four weeks with additional 120 mg doses on days eight and 15 of the first month of therapy.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

# ECULIZUMAB

## Products Affected

- SOLIRIS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	<p>Vaccination against Neisseria meningitides at least two weeks prior to initiation unless treatment cannot be delayed, and patient must have one of the following diagnoses: A diagnosis of Paroxysmal nocturnal hemoglobinuria (PNH) with documented baseline value for serum lactate dehydrogenase (LDH), patient is not on another terminal complement inhibitor, OR a diagnosis of Atypical hemolytic uremic syndrome (aHUS) with documented baseline value for serum lactate dehydrogenase (LDH), patient is 2 months of age or older and has a weight of at least five kilograms, patient does not have Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS), patient is not on another terminal complement inhibitor, OR a diagnosis of generalized Myasthenia Gravis (gMG) with positive serologic test for anti-acetylcholine antibodies, Myasthenia Gravis Foundation of America (MGFA) Clinical Classification Class II to IV, documented baseline MG-Activities of Daily Living (MG-ADL) total score greater than or equal to 6, and patient has had an inadequate treatment response, intolerance or contraindication to two or more immunosuppressants such as azathioprine, cyclophosphamide, cyclosporine, mycophenolate, tacrolimus, methotrexate, etc, and has had an inadequate treatment response, intolerance, or contraindication to chronic IVIG therapy, OR a diagnosis of Neuromyelitis optica spectrum disorder (NMOSD) with positive serologic test for anti-aquaporin-4 immunoglobulin G (AQP4-IgG)/NMO-IgG antibodies. For reauthorization, patient must have a significant clinical response as evidenced by: documentation of a reduction in serum LDH from pretreatment baseline (PNH, aUHS), documentation of reduction of (MG-ADL) total score from baseline (gMG), or patient has had fewer relapses while on therapy (NMOSD)</p>
Age Restrictions	Must be 2 months or older for aHUS diagnosis, must be 18 years of age or older for PNH, gMG or NMOSD diagnosis
Prescriber Restrictions	Prescriber must be enrolled in the Soliris REMS program



<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	Frequency of billing = 900 mg/90 units weekly for the first four weeks, followed by 1,200 mg/120 units for the fifth dose one week later, then 1200 mg /120 units every two weeks thereafter, maximum billing unit(s) = 1,200 mg = 120 units

# EPOETIN

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## Products Affected

- EPOGEN
- PROCRIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	See ESA policy, requires clinical pharmacist review
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

# GROWTH HORMONE

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## Products Affected

- ZORBTIVE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	See Growth Hormone Policy, requires clinical pharmacist review
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

# HYALURONAN

## Products Affected

- DUROLANE
- EUFLEXXA
- GEL-ONE
- GELSYN-3
- HYALGAN
- MONOVISC
- ORTHOVISC
- SUPARTZ FX
- SYNOJOYNT
- TRILURON
- VISCO-3

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Must have documented failure, inadequate response, or intolerance to at least two of the following pharmacologic therapies: Two oral or topical anti-inflammatory drugs (NSAIDs), acetaminophen, one or more trials in the last 12 months of intra-articular steroid injections unless intolerant or contraindicated, and at least one course of physical therapy for knee osteoarthritis, no contraindications to the injections (active joint infection, bleeding disorder), For treatment continuation: Patient has successfully used hyaluronic acid derivatives in the same knee (there must be at least a six-month interval before approval of a repeat course)
<b>Age Restrictions</b>	Synojoynt, Durolane and Visco-3: Must be 22 years of age or older, Triluron, Hyalgan, Supartz and Euflexxa: Must be 18 years of age or older
<b>Prescriber Restrictions</b>	Orthopedics, Pain Management Specialist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	Must use modifiers RT, LT for applicable knee(s), Maximum billing units per knee per 180 days: 60 units (Durolane, Synojoynt, Triluron), 5 units (Hyalgan, Supartz), 3 units (Visco-3)

# INCOBOTULINUMTOXINA

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## Products Affected

- XEOMIN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Cosmetic uses
<b>Required Medical Information</b>	Conservative treatments, for example, physical therapy, oral medications, etc, have been tried or considered, have failed and/or are contraindicated
<b>Age Restrictions</b>	Must be 18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	Maximum billing unit(s) equals 400 units

# INFLIXIMAB

## Products Affected

- AVSOLA
- INFLECTRA
- INFLIXIMAB
- RENFLEXIS

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. For chemotherapy-related indications, see PA ANTINEOPLASTIC
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Alternative, conventional therapy has been tried or considered, has failed, or is contra-indicated, patient was screened and showed absence of latent (untreated) tuberculosis prior to therapy initiation, patient has been screened for the presence of hepatitis B virus (HBV) prior to initiating treatment, and patient has no active infection, Reauthorization: This may be granted if: Patient continues to meet initial coverage criteria and patient has shown a positive clinical response such as symptoms improvement or lack of disease progression
<b>Age Restrictions</b>	Must be 6 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

# INTRAVENOUS IRON

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## Products Affected

- FERAHEME
- INJECTAFER

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Trial and failure of oral iron supplementation, and labs indicating deficiency, e.g. anemia, low iron saturation, etc.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

# IVIG

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## Products Affected

- GAMMAGARD LIQUID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	See IVIG policy, requires clinical pharmacist review
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	



# LUSPATERCEPT

## Products Affected

- REBLOZYL

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Active hepatitis C (HCV) infection, active infectious hepatitis B (HBV) as demonstrated by a positive HCV-RNA test of sufficient sensitivity, known human immunodeficiency virus (HIV) that is not controlled by antiretroviral (ART) therapy, recent deep vein thrombosis or stroke requiring medical intervention less than or equal to 24 weeks prior, major organ damage as evidenced by any of the following: Liver disease with an ALT greater than 3x the ULN or history of evidence of cirrhosis, Heart disease, heart failure NYHA classification three or higher, or significant arrhythmia requiring treatment, or recent myocardial infarction within six months of treatment, Lung disease, including pulmonary fibrosis or pulmonary hypertension which are clinically significant, that is, equal to or greater than Grade 3, Renal insufficiency such as creatinine clearance less than 60 mL/min
<b>Required Medical Information</b>	Patient has a clinically documented diagnosis of beta-thalassemia or Hemoglobin E/beta-thalassemia. Beta-thalassemia with mutation and/or multiplication of alpha globin is allowed. Patient is regularly transfused, defined as: 6-20 Red Blood Cell (RBC) units in the 24 weeks prior and no transfusion-free period for equal to or greater than 35 days during that period, patient does not have a diagnosis of Hemoglobin S/beta-thalassemia or alpha (a)-thalassemia (for example, Hemoglobin H), and patient is not pregnant or breastfeeding, Continuation of therapy: Patient continues to meet the initial coverage criteria, patient has experienced a clinically significant reduction in transfusion burden from baseline, patient has an absence of unacceptable toxicity from the drug such as severe thromboembolic events or hypertension
<b>Age Restrictions</b>	Patient must be 18 years of age or older
<b>Prescriber Restrictions</b>	Must be prescribed by, or in consultation with, a hematologist, or other specialist with expertise in the diagnosis and treatment of thalassemia
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	Frequency of billing equal to 1.25 mg/kg every three week

# MEPOLIZUMAB

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## Products Affected

- NUCALA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	See Nucala Policy, requires clinical pharmacist review
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

# NUSINERSEN

## Products Affected

- SPINRAZA (PF)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	<p>Genetic testing results demonstrate homozygous SMN1 deletion, or any combination of SMN1 deletions or other mutations that result in the functional loss of all SMN1 genes. In addition to demonstrating loss of functional SMN1 genes, genetic test results include the number of copies of SMN2. Pre-symptomatic: Defined by genetic testing demonstrating a homozygous SMN1 deletion or mutation, and less than or equal to three copies of SMN2 OR Symptomatic: Patient with clinical signs of SMA with level of function necessary to preserve communication, for instance finger or eye movements in response to prompt by examiner. For nusinersen, it can be safely administered intrathecally, taking into consideration the patient's scoliosis status. Specifically, for older patients with SMA, the drug may only be authorized if beneficiary has any of the following: No scoliosis, scoliosis without spine surgery, scoliosis post spine surgery with preserved window of accessibility for intrathecal injection, under fluoroscopic or ultrasound guidance if needed, scoliosis post spine surgery for example, fusion) but with surgical placement of an indwelling catheter or establishment of a new window for IT accessibility, and the patient does not have a coexisting terminal condition or a condition with which the risk of nusinersen treatment outweighs the potential benefit.</p>
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	6 months
Other Criteria	<p>Medical note from neuromuscular specialist SCC containing: Patient demographics, including age of onset, results of genetic testing, including name of laboratory, number of copies of SMN2, and whether SMN1 sequencing was done, neurologic status, specifically if patient is non-sitter, sitter or walker, pulmonary status, nutrition and dietary status (with</p>

<b>PA Criteria</b>	<b>Criteria Details</b>
	review by registered dietitian), and results of at least one neuromotor assessment with a score used to establish a clinical baseline, e.g. CHIP INTEND, HFMSE, TUG, RULM, that is appropriate for clinical status, e.g. non-sitters, sitters, walkers, and non-ambulatory older patients

# OCRELIZUMAB

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## Products Affected

- OCREVUS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Hepatitis B virus screening is required before the first dose.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	Start dose: 300 mg intravenous infusion, followed two weeks later by a second 300 mg intravenous infusion and subsequent doses: 600 mg intravenous infusion every six months

# OCTREOTIDE

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## Products Affected

- SANDOSTATIN LAR DEPOT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

# OMALIZUMAB

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## Products Affected

- XOLAIR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	See Xolair Policy, requires clinical pharmacist review
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

# ONABOTULINUMTOXINA

## Products Affected

- BOTOX

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Cosmetic uses
<b>Required Medical Information</b>	For prophylaxis of chronic migraine: Diagnosis of chronic migraine, defined by all of the following: Greater than or equal to 15 headache days per month, greater than or equal to 8 migraine days per month, headaches last 4 hours per day or longer, and trial and failure, unless contraindicated or intolerant, to prophylactic therapy with one agent from two of the following therapeutic classes: antidepressant, antiepileptic, and beta-blocker. For overactive bladder: Diagnosis of overactive bladder and one of the following symptoms: urge urinary incontinence, urgency, frequency, and trial and failure, unless contraindicated or intolerant, to two anticholinergic medications. For other conditions: The patient had been unresponsive to conventional methods of treatments such as medication, physical therapy and other appropriate methods used to control or treat this condition.
<b>Age Restrictions</b>	Must be 2 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	Maximum billing unit(s) equals 400 units



# RASBURICASE

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## Products Affected

- ELITEK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	Safety and efficacy has been established only for a single course of treatment once daily for 5 days

# RIMABOTULINUMTOXINB

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## Products Affected

- MYOBLOC

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Cosmetic uses
<b>Required Medical Information</b>	The patient had been unresponsive to conventional methods of treatments such as medication, physical therapy and other appropriate methods used to control or treat this condition
<b>Age Restrictions</b>	Must be 18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	Maximum billing unit(s) equals 5000 units

# RITUXIMAB

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## Products Affected

- RIABNI
- RITUXAN
- RUXIENCE
- TRUXIMA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. For chemotherapy-related indications, refer to PA ANTINEOPLASTIC
Exclusion Criteria	
Required Medical Information	Alternative treatments have been tried or considered, have failed, or are contraindicated.
Age Restrictions	
Prescriber Restrictions	Specialist (e.g., Oncologist, Hematologist, Dermatologist, etc.)
Coverage Duration	6 months
Other Criteria	

# ROMIPLOSTIM

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## Products Affected

- NPLATE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Insufficient response to therapy, as indicated by 1 or more of the following: Corticosteroids, Intravenous immunoglobulin (IVIG), or Splenectomy, Platelet count less than 30,000/mm <sup>3</sup> (30 x10 <sup>9</sup> /L), and clinical condition increases risk of bleeding, Patient not breast-feeding or pregnant
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

# TEPROTUMUMAB

## Products Affected

- TEPEZZA

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Requires clinical pharmacist review, Patient must have a clinical diagnosis of Graves disease associated with active thyroid eye disease (TED) with a clinical activity score (CAS) of greater than or equal to 4 for the most severely affected eye or patient has moderately to severely active TED, associated with at least one of the following: Lid retraction equal to or greater than 2 mm, moderate or severe soft tissue involvement, proptosis equal to or greater than 3 mm, diplopia, or corneal exposure, and Patient does not require surgical ophthalmological intervention, patient must not have poorly controlled diabetes, Diabetic patient must have well controlled disease (defined as HgbA1c less than 9.0 percent at most recent clinic visit), and patient has a contraindication, intolerance, or lack of response to glucocorticoids or a documented justification why the use of glucocorticoids is not appropriate
<b>Age Restrictions</b>	Patient must be 18 years of age or older
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with an ophthalmologist, endocrinologist or a physician who specializes in treatment of thyroid eye disease
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	Maximum of 8 infusions and frequency of billing equal to 10 mg/kg initial dose, then 20 mg/kg every 3 weeks for 7 additional doses

## **Index of Drugs**

INDEX \e " " \c "2" \h "A" \z "1033"