



**Department Of Pharmacy (Medicaid, Child Health Plus, Medicare Part B, Qualified Health Plan, Essentials Plan, Enriched Health (HARP))**

**Medications Requiring Authorization under Medical Benefit – Fax request to (718) 536-3383**

(Last Revised 07/31/17)

- It is the policy of Affinity Health Plan to require prior authorization for medical claims for the all drugs listed within this document when administered in an office or clinic setting. Some devices and supplies will also require prior authorization if listed.
- In addition, all drugs requested by nonparticipating providers shall require prior authorization i.e. Specialty Pharmacies.
- All drugs that are self-administered are covered as part of the Pharmacy Benefit. Prior authorization will be required in order to be covered as a Medical Benefit.
- Any drug that does not have an indication supported by FDA or Compendia requires authorization. Acceptable Compendia are Micromedex DrugDex and NCCN (National Comprehensive Cancer Network).

Items	Covered Benefit for	Preferred Vendor	Contact Information
Enteral formula	Medicaid/CHP limits 1000-2000 calories/day	CVS Caremark	Phone: 877-432-6793 Fax: 866-255-7569
	Enriched Health		Phone: 877-432-6793 Fax: 866-255-7569
	Medicare		Phone: 855-344-0930 Fax: 855-633-7673
	QHP		Phone: 855-582-2022 Fax: 855-245-2134
	EP		Phone: 800-294-5979 Fax: 855-245-2134
Enteral supplies	All lines of business	Coram	Phone: 888-334-7978 Fax: 800-693-7322
Insulin pump/supplies, Continuous Glucose Monitoring	All lines of business	Better Living Now	Phone 1-800-854-5729 Fax: 800-654-7515 Email: <a href="mailto:insulinpump@betterlivingnow.com">insulinpump@betterlivingnow.com</a>
Durable Medical Equipment (DME), Supplies, Orthodontics, and Prosthetics*	All lines of business	Reliacare Alliance, IPA	Phone: 877-331-5170 Fax : 718-701-5668

\*Review the quantities in the "Fee Schedule" Excel document for a list of Medicaid covered supplies/DME with quantity limits at <https://www.emedny.org/ProviderManuals/DME/index.aspx> [https://www.emedny.org/ProviderManuals/Pharmacy/PDFS/Pharmacy\\_Procedure\\_Codes.pdf](https://www.emedny.org/ProviderManuals/Pharmacy/PDFS/Pharmacy_Procedure_Codes.pdf)

**Key for Line of Business (LOB):**

ME – Medicaid    CHP – Child Health Plus    MA – Medicare    QHP – Qualified Health Plan    EP – Essentials Plan    HARP – Enriched Health

Brand	Generic	LOB	Code	1 Billable Unit	Covered Uses	Required Medical Information and Criteria	Exclusion Criteria
<b>Miscellaneous Codes</b>	Unclassified Meds	ME CHP MA QHP EP HARP	C9399 J3490 J3590 J7199 J7599 J7799 J8498 J8499 J8597 J8999 J9999	1 per NDC package size		Clinical documentation to support FDA or Compendia indication	Not to be used if drug specific code exists
<b>ENDOCRINE</b>							
<b>Lupron Depot Lupron Depot-Ped</b>	Leuprolide	ME CHP MA QHP EP HARP	J1950	3.75 mg	<ul style="list-style-type: none"> <li>Central Precocious Puberty (CPP)</li> <li>Uterine leiomyomata with anemia</li> <li>Breast Cancer (BC)</li> <li>Endometriosis</li> <li>Gender Dysphoria (GD)</li> </ul>	<ul style="list-style-type: none"> <li>CPP: GnRH test, bone age assessment, imaging of the brain, age.</li> <li>Liomyomata: Laboratory confirmation of anemia</li> <li>BC: hormone receptor (+)</li> <li>GD: Tanner Stage 2 of puberty in adolescents</li> </ul>	<ul style="list-style-type: none"> <li>Delaying puberty for short stature</li> <li>In vitro fertilization</li> <li>Preserve ovarian function during chemotherapy</li> </ul>
<b>Lupron Depot Eligard</b>	Leuprolide	ME CHP MA QHP EP HARP	J9217	7.5 mg	<ul style="list-style-type: none"> <li>Ovarian Cancer</li> <li>Prostate Cancer</li> <li>Gender Dysphoria (GD)</li> </ul>	<p><b>Note: no authorization needed for prostate CA</b></p> <ul style="list-style-type: none"> <li>GD: Tanner Stage 2 of puberty in adolescents</li> </ul>	<ul style="list-style-type: none"> <li>Premenstrual syndrome</li> </ul>
<b>Supprelin LA</b>	Histrelin Implant	ME CHP MA QHP EP HARP	J9226	50 mg	<ul style="list-style-type: none"> <li>Central Precocious Puberty</li> </ul>	GnRH test, bone age assessment, imaging of the brain, age.	<ul style="list-style-type: none"> <li>Age ≤ 2</li> <li>Delaying puberty for short stature</li> </ul>

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<b>Makena</b>	Hydroxy-progesterone Caproate	ME CHP MA QHP EP HARP	J1725	1 mg	Asymptomatic women with singleton pregnancy at high risk for preterm birth	<ul style="list-style-type: none"> <li>Current weeks gestation and estimated delivery date.</li> <li>History of spontaneous singleton preterm birth.</li> </ul>	Short cervix
	17 Hydroxy-progesterone Compounded Injection	ME CHP MA QHP EP HARP	J3490	250mg	Asymptomatic women with singleton pregnancy at high risk for preterm birth	<b>Note: no prior authorization required when obtaining compounded agent from Alere.</b> Prior authorization required from Alere for nurse home administration.	Short cervix
<b>HEMATOLOGICS</b>							
<b>Soliris</b>	Eculizumab	QHP EP	J1300	10 mg	<ul style="list-style-type: none"> <li>Paroxysmal Nocturnal Hemoglobinuria</li> <li>Atypical Hemolytic Uremic Syndrome</li> </ul>	Confirmed Dx through laboratory test	Shiga toxin E. Coli related to hemolytic uremic syndrome (STEC-HUS).
<b>Coagadex</b>	Human Factor X	ME HARP	J7175	IU	<ul style="list-style-type: none"> <li>Factor X deficiency</li> </ul>	<ul style="list-style-type: none"> <li><b>Factor X deficiency:</b> <ul style="list-style-type: none"> <li>Age ≥ 12 years old</li> <li>For on demand treatment of bleeding for mild Factor X deficiency</li> <li>Prolonged aPTT, PT, and mild Factor X deficiency confirmed through laboratory evaluation</li> </ul> </li> </ul>	Non-FDA approved indication
<b>Vonvendi</b>	Recombinant von Willebrand factor	ME HARP	J7179	IU	<ul style="list-style-type: none"> <li>Von Willebrand Disease (VWD)</li> </ul>	<ul style="list-style-type: none"> <li>For mild-moderate VWD, with documentation that DDAVP is known to have an insufficient</li> </ul>	Non-FDA approved indication

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						response or a documented clinical reason for not using DDAVP	
<b>Corifact</b>	Human Factor XIII	ME HARP	J7180	IU	<ul style="list-style-type: none"> <li>Factor XIII deficiency</li> </ul>	<ul style="list-style-type: none"> <li><b>Factor XIII deficiency:</b> <ul style="list-style-type: none"> <li>For routine prophylactic treatment of Factor XIII deficiency</li> <li>FXIII deficiency confirmed through laboratory evaluation</li> </ul> </li> </ul>	Non-FDA approved indication
<b>Tretten</b>	Recombinant Factor XIII A Sub-unit	ME HARP	J7181	IU	<ul style="list-style-type: none"> <li>Factor XIII deficiency</li> </ul>	<ul style="list-style-type: none"> <li><b>Factor XIII deficiency:</b> <ul style="list-style-type: none"> <li>For routine prophylactic treatment of Factor XIII A–subunit deficiency</li> <li>FXIII deficiency confirmed through laboratory evaluation</li> </ul> </li> </ul>	Non-FDA approved indication  Congenital Factor XIII B-subunit deficiency
<b>Novoeight</b>	Recombinant Factor VIII	ME HARP	J7182	IU	<ul style="list-style-type: none"> <li>Hemophilia A</li> </ul>	<ul style="list-style-type: none"> <li>Confirmed diagnosis with laboratory test</li> </ul>	Non-FDA approved indication  Von Willebrand Disease (VWD)
<b>Wilate</b>	VWF complex	QHP ME HARP	J7183	IU	<ul style="list-style-type: none"> <li>VWD</li> </ul>	<ul style="list-style-type: none"> <li>For mild-moderate VWD, with documentation that DDAVP is known to have an insufficient response or a documented clinical reason for not using DDAVP</li> </ul>	Non-FDA approved indication

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<b>Xyntha</b>	Factor VIII (antihemophilic factor, recombinant)	QHP ME HARP	J7185	IU	<ul style="list-style-type: none"> <li>Hemophilia A</li> </ul>	<ul style="list-style-type: none"> <li>Confirmed diagnosis with laboratory test</li> </ul>	<p>Non-FDA approved indication</p> <p>Von Willebrand Disease (VWD)</p>
<b>Alphanate</b>	Antihemophilic factor VIII/VWF complex	QHP ME HARP	J7186	IU	<ul style="list-style-type: none"> <li>Hemophilia A</li> <li>Acquired Factor VIII deficiency</li> <li>VWD surgical bleeding non responsive to DDAVP</li> <li>VWD</li> </ul>	<ul style="list-style-type: none"> <li><b>VWD:</b> <ul style="list-style-type: none"> <li>For mild-moderate VWD, with documentation that DDAVP is known to have an insufficient response or a documented clinical reason for not using DDAVP</li> </ul> </li> </ul>	<p>Severe VWD (Type 3) undergoing major surgery</p>
<b>Humate P</b>	VWF complex	QHP ME HARP	J7187	IU	<ul style="list-style-type: none"> <li>Hemophilia A</li> <li>VWD</li> </ul>	<ul style="list-style-type: none"> <li><b>Hemophilia A</b> <ul style="list-style-type: none"> <li>Confirmed severity of diagnosis with laboratory tests</li> <li>Absence of or low inhibitor titers</li> <li>Mild disease, documentation that DDAVP is known to have an insufficient response or a documented clinical reason for not using DDAVP</li> </ul> </li> <li><b>VWD:</b> <ul style="list-style-type: none"> <li>For mild-moderate VWD, with documentation that DDAVP is known to</li> </ul> </li> </ul>	<p>Non-FDA approved indication</p> <p>Prophylaxis of spontaneous bleeding episodes in VWD</p>

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						have an insufficient response or a documented clinical reason for not using DDAVP	
<b>Obizur</b>	Recombinant Factor VIII	ME HARP	J7188	IU	<ul style="list-style-type: none"> <li>Acquired Hemophilia</li> </ul>	<ul style="list-style-type: none"> <li>≥18 years old</li> <li><b>Absence</b> of inhibitors confirmed with laboratory diagnosis</li> </ul>	Non-FDA approved indication
<b>NovoSeven RT</b>	Factor VII (antihemophilic factor, recombinant)	QHP ME HARP	J7189	1 mcg	<ul style="list-style-type: none"> <li>Hemophilia A with inhibitors</li> <li>Hemophilia B with inhibitors</li> <li>Acquired Hemophilia</li> <li>Congenital Factor VII deficiency</li> <li>Glanzmann's thrombasthenia refractory to transfusions</li> </ul>	<ul style="list-style-type: none"> <li>Confirmed diagnosis with laboratory test</li> <li>Hemophilia A and B presence of inhibitors confirmed with laboratory diagnosis</li> </ul>	Non-FDA approved indication
<b>Hemofil Koate-DVI Monoclate-P</b>	Factor VIII (antihemophilic factor, human)	QHP ME HARP	J7190	IU	<ul style="list-style-type: none"> <li>Hemophilia A</li> </ul>	Confirmed diagnosis with laboratory test	Non-FDA approved indication  Von Willebrand Disease (VWD)
<b>Advate Helixate FS Kogenate FS Kovaltry Recombinate</b>	Factor VIII (antihemophilic factor, recombinant)	QHP ME HARP	J7192	IU	<ul style="list-style-type: none"> <li>Hemophilia A</li> </ul>	Confirmed diagnosis with laboratory test	Non-FDA approved indication  Von Willebrand Disease (VWD)
<b>AlphaNine SD Mononine</b>	Factor IX (antihemophilic factor, purified, non-	QHP ME HARP	J7193	IU	<ul style="list-style-type: none"> <li>Hemophilia B</li> </ul>	Confirmed diagnosis with laboratory test	Non-FDA approved indication

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	recombinant)						
<b>Bebulin VH</b> <b>Profilnine</b>	Factor IX, complex	QHP ME HARP	J7194	IU	<ul style="list-style-type: none"> <li>Hemophilia B</li> </ul>	<ul style="list-style-type: none"> <li>Confirmed diagnosis with laboratory test</li> <li><b>Bebulin VH:</b> Documentation of no allergy to heparin or history of heparin induced thrombocytopenia</li> <li><b>Profilnine SD:</b> Documentation of no evidence of DIC nor fibrinolysis</li> </ul>	<p>Non-FDA approved indication</p> <p>Factor VII deficiency</p>
<b>BeneFIX</b> <b>Ixinity</b>	Factor IX (antihemophilic factor, recombinant)	QHP ME HARP	J7195	IU	<ul style="list-style-type: none"> <li>Hemophilia B</li> </ul>	<ul style="list-style-type: none"> <li>Confirmed diagnosis with laboratory test</li> </ul>	<p>Non-FDA approved indication</p> <p><b>Ixinity:</b> &lt; 12 years of age</p>
<b>Thrombate III</b>	Human Antithrombin III	ME HARP	J7197	IU	<ul style="list-style-type: none"> <li>Antithrombin deficiency</li> </ul>	<ul style="list-style-type: none"> <li>Confirmed diagnosis with laboratory tests</li> </ul>	<p>Non-FDA approved indication</p>
<b>Feiba NF</b> <b>Feliba VH</b>	Anti-inhibitor	QHP ME HARP	J7198	IU	<ul style="list-style-type: none"> <li>Hemophilia A with inhibitors</li> <li>Hemophilia B with inhibitors</li> </ul>	<ul style="list-style-type: none"> <li>Confirmed diagnosis with laboratory tests</li> <li>Hemophilia A and B presence of inhibitors confirmed with laboratory diagnosis</li> <li>No evidence of DIC, acute thrombosis or embolism</li> </ul>	<p>Non-FDA approved indication</p> <p>Coagulation factor deficiencies in the absence of inhibitors to factor VIII or factor IX</p>
<b>Afstyla</b>	Recombinant Factor VIII	ME HARP	J7199		<ul style="list-style-type: none"> <li>Hemophilia A</li> </ul>	<ul style="list-style-type: none"> <li>Confirmed diagnosis with laboratory test</li> </ul>	<p>Non-FDA approved indication</p>

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							Von Willebrand Disease (VWD)
<b>Rixubis</b>	Recombinant Factor IX	ME HARP	J7200	IU	<ul style="list-style-type: none"> <li>Hemophilia B</li> </ul>	<ul style="list-style-type: none"> <li>Confirmed diagnosis with laboratory test</li> </ul>	Non-FDA approved indication  Induction of Immune tolerance in patients with Hemophilia B
<b>Alprolix</b>	Recombinant Factor IX, Fc fusion protein	ME HARP	J7201	IU	<ul style="list-style-type: none"> <li>Hemophilia B</li> </ul>	<ul style="list-style-type: none"> <li>Confirmed diagnosis with laboratory test</li> </ul>	Non-FDA approved indication  Induction of Immune tolerance in patients with Hemophilia B
<b>Idelvion</b>	Recombinant Factor IX, albumin fusion protein	ME HARP	J7202	IU	<ul style="list-style-type: none"> <li>Hemophilia B</li> </ul>	<ul style="list-style-type: none"> <li>Confirmed diagnosis with laboratory test</li> </ul>	Non-FDA approved indication  Induction of Immune tolerance in patients with Hemophilia B
<b>Elocate</b>	Recombinant Factor VIII, Fc fusion protein	ME HARP	J7205	IU	<ul style="list-style-type: none"> <li>Hemophilia A</li> </ul>	<ul style="list-style-type: none"> <li>Confirmed diagnosis with laboratory test</li> </ul>	Non-FDA approved indication  Von Willebrand Disease (VWD)
<b>Adynovate</b>	Recombinant, PEGylated Factor VIII	ME HARP	J7207	IU	<ul style="list-style-type: none"> <li>Hemophilia A</li> </ul>	<ul style="list-style-type: none"> <li>Confirmed diagnosis with laboratory test</li> </ul>	Non-FDA approved indication  Von Willebrand Disease (VWD)



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<b>Nuwiq</b>	Recombinant Factor VIII	ME HARP	J7209		<ul style="list-style-type: none"> <li>Hemophilia A</li> </ul>	<ul style="list-style-type: none"> <li>Confirmed diagnosis with laboratory test</li> </ul>	Non-FDA approved indication
<b>Epogen Procrit</b>	Epoetin alpha Epoetin alpha	QHP EP	J0885 J0885	1000 units 1000 units	<ul style="list-style-type: none"> <li>Anemia, CKD non-dialysis</li> <li>Anemia, chemotherapy induced, non-myeloid cancer</li> <li>Anemia, zidouvidine or ribavirin ADR</li> <li>Surgical procedure, transfusion of blood product, allogeneic; prophylaxis</li> </ul>	<ul style="list-style-type: none"> <li>Current Hgb</li> <li>Iron studies (excluding MDS) &amp; evidence of adequate iron intake</li> </ul>	<ul style="list-style-type: none"> <li>SQ route is Pharmacy benefit and requires authorization from Caremark.</li> <li>Anemia, CHF</li> <li>Anemia, radiation</li> <li>Anemia during puerperium</li> <li>Anemia, dialysis</li> </ul>
<b>Aranesp</b>	Darbepoetin alfa	QHP EP	J0881	1 mcg	<ul style="list-style-type: none"> <li>Anemia, CKD non-dialysis</li> <li>Anemia, chemotherapy induced, non-myeloid cancer</li> </ul>	<ul style="list-style-type: none"> <li>Current Hgb</li> <li>Iron studies (excluding MDS) &amp; evidence of adequate iron intake</li> </ul>	<ul style="list-style-type: none"> <li>SQ route is Pharmacy benefit and requires authorization from Caremark.</li> <li>Non-FDA approved indication</li> </ul>
<b>Neupogen Neulasta</b>	Filgrastim Pegfilgrastim	QHP EP	J1442 J2505	300 mcg 6 mg	<ul style="list-style-type: none"> <li>Febrile neutropenia, in non-myeloid cancer;</li> <li>Neutropenia prophylaxis</li> <li>Harvesting of peripheral blood stem cells, prior to autologous stem-cell</li> </ul>	<ul style="list-style-type: none"> <li>ANC</li> <li>Chemotherapy regimen is intermediate-high risk of neutropenia</li> <li>Patient risk factors</li> </ul>	Non-FDA approved indication

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					transplantation		
<b>Leukine</b>	Sargramostim	QHP EP	J2820	50 mcg	<ul style="list-style-type: none"> <li>•Allogeneic bone marrow transplantation, Myeloid reconstitution in HLA-matched related donors</li> <li>•Autologous bone marrow transplant, Myeloid reconstitution following transplant in patients with non-Hodgkin's lymphoma, Hodgkin's disease, and acute lymphoblastic lymphoma.</li> <li>•Bone marrow transplant, Delay or failure of myeloid engraftment.</li> <li>•Febrile neutropenia, In acute myelogenous leukemia following induction chemotherapy; Prophylaxis</li> <li>•Harvesting of peripheral blood stem cells</li> <li>•Peripheral blood stem cell graft, Autologous, myeloid reconstitution following transplant in patients mobilized with granulocyte macrophage colony stimulating factor</li> </ul>	CBC w/differential Renal function LFT	Non-FDA approved indication
<b>Mozobil</b>	Plerixafor	QHP EP	J2562	1 mg	Combination with granulocyte-colony stimulating factor (G-CSF) to mobilize	<ul style="list-style-type: none"> <li>• Cr at baseline</li> <li>• CBC w/differential</li> </ul>	Non-FDA approved indication

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					hematopoietic stem cells to the peripheral blood for collection and subsequent autologous transplantation in patients with non-Hodgkin’s lymphoma and multiple myeloma		
<b>Neumega</b>	Oprelvekin	QHP EP	J2355	5 mg	Prevention of severe thrombocytopenia and the reduction of the need for platelet transfusions following myelosuppressive chemotherapy	<ul style="list-style-type: none"> <li>• Platelet count &lt;20,000/mcL</li> <li>• Diagnosis of nonmyeloid cancer</li> <li>• CBC and platelets</li> <li>• Absence of atrial arrhythmias or fluid retention</li> </ul>	Non-FDA approved indication
<b>IMMUNOLOGIC</b>							
<b>Cytogam</b>	Immune Globulin		J0850	50 ml	<ul style="list-style-type: none"> <li>• Primary Immune Deficiency:</li> <li>• Congenital Agammaglobulinemia, Hypogammaglobulin-emia</li> <li>• Bone Marrow Transplant</li> <li>• Kawasaki</li> </ul>	<ul style="list-style-type: none"> <li>• IgG Subclass levels – levels should be while patient is free from infection</li> <li>• Serum antibody titers to pneumococcus, tetanus, and/or diphtheria</li> <li>• Details of recurrent infections</li> <li>• Re-Authorizations – trough IgG levels; documenting patient response to Ig.</li> </ul>	<ul style="list-style-type: none"> <li>• Fibromyalgia</li> <li>• Lyme Disease</li> <li>• Pediatric Epilepsy</li> <li>• Neuropathy</li> </ul>
<b>Bivigam</b>		ME	J1556	500mg			
<b>Privigen</b>		CHP	J1459	500 mg			
<b>Gammaplex</b>		MA	J1460	1 ml			
		QHP	J1557	500 mg			
<b>Hizentra</b>		EP	J1559	100 mg			
<b>Gammaked</b>		HARP	J1561	500 mg			
<b>Gamunex</b>			J1561	500 mg			
<b>Vivaglobin</b>		ME	J1562	100 mg			
<b>Gammagard</b>	CHP	J1566	500 mg				
	MA						
	QHP						
						Date of transplant, detailed patient history	

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Octagam Carimune		EP HARP	J1569 J1568 J1566	500 mg 500mg 500mg		Laboratory results: <ul style="list-style-type: none"> <li>• CBC</li> <li>• Serum ESR</li> <li>• Serum</li> <li>• C-reactive protein</li> <li>• Serum LFTs</li> </ul>	
Flebogamma	Immune Globulin	ME CHP MA QHP EP HARP	J1572	500mg	<p>Secondary Immunodeficiency:</p> <ul style="list-style-type: none"> <li>• Chronic Lymphocytic Leukemia with Hypogammaglobulinemia (CLL)</li> <li>• B cell CLL</li> </ul> <p>Hematology:</p> <ul style="list-style-type: none"> <li>• Idiopathic Thrombocytopenia Purpura (ITP)</li> <li>• Prophylaxis of rubella during pregnancy</li> <li>• Prophylaxis of hepatitis A</li> <li>• Post-exposure prophylaxis varicella</li> </ul> <p>Neurological Conditions:</p> <ul style="list-style-type: none"> <li>• Chronic Inflammatory Demyelinating Polyneuropathy (CIPD)</li> <li>• Inflammatory Myopathies (Polymyositis, Dermatomyositis)</li> </ul>	<ul style="list-style-type: none"> <li>• Total IgG levels</li> <li>• Hematology: Laboratory values used to confirm diagnosis</li> <li>• Neurology: Testing used to confirm diagnosis (examples: EMG, Nerve Conduction Study (NCS), muscle</li> </ul>	

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					<ul style="list-style-type: none"> <li>Guillain-Barre Syndrome</li> <li>Myasthenia Gravis exacerbation</li> <li>Multifocal Motor Neuropathy</li> <li>Relapsing/Remitting Multiple Sclerosis</li> </ul>	<ul style="list-style-type: none"> <li>biopsy, MRI, CSF protein, Anti-Mag antibodies, Anti-GD1a, Anti-GD1b)</li> <li>Documentation of standard treatment tried/failed/contraindicate</li> <li>Multifocal Motor Neuropathy – Anti-GM 1 antibody results</li> </ul>	
<b>METABOLIC</b>							
<b>Aldurazyme</b>	Laronidase	QHP EP	J1931	0.1 mg	Hurler and Hurler-Scheie forms of Mucopolysaccharidosis, Type I and Scheie form with moderate to severe symptoms	Enzyme assay showing deficiency of L-iduronidase	Non-FDA approved indication
<b>Cerezyme VPRIV Elelyso</b>	Imiglucerase Velaglucerase alfa Taliglucerase alfa	QHP EP	J1786 J3385 J3060	10 units 100 units 10 units	Type 1 Gaucher disease in pediatric and adults with one or more of the following: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly	<ul style="list-style-type: none"> <li>Enzyme assay demonstrating deficiency of beta glucosidase enzyme activity or by DNA testing</li> <li>≥ 1 disease complications</li> </ul>	<ul style="list-style-type: none"> <li>Non-FDA approved indication</li> <li>Combined use with Zevesca</li> </ul>
<b>Elaprase</b>	Idursulfase	QHP EP	J1743	1 mg	Hunter syndrome or (mucopolysaccharidosis II)	<ul style="list-style-type: none"> <li>Enzyme assay shown deficiency of iduronate-2-sulfate enzyme activity or by DNA testing</li> </ul>	Non-FDA approved indication
<b>Fabrazyme</b>	Agalsidase beta	QHP EP	J0180	1 mg	Fabry's disease	<ul style="list-style-type: none"> <li>Assay shown deficiency of alpha galactosidase enzyme activity or DNA testing</li> <li>Symptoms description</li> </ul>	Non-FDA approved indication

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<b>Myozyme</b>	Alglucosidase alfa	QHP EP	J0220	10 mg	Pompe disease, infantile onset	Enzyme test demonstrate reduce GAA enzyme activity or DNA testing for mutation in the GAA gene	Non-FDA approved indication
<b>Lumizyme</b>	Alglucosidase alfa	QHP EP	J0221	10 mg	8 years of age or older with late-onset (non-infantile) Pompe disease (GAA deficiency) who do not have evidence of cardiac hypertrophy	Enzyme test demonstrate reduce GAA enzyme activity or DNA testing for mutation in the GAA gene	Non-FDA approved indication
<b>Naglazyme</b>	Galsulfase	QHP EP	J1458	1 mg	Mucopolysaccharidosis type VI (Maroteaux-Lamy syndrome)	Assay shown deficiency of N-acetylgalactosamine-4-sulfatase enzyme activity or by DNA testing	Non-FDA approved indication
<b>Vimizim</b>	Elosulfase alfa	QHP EP	J1322	1 mg	Mucopolysaccharidosis type IVA (Morquio A syndrome)	Assay shown deficiency of N-acetylgalactosamine-6-sulfatase enzyme activity or by DNA testing	Non-FDA approved indication
<b>Aralast Glassia</b>	Alpha1-proteinase inhibitor	QHP EP	J0256 J0257	10 mg 10 mg	Alpha-1-antitrypsin deficiency	<ul style="list-style-type: none"> <li>• Pretreatment serum Alpha 1-antitrypsin (AAT) levels</li> <li>• Post-bronchodilation FEV1 % of predicted</li> </ul>	Non-FDA approved indication
<b>NEUROLOGIC</b>							
<b>Botox</b>	Onabotulinumtoxin A	ME CHP MA QHP EP HARP	J0585	1 unit	<ul style="list-style-type: none"> <li>• Primary axillary hyperhidrosis in adults</li> <li>• Chronic migraine prophylaxis</li> <li>• Overactive bladder</li> <li>• Neurogenic bladder</li> <li>• Blepharospasm (≥12 years old)</li> </ul>	<ul style="list-style-type: none"> <li>• Trial of topical agents</li> <li>• Trial of at least 3 classes of migraine prophylaxis meds for at least 2 month duration for each agent</li> <li>• Failure/intolerance to other drugs</li> </ul>	<ul style="list-style-type: none"> <li>•Cosmetics uses</li> <li>•Diabetic neuropathic pain</li> <li>•Spasticity related to stroke (except Botox)</li> <li>•Writer’s cramp</li> <li>• Laryngeal</li> </ul>

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					<ul style="list-style-type: none"> <li>• Strabismus (≥12 years old)</li> <li>• Cervical Dystonia (≥16 years old)</li> <li>• Hemifacial Spasm</li> <li>• <b>Botox ONLY:</b> Upper and Lower extremity spasticity in adults including related to stroke</li> <li>• Spasticity related to Cerebral Palsy</li> <li>• Achalasia</li> <li>• Sialorrhea, Parkinson's</li> </ul>	<ul style="list-style-type: none"> <li>• Neurologic workup with previous treatments</li> </ul>	<ul style="list-style-type: none"> <li>• dystonia</li> <li>• Motor tics</li> <li>• Anal fissure</li> <li>• Excessive salivation from other neurologic disorder</li> </ul>
<b>Myobloc</b>	Rimabotulinumtoxin	ME CHP MA QHP EP HARP	J0587	100units	<ul style="list-style-type: none"> <li>• Cervical Dystonia</li> </ul>	Neurologic workup with previous treatments	
<b>Xeomin</b>	Incobotulinumtoxin A	ME CHP MA QHP EP HARP	J0588	1 unit	<ul style="list-style-type: none"> <li>• Blepharospasm</li> <li>• Cervical Dystonia</li> </ul>	Neurologic workup with previous treatments	
<b>Dysport</b>	Abobotulinumtoxin	ME CHP MA QHP EP HARP	J0586	5 units	<ul style="list-style-type: none"> <li>• Blepharospasm</li> <li>• Cervical Dystonia</li> <li>• Upper extremity spasticity in adults</li> <li>• Lower extremity spasticity in pediatric patients related to Cerebral Palsy (≥ 2 to ≤ 17 years old)</li> </ul>	Neurologic workup with previous treatments	

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<b>Novantrone</b>	Mitoxantrone	QHP EP	J9293	5 mg	Relapsing forms of Multiple Sclerosis	<ul style="list-style-type: none"> <li>Baseline or current cardiac function &amp; LVEF</li> <li>CBC with Diff</li> <li>Hepatic function</li> <li>Lifetime cumulative dose</li> </ul> <p><b>Note: no authorization needed for Acute myeloid leukemia or prostate cancer.</b></p>	Non-FDA approved indication
<b>Tysabri</b>	Natalizumab	QHP EP	J2323	1 mg	<ul style="list-style-type: none"> <li>Relapsing forms of Multiple Sclerosis</li> <li>Crohn’s disease moderate-severe</li> </ul>	<ul style="list-style-type: none"> <li>Anti-John Cunningham Virus (JCV) antibody negative</li> <li>MS: Insufficient response to other biologics &amp; MRI scan</li> <li>Crohn's Disease: Prior treatment use</li> </ul>	Non-FDA approved indication
<b>OPHTHALMIC</b>							
<b>Avastin</b>	Bevacizumab	ME QHP EP HARP	C9257 Facilities Only  J9035	0.25 mg  10 mg	<ul style="list-style-type: none"> <li>Diabetic macular edema</li> <li>Diabetic retinopathy with macular edema</li> <li>Retinal vascular occlusion</li> <li>Wet age related macular degeneration</li> <li>Classic subfoveal choroidal neovascularization due to AMD</li> <li>Retinopathy of prematurity</li> <li>Glaucoma associated</li> </ul>	<ul style="list-style-type: none"> <li>Confirmed diagnosis through optical coherence tomography</li> <li>Visual acuity</li> <li>Informed consent for compounded formulation</li> <li>Macular edema - Clinically significant with central involvement/vision loss</li> </ul> <p><b>Note: no authorization needed for cancer indications when supported by FDA or Compendia</b></p>	<ul style="list-style-type: none"> <li>Dry age related macular degeneration</li> <li>Proliferative diabetic retinopathy without macular edema <b>EXCEPT Lucentis</b></li> <li>Combination</li> </ul>



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					with vascular eye disorders <ul style="list-style-type: none"> <li>• Pathologic myopia with subfoveal choroidal neovascularization</li> </ul>		therapy with intravitreal pharmacotherapy
<b>Eylea</b>	Aflibercept	ME QHP EP HARP	J0178	1mg	<ul style="list-style-type: none"> <li>• Diabetic macular edema</li> <li>• Diabetic retinopathy with macular edema</li> <li>• Retinal vascular occlusion</li> <li>• Wet age related macular degeneration</li> </ul>	<ul style="list-style-type: none"> <li>• Confirmed diagnosis through optical coherence tomography</li> <li>• Visual acuity</li> <li>• Macular edema - Clinically significant with central involvement/vision loss</li> </ul>	<ul style="list-style-type: none"> <li>• Dry age related macular degeneration</li> </ul>
<b>Lucentis</b>	Ranibizumab	ME QHP EP HARP	J2778	0.1 mg	<ul style="list-style-type: none"> <li>• Diabetic macular edema</li> <li>• Diabetic retinopathy with or without macular edema</li> <li>• Retinal vascular occlusion</li> <li>• Wet age related macular degeneration</li> </ul>	<ul style="list-style-type: none"> <li>• Confirmed diagnosis through optical coherence tomography</li> <li>• Visual acuity</li> <li>• Macular edema - Clinically significant with central involvement/vision loss</li> </ul>	<ul style="list-style-type: none"> <li>• Proliferative diabetic retinopathy without macular edema</li> </ul>
<b>Macugen</b>	Pegaptanib	ME QHP EP HARP	J2503	0.3 mg	<ul style="list-style-type: none"> <li>• Diabetic macular edema</li> <li>• Diabetic retinopathy with macular edema</li> <li>• Wet age related macular degeneration</li> </ul>	<ul style="list-style-type: none"> <li>• Confirmed diagnosis through optical coherence tomography</li> <li>• Visual acuity</li> <li>• Macular edema - Clinically significant with central involvement/vision loss</li> </ul>	
<b>Visudyne</b>	Verteporfin	ME QHP	J3396	0.1 mg	<ul style="list-style-type: none"> <li>• Wet age related macular degeneration</li> </ul>	<ul style="list-style-type: none"> <li>• Confirmed diagnosis through optical</li> </ul>	<ul style="list-style-type: none"> <li>• Combination</li> </ul>

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		EP HARP			<ul style="list-style-type: none"> <li>Classic subfoveal choroidal neovascularization due to AMD</li> <li>Pathologic myopia with subfoveal choroidal neovascularization</li> <li>Histoplasmosis retinitis</li> </ul>	<ul style="list-style-type: none"> <li>coherence tomography</li> <li>Visual acuity</li> <li>Documentation to support that lesion compromises <math>\geq 50\%</math> of entire lesion &amp; treatment spot <math>\leq 6.4</math> mm diameter</li> </ul>	therapy with intravitreal pharmacotherapy
<b>RESPIRATORY</b>							
<b>Synagis</b>	Palivizumab	ME CHP MA QHP EP HARP	90378	50 mg	Seasonal usage: November-March Prevention of lower respiratory tract disease in infants at high risk for RSV: <ul style="list-style-type: none"> <li>Chronic Lung Disease</li> <li>Premature Infant</li> <li>Congenital Abnormality of airway/Neuro-muscular Condition</li> <li>Hemodynamically unstable chronic heart disease</li> </ul>	<ul style="list-style-type: none"> <li>Gestational age</li> <li>Weight</li> <li>Risk factors</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> <li>Age &gt; 12 months</li> <li>Healthy infants born <math>\geq 29</math> wks/0 days gestation</li> </ul>
<b>Cinryze Berinert</b>	C1 esterase inhibitor (human)	ME CHP MA QHP EP HARP	J0598 J0597	10 units 10 units	Hereditary angioedema (HAE) (>12 years old) prophylaxis	<ul style="list-style-type: none"> <li>Previous medication trials</li> <li>Confirmed diagnosis of HAE by laboratory testing</li> </ul>	<ul style="list-style-type: none"> <li>Emergency CABG</li> </ul>
<b>Firazyr Kalbitor</b>	Icatibant Ecallantide	ME CHP MA	J1744 J1290	1 mg	Acute attacks of HAE	<ul style="list-style-type: none"> <li>Laboratory confirmation of HAE</li> <li>Administered by</li> </ul>	Non-FDA approved indication

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		QHP EP HARP				appropriate health care specialist	
<b>Xolair</b>	Omalizumab	ME CHP MA QHP EP HARP	J2357	5 mg	<ul style="list-style-type: none"> <li>Moderate to severe persistent asthma &amp; (+) skin test reactive to perennial allergen &amp; inadequately controlled by corticosteroids.</li> <li>Moderate to severe urticaria unresponsive to 6 months of antihistamines, corticosteroids or leukotriene.</li> </ul>	<ul style="list-style-type: none"> <li>Age ≥ 12 y/o</li> <li>IgE level</li> <li>Body Weight</li> <li>Documented medication history</li> </ul> <p>Treatment history</p>	<ul style="list-style-type: none"> <li>Allergy to peanuts</li> <li>Allergic rhinitis prophylaxis</li> <li>Latex Allergy</li> <li>Dosing outside FDA label.</li> </ul>
<b>Rheumatologic</b>							
<b>Euflexxa Gel-One Hyalgan Orthovisc Supartz Monovisc Synvisc GelSyn-3</b>	Hyaluronate sodium	ME CHP MA QHP EP HARP	J7323 J7326 J7321 J7324 J7321 J7327 J7325 J7328	20mg/2ml Per dose 20mg/2ml 30mg/2ml 25mg/2.5ml Per dose 1mg 0.1 mg	Treatment of pain in Osteoarthritis (OA) of the knee is no longer considered a covered benefit for <b>Medicaid</b> .	<ul style="list-style-type: none"> <li>Radiographic studies to support diagnosis</li> <li>Pharmacological treatment history including use of intraarticular steroids</li> <li>History of weight loss and rehab therapy</li> </ul>	<ul style="list-style-type: none"> <li>OA knee</li> <li>Non-FDA approved indication</li> </ul>
<b>Prolia Xgeva</b>	Denosumab	QHP EP ME HARP	J0897	1 mg 1mg	<ul style="list-style-type: none"> <li>Treatment of postmenopausal women with osteoporosis at high risk of fracture</li> <li>Treatment to increase bone mass in men with osteoporosis at high</li> </ul>	<ul style="list-style-type: none"> <li>Duration &amp; response to trial of oral bisphosphate</li> <li>Bone mineral density pretreatment T-score</li> <li>Fracture risk factors</li> <li>Serum calcium</li> <li>Oral exam</li> <li>Pregnancy status</li> </ul>	Non-FDA approved indication



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<b>Forteo</b>	Teriparatide	QHP EP ME HARP	J3110	10 mcg	<ul style="list-style-type: none"> <li>• Treatment of postmenopausal women with osteoporosis at high risk for fracture</li> <li>• Treatment to increase bone mass in men with primary or hypogonadal osteoporosis at high risk for fracture</li> <li>• Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture</li> </ul>	<ul style="list-style-type: none"> <li>• Duration &amp; response to trial of oral bisphosphate</li> <li>• Bone mineral density pretreatment T-score</li> <li>• Fracture risk factors</li> </ul>	<ul style="list-style-type: none"> <li>• Non-FDA approved indication</li> <li>• Paget’s disease of bone</li> </ul>
<b>Actemra Simponi Aria</b>	Tocilizumab Golimumab	QHP EP	J3262 J1602	1 mg 1 mg	<ul style="list-style-type: none"> <li>• Rheumatoid Arthritis IV route</li> </ul>	<ul style="list-style-type: none"> <li>• Screened for latent TB</li> <li>• History of past treatment regimens</li> </ul>	<ul style="list-style-type: none"> <li>• SQ route is Pharmacy benefit and requires authorization from Caremark</li> <li>• Non-FDA approved indications</li> </ul>
<b>Orencia</b>	Abatacept	QHP EP	J0129	10 mg	<ul style="list-style-type: none"> <li>• Rheumatoid Arthritis (<b>IV route ONLY</b>)</li> <li>• Adult Psoriatic Arthritis (<b>IV route ONLY</b>)</li> </ul>	<ul style="list-style-type: none"> <li>• Screened for latent TB</li> <li>• History of past treatment regimens</li> </ul>	<ul style="list-style-type: none"> <li>• SQ route is Pharmacy benefit and requires authorization from Caremark</li> </ul>

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							<ul style="list-style-type: none"> <li>Non-FDA approved indications</li> </ul>
<b>Remicade</b>	Infliximab	QHP EP	J1745	10 mg	<ul style="list-style-type: none"> <li>Crohn’s disease</li> <li>Ulcerative colitis</li> <li>Rheumatoid Arthritis</li> <li>Severe plaque psoriasis</li> <li>Psoriatic arthritis</li> </ul>	<ul style="list-style-type: none"> <li>Screened for latent TB</li> <li>History of past treatment regimens</li> </ul>	Non-FDA approved indication
<b>Supplies</b>							
<b>Insulin Pump &amp; Supplies</b>	External ambulatory infusion pump, insulin Disposable insulin delivery system	ME CHP MA QHP EP HARP	E0784  A9274	1 unit	<ul style="list-style-type: none"> <li>Type 1 or Type 2 diabetes AND the patient has completed a comprehensive diabetes education program and has been on multiple injections of insulin with frequent self-adjustments for at least 6 months OR</li> <li>Gestational diabetes AND has the patient completed a comprehensive diabetes education program.</li> </ul>	<ul style="list-style-type: none"> <li>C-peptide</li> <li>Evidence of member motivation &amp; pump training</li> <li>Glucose monitoring log</li> <li>Insulin frequency</li> </ul>	
<b>Continuous Glucose Monitoring Systems</b>	Sensor Transmitter Receiver Monitor	ME CHP MA QHP EP HARP	A9276 A9277 A9278	1 unit	Adults with Type I DM without adequate control despite frequent self-monitoring of blood glucose levels	<ul style="list-style-type: none"> <li>Glucose monitoring log</li> <li>Insulin frequency</li> </ul>	<ul style="list-style-type: none"> <li>Type II DM</li> <li>Children/Adolescents with Type I DM</li> <li>Pregnancy/ Gestational DM</li> </ul>

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<b>MISCELLANEOUS</b>							
<b>Caverject</b> <b>Muse</b> <b>Pavacot</b> <b>Oraverse</b>	Alprostadil Alprostadil urethral Papaverine Phentolamine	ME CHP MA QHP EP HARP	J0270 J0275 J2440 J2760	1.25 mcg 125 mcg 60 mg 5 mg	Diagnosis of Erectile Dysfunction (ED)	Complete physical examination.	<ul style="list-style-type: none"> <li>• Treatment of ED</li> <li>• Registered Sex Offender</li> <li>• Male infertility</li> </ul>
<b>Solesta</b>	Dextranomer/ hyaluronic acid copolymer implant, anal canal	ME CHP MA QHP EP HARP	L8605	1 ml	Fecal incontinence	<ul style="list-style-type: none"> <li>• History of trial of pharmacologic &amp; non-pharmacologic therapies.</li> <li>• Cleveland clinic Florida Incontinence Score (CCFIS) &amp; history of fecal incontinence.</li> </ul>	<ul style="list-style-type: none"> <li>• Urinary incontinence</li> <li>• Vesicoureteral reflux</li> </ul>