

Prior Authorization:

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Prior Authorization Standard

PA Criteria

Prior Authorization Group

ACNE

Drug Names

AVITA CREAM, AVITA GEL, RETIN-A MICR GEL, TRETINOIN CREAM, TRETINOIN GEL

Covered Uses

All FDA-approved indications not otherwise excluded from Part D, keratosis follicularis (Darier's disease, Darier-White disease)

Exclusion Criteria

Cosmetic use

Required Medical Information

Age Restrictions

Approve for those 12 years of age and older

Prescriber Restrictions

Coverage Duration

12 months

Other Criteria

Prior Authorization Group

AFINITOR

Drug Names

AFINITOR

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

6 months

Other Criteria

Prior Authorization Group	AMPHETAMINES
Drug Names	DEXTROAMPHETAMINE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	MAOI concurrent use or within the last 14 days
Required Medical Information	Sleep studies for narcolepsy diagnosis
Age Restrictions	Approve for those 3 years of age and older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Monitor for weight loss, decreased growth velocity in children, increased heart rate and blood pressure, appearance or worsening of aggressive behavior or hostility, sleep disturbances and long-term usefulness of the drug

Prior Authorization Group	BYETTA
Drug Names	BYETTA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	End-stage renal disease or severe renal function impairment (creatinine clearance less than 30mL/min), all Part D-excluded indications
Required Medical Information	HbA1c, creatinine clearance, previous antidiabetic medication use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

<i>Prior Authorization Group</i>	CELEBREX
<i>Drug Names</i>	CELEBREX
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Post-operative pain following CABG surgery, allergic-type reaction to aspirin, NSAIDs, or sulfonamides
<i>Required Medical Information</i>	Evaluation of cardiovascular disease or risk factors for cardiovascular disease
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	6 months for FAP and JRA, 12 months for dysmenorrhea, OA, RA, AS, 1 month for acute pain
<i>Other Criteria</i>	For all diagnoses, patient must undergo determination of risk versus benefit of treatment with celecoxib for an NSAID-related gastrointestinal (GI) adverse event such as an NSAID-associated gastric ulcer or gastrointestinal bleeding

<i>Prior Authorization Group</i>	CHANTIX
<i>Drug Names</i>	CHANTIX
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Concurrent Zyban use
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 weeks initial, 12 weeks additional upon renewal
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	CIMZIA
<i>Drug Names</i>	CIMZIA
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patients are excluded if they have an active infection or on are on concurrent biologic response modifier. Patient must also be assessed for the risk of hepatitis B and if appropriate, be tested.
<i>Required Medical Information</i>	Patient must demonstrate inadequate response to at least 1 conventional therapy for Crohn's disease (i.e., prednisone, budesonide, sulfasalazine, azathioprine, mesalamine, infliximab or adalimumab)
<i>Age Restrictions</i>	Approve for those 18 years of age or older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	

Prior Authorization Group	DIFFERIN
Drug Names	DIFFERIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Cosmetic use
Required Medical Information	
Age Restrictions	Approve for those 12 years of age and older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

Prior Authorization Group	ENBREL
Drug Names	ENBREL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, reactive arthritis, inflammatory bowel disease arthritis
Exclusion Criteria	Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patients are excluded if they have an active infection or on are on concurrent biologic response modifier. Patient must also be assessed for the risk of hepatitis B and if appropriate, be tested.

Required Medical Information	Rheumatoid Arthritis/Juvenile Rheumatoid Arthritis - patient must demonstrate inadequate response to at least 1 DMARD or intolerance to 2 DMARDs. Psoriasis - patient must be a candidate for systemic therapy or phototherapy. Ankylosing spondylitis - patient must demonstrate inadequate response or intolerance to at least 2 NSAIDs. If the ankylosing spondylitis is predominantly peripheral arthritis, patient must demonstrate an inadequate response or intolerance to sulfasalazine only. Reactive arthritis - patient must demonstrate inadequate response or intolerance to at least 2 of the following, NSAIDs, intra-articular steroid injections, or sulfasalazine, if indicated. IBDA - patient has to be refractory to at least 2 standard therapies.
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Age Restrictions	Psoriasis - Approve for those 18 years of age or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

<i>Prior Authorization Group</i>	EPO
<i>Drug Names</i>	PROCRIT
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	CRF, Hepatitis C, elective surgery, HIV/zidovudine - transferrin saturation less than 20% and patient not receiving iron supplementation where clinically appropriate. CRF, Hepatitis C, elective surgery, HIV/zidovudine, MDS, and anemia in patients with non-myeloid malignancies - hemoglobin level of the patient (not the result of a recent blood transfusion) greater than 13 g/dL. Lack of initial diagnosis of anemia (hematocrit less than 30% and/or hemoglobin less than 10 g/dL and/or symptomatic with hemoglobin 10-11g/dL).
<i>Required Medical Information</i>	CRF, Hepatitis C, elective surgery, HIV/zidovudine - iron status of the patient has been evaluated (serum transferrin saturation). CRF, Hepatitis C, elective surgery, HIV/zidovudine, and anemia of cancer - Hemoglobin level of the patient be monitored prior to each dose when initiating therapy, for dose changes, and at regular intervals when the dose is stabilized. Hemoglobin level of the patient will be monitored prior to each dose when initiating therapy, for dose changes, and at regular intervals when the dose is stabilized. Blood pressure of the patient will be monitored throughout therapy. Patient will be monitored for the occurrence of thrombotic events.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Initiation of therapy and/or dose changes - 6 weeks. Stable on therapy - 12 weeks.
<i>Other Criteria</i>	Once on therapy, compared to pretreatment baseline, the patient must show an objective clinical response (e.g., hemoglobin rise greater than 1 g/dL and/or hematocrit rise greater than 3%) to an appropriate dose/dose increase and duration of therapy.

<i>Prior Authorization Group</i>	GROWTH HORMONE
<i>Drug Names</i>	NORDITROPIN, SAIZEN, TEV-TROPIN
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Severe respiratory impairment or sleep apnea (Prader-Willi syndrome)
<i>Required Medical Information</i>	Growth hormone stimulation tests
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	6 months
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	HUMIRA
<i>Drug Names</i>	HUMIRA
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Patients are excluded if they have an active infection or on are on concurrent biologic response modifier.
<i>Required Medical Information</i>	Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patient must also be assessed for the risk of hepatitis B and if appropriate, be tested.
<i>Age Restrictions</i>	Rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, Crohn's disease, plaque psoriasis - Approve for those 18 years of age or older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	RA/JIA - patient must demonstrate inadequate response to at least 1 DMARD or intolerance to 2 DMARDs. Psoriasis - patient must be a candidate for systemic therapy or phototherapy. Ankylosing spondylitis - patient must demonstrate inadequate response or intolerance to at least 2 NSAIDs. If the ankylosing spondylitis is predominantly peripheral arthritis, patient must demonstrate an inadequate response or intolerance to sulfasalazine only. Crohn's disease - patient must demonstrate an inadequate response to 2 conventional therapies or Remicade.

<i>Prior Authorization Group</i>	INCRELEX
<i>Drug Names</i>	INCRELEX
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Closed epiphyses. Other secondary causes of growth failure. Pre-existing thyroid and/or nutritional deficits. Presence of active or suspected neoplasia.
<i>Required Medical Information</i>	Failure of a growth hormone stimulation test. Genetic testing for growth hormone gene deletion. Lab testing for neutralizing antibodies to growth hormone.
<i>Age Restrictions</i>	Approve for those 2 years of age or older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	Height of the patient greater than or equal to 3 standard deviations below the norm for children of the same age and gender prior to beginning Increlex therapy. Basal IGF-1 level greater than or equal to 3 standard deviations below the norm for children of the same age and gender prior to beginning Increlex therapy. Increase in height velocity of 2 cm/year within the first year of Increlex therapy.
<i>Prior Authorization Group</i>	INFERGEN
<i>Drug Names</i>	INFERGEN
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Patient must have compensated liver disease with detectable levels of hepatitis C virus RNA in the serum
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	3 to 9 months depending on genotype and initial vs. renewal therapy
<i>Other Criteria</i>	2-log decrease in viral load for renewals

<i>Prior Authorization Group</i>	ITRACONAZOLE
<i>Drug Names</i>	INTRACONAZOLE CAPS
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D, recalcitrant or very severe disfiguring or disabling infections caused by pityriasis versicolor, tinea corporis, tinea cruris, or tinea pedis that is unresponsive to griseofulvin or topical antifungals, severe fungal infections caused by Blastomycosis, Histoplasmosis, Aspergillosis (prophylaxis), Basidiobolomycosis, Chromomycosis, Coccidioidomycosis, Cryptococcosis, Cryptococcal Meningitis (treatment or suppression), Chronic Mucocutaneous Candidiasis, Histoplasmosis suppression in immunocompromised patients, Leishmaniasis (cutaneous treatment), Paracoccidioidomycosis, Paronychia, Penicillium marneffeii in adults, Fungal pneumonia and septicemia treatment, Sporotrichosis disseminated (treatment), Tinea manuum, Vulvovaginal Candidiasis
<i>Exclusion Criteria</i>	Congestive heart failure, history of congestive heart failure, evidence of left ventricular dysfunction.
<i>Required Medical Information</i>	LFTs, fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy)
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Onychomycosis-2 months fingernails, 3 months toenails, all others uses 6 months
<i>Other Criteria</i>	

Prior Authorization Group	IVIG
Drug Names	GAMMAGARD, GAMUNEX
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	HSCT - IVIG is to be used in patients that have developed severe hypogammaglobulinemia (IgG less than 400) within the first 100 days post transplant.
Age Restrictions	BMT - patients have to be 20 years of age or older. HIV - patient has to be younger than 13 years of age.
Prescriber Restrictions	
Coverage Duration	4 mos- CIDP, BMT, HSCT 6 mos - ITP, Kawasaki, Parvovirus B19 12 mos - remaining covered uses
Other Criteria	Kawasaki disease - IVIG is to be used in conjunction with high dose aspirin. BMT - IVIG is to be used within the first 100 days after BMT. Dermatomyositis - IVIG is to be used only if corticosteroid is not a therapeutic option. GBS - IVIG is to be used for patients who require aid to walk within 2 or 4 weeks from the onset of neuropathic symptoms. Hyperimmunoglobulinemia E syndrome - diagnosis has to be coincident with eczema and atopic dermatitis. RRMS - IVIG is to be used as 2nd line treatment.

Prior Authorization Group	LIDODERM
Drug Names	LIDODERM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Sensitivity to local anesthetics of the amide type (e.g., procaine, tetracaine, benzocaine), skin is broken or inflamed where the patch is to be applied.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

<i>Prior Authorization Group</i>	METHYLPHENIDATES
<i>Drug Names</i>	CONCERTA, METADATE CD, METHYLIN, METHYLPHENIDATE, RITALIN LA
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	MAOI concurrent use or within the last 14 days
<i>Required Medical Information</i>	Sleep studies for narcolepsy diagnosis
<i>Age Restrictions</i>	Approved for those 6 years of age or older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	Monitor for weight loss, decreased growth velocity in children, increased heart rate and blood pressure, appearance or worsening of aggressive behavior or hostility, sleep disturbances and long-term usefulness of the drug
<i>Prior Authorization Group</i>	NEULASTA
<i>Drug Names</i>	NEULASTA
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Neulasta treatment within the last 14 days. Treatment of acute afebrile neutropenia.
<i>Required Medical Information</i>	Current and periodic monitoring of WBC count at initiation of and during therapy.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	6 months
<i>Other Criteria</i>	Neulasta administration will be delayed a minimum of 24 hours after the administration of cytotoxic chemotherapy.

<i>Prior Authorization Group</i>	NEUTROPHIL
<i>Drug Names</i>	NEUPOGEN
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D, bone marrow transplantation failure or engraftment delay. Neutropenia AIDS associated with treatment or disease, myelodysplastic syndromes, drug-induced neutropenia.
<i>Exclusion Criteria</i>	Treatment of acute afebrile neutropenia. Patients not at high risk for infection-associated complications or not having prognostic factors that are predictive of poor clinical outcomes.
<i>Required Medical Information</i>	Current and periodic monitoring of WBC count at initiation of and during therapy.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	3 months
<i>Other Criteria</i>	Treatment to be halted in the event of excessive leukocytosis.
<i>Prior Authorization Group</i>	OCTREOTIDE
<i>Drug Names</i>	OCTREOTIDE
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	OSTEOPOROSIS
<i>Drug Names</i>	FORTEO
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Paget's disease, unexplained elevation of alkaline phosphatase, open epiphyses, bone cancer or cancer that has metastasized to the bone, history of breast cancer, prior radiation therapy involving the skeleton, hypercalcemia, treatment with Forteo for greater than or equal to 24 months, concurrent bisphosphonate therapy during treatment with Forteo
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	For diagnosis of primary osteoporosis or hypogonadal osteoporosis patient must have at least one of the following: history of osteoporotic fractures, multiple risk factors for fractures, OR has failed or is intolerant to traditional osteoporosis therapy

<i>Prior Authorization Group</i>	PEGASYS
<i>Drug Names</i>	PEGASYS
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	For chronic hepatitis C, patient must have compensated liver disease with detectable levels of HCV RNA in the serum. For chronic hepatitis B, patient must have a positive serum marker for HBV replication, persistently elevated aminotransferase levels greater than 2 times ULN, or signs of chronic hepatitis B on liver biopsy, or cirrhosis of the liver as evidenced by radiological or clinical data, or extrahepatic complications.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Chronic hepatitis C - 3 to 9 months. Chronic hepatitis B - 12 months.
<i>Other Criteria</i>	For chronic hepatitis C, patient must have 2-log decrease in viral load for renewals.
<i>Prior Authorization Group</i>	PEGINTRON
<i>Drug Names</i>	PEGINTRON
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Patient must have compensated liver disease with detectable levels of hepatitis C virus RNA in the serum
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	3 to 9 months depending on genotype and initial vs. renewal therapy
<i>Other Criteria</i>	2-log decrease in viral load for renewals

<i>Prior Authorization Group</i>	PROVIGIL
<i>Drug Names</i>	PROVIGIL
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	If diagnosis is narcolepsy require polysomnography, if diagnosis of OSAHS require polysomnography and whether pt using CPAP
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	

Prior Authorization Group	REMICADE
Drug Names	REMICADE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Patients are excluded if they have an active infection or moderate to severe CHF.
Required Medical Information	Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patient must also be assessed for the risk of hepatitis B and if appropriate, be tested.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	RA - patient must demonstrate inadequate response to at least 1 DMARD or intolerance to 2 DMARDs. Remicade is to be used in combination with methotrexate. Crohn's disease - patient must demonstrate an inadequate response to at least 2 first-line agents unless the patient has multiple draining enterocutaneous or rectovaginal fistulae. Ulcerative colitis - patient must demonstrate an inadequate response to at least 2 first-line agents such as oral or rectal 5-ASA products or glucocorticosteroids. Ankylosing spondylitis - patient must demonstrate inadequate response to at least 2 NSAIDs or intolerance to 2 NSAIDs. If the ankylosing spondylitis is predominantly peripheral arthritis, patient must demonstrate an inadequate response or intolerance to sulfasalazine only. Psoriasis - patient must be a candidate for systemic therapy or phototherapy. Reactive arthritis - patient must demonstrate inadequate response to at least 2 first-line agents such as NSAIDs or DMARDs. IBDA - patient must demonstrate an inadequate response to at least 2 first-line agents such as sulfasalazine, azathioprine, 6-mercaptopurine, MTX or oral steroids.

Prior Authorization Group REVATIO
Drug Names REVATIO
Covered Uses All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria Concurrent nitrate therapy. PAH associated with any of the following: left heart disease, chronic thrombotic disease, embolic disease, compression of pulmonary vessels, lung diseases, hypoxemia, sarcoidosis

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration 12 months

Other Criteria

Prior Authorization Group REVLIMID
Drug Names REVLIMID
Covered Uses All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria Pregnancy
Required Medical Information If female of child bearing potential, pregnancy excluded by 2 negative urine or serum pregnancy tests. For MM requirement of combination therapy with dexamethasone and at least one prior MM treatment. For MDS: diagnosis of anemia due to Low- or Intermediate-1-risk MDS associated with a deletion 5q cytogenetic abnormality, transfusion dependent

Age Restrictions

Prescriber Restrictions

Coverage Duration 12 months

Other Criteria Instruction regarding importance and proper utilization of appropriate contraceptive methods. Monitor CBC on regular basis.

<i>Prior Authorization Group</i>	RIBAVIRIN
<i>Drug Names</i>	REBETOL SOLN, RIBAPAK, RIBASPHERE, RIBAVIRIN
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	History of unstable heart disease, hemoglobin less than 8.5, creatinine clearance less than 50, pregnancy, hemoglobinopathy.
<i>Required Medical Information</i>	Patient must have detectable levels of HCV RNA in the serum and be on an alfa interferon product concurrently.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	4 to 8 months, depending on genotype and initial vs. renewal therapy.
<i>Other Criteria</i>	2-log decrease in viral load for renewals

Prior Authorization Group	RITUXAN
Drug Names	RITUXAN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Chronic lymphocytic leukemia (CLL). Immune thrombocytopenic purpura (ITP). Waldenstrom's macroglobulinemia.
Exclusion Criteria	RA - Rituxan cannot be used concomitantly with another biologic DMARD.
Required Medical Information	Prescriber has to assess the patient for the risk of hepatitis B, and if clinically indicated, test the patient for hepatitis B infection before initiation or continuation of therapy with Rituxan.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	NHL, RA, CLL, Waldenstrom's macroglobulinemia - 12 months. ITP - 1 month.
Other Criteria	For NHL, the diagnosis must fall into one of the following categories of CD20-positive B-cell NHL: - relapsed or refractory, low-grade or follicular - previously untreated follicular, in combination with CVP chemotherapy - low grade in patients with stable disease or who achieve a partial or complete response following first-line treatment with CVP chemotherapy - diffuse large B-cell, treated first line in combination with CHOP or other anthracycline-based chemotherapy - relapsed or refractory diffuse large B-cell lymphoma. For ITP, patient has to be refractory to first line treatment with corticosteroids and/or IVIG.

Prior Authorization Group	SANDOSTATIN LAR
Drug Names	SANDOSTATIN LAR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Patient had prior therapy with sandostatin injection (not depot form) and treatment was effective and tolerated.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

Prior Authorization Group SOMATULINE DEPOT
Drug Names SOMATULINE DEPOT
Covered Uses All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria
Required Medical Information
Age Restrictions
Prescriber Restrictions
Coverage Duration 12 months
Other Criteria Either surgery and/or radiotherapy is not a therapeutic option for the patient or the patient has had inadequate response to surgery and/or radiotherapy

Prior Authorization Group SOMAVERT
Drug Names SOMAVERT
Covered Uses All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria
Required Medical Information Monitor IGF-1 levels at 6 month intervals after IGF-1 levels stabilize within normal range. Monitor LFTs as recommended during therapy.
Age Restrictions
Prescriber Restrictions
Coverage Duration 12 months
Other Criteria Prior to initiation of therapy IGF-1 levels were above age and gender adjusted normal range. If patient has been on therapy for the past 6 months demonstration of significant decrease in IGF-1 levels required. Patients were considered for/received treatment with surgery, radiation therapy, or medical treatment for acromegaly but rejected as inappropriate or had inadequate response.

<i>Prior Authorization Group</i>	STEROIDS, ANABOLIC
<i>Drug Names</i>	OXANDROLONE
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Known or suspected carcinoma of the prostate or breast (in male patients), carcinoma of the breast in women with hypercalcemia, pregnancy, nephrosis (the nephrotic phase of nephritis), hypercalcemia.
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	6 months
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	STRATTERA
<i>Drug Names</i>	STRATTERA
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	MAOI concurrent use or within the last 14 days
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	Approved for those 6 years of age or older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	monitor for suicidality, clinical worsening, changes in behavior, blood pressure changes, heart rate changes, weight loss, decreased growth velocity in children, sleep disturbances, liver injury

<i>Prior Authorization Group</i>	SYMLIN
<i>Drug Names</i>	SYMLIN
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	HbA1c greater than 9%, recurrent severe hypoglycemia requiring assistance during the past 6 months, presence of hypoglycemia unawareness, confirmed diagnosis of gastroparesis, require the use of drugs that stimulate gastrointestinal motility
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	

Prior Authorization Group	TERBINAFINE
Drug Names	TERBINAFINE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	LFTs, fungal diagnostic test (e.g., KOH preparation, positive fungal culture, or nail biopsy)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	2 months for fingernails only, 3 months if toenail involvement
Other Criteria	

Prior Authorization Group	TESTOSTERONES
Drug Names	ANDRODERM, ANDROGEL, TESTIM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Female, prostate cancer, breast cancer
Required Medical Information	Before the start of testosterone therapy patient has (or patient currently has) a confirmed low testosterone level (i.e. total testosterone less than 300 ng/dL, free or bioavailable, testosterone less than 5 ng/dL) or absence of endogenous testosterone
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

Prior Authorization Group	THALOMID
Drug Names	THALOMID
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	If female of child bearing potential, pregnancy excluded by 2 negative urine or serum pregnancy tests. For MM requirement of combination therapy with dexamethasone. For ENL if have moderate to severe neuritis Thalomid can not be used as monotherapy.

Age Restrictions

Prescriber Restrictions

Coverage Duration	12 months
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Other Criteria	Instruction regarding importance and proper utilization of appropriate contraceptive methods.
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Prior Authorization Group	TOPICAL-ULCERS
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Drug Names	REGRANEX
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Covered Uses	All FDA-approved indications not otherwise excluded from Part D
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Exclusion Criteria	Neoplasm at intended site of application, active wound infection not under control by way of active treatment
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Required Medical Information	Ulcer size after 10 weeks of therapy, does ulcer have adequate blood supply, ulcer extending into subcutaneous tissue or beyond
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Age Restrictions

Prescriber Restrictions

Coverage Duration	3 months, then additional 2 months upon renewal
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Other Criteria

Prior Authorization Group	XENAZINE
Drug Names	XENAZINE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Actively suicidal, untreated or inadequately treated depression, impaired hepatic function, current use of monoamine oxidase inhibitors or reserpine.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	In patients who are taking reserpine, at least 20 days should elapse after stopping reserpine before initiation of Xenazine therapy.

Prior Authorization Group	XOLAIR
Drug Names	XOLAIR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Xolair is not to be used as monotherapy.
Required Medical Information	Positive aeroallergen skin or blood test. Pre-treatment IgE level to be between 30 and 700 IU/mL
Age Restrictions	12 years of age and above
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Patient must be inadequately controlled on inhaled corticosteroids.

Prior Authorization Group

B vs D

Drug Names

ACETYLCYSTEINE, ALBUTEROL SULFATE, ALBUTEROL SULFATE/IPRATROPIUM BROMIDE, AMINESS, AMINOSYN, AZASAN, AZATHIOPRINE, CELLCEPT, CHORIONIC GONADOTROPIN, CLIMIMIX , CLINISOL SF 15%, COLISTIMETHATE SODIUM, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, DECAVAC, DIPHTHERIA/TETANUS TOXOID PEDIATRIC, EMEND, ENGERIX-B, FREAMINE , GENGRAF, GRANISETRON HCL, GRANISOL, HEPATAMINE, HEPATASOL, INTRALIPID, IPRATROPIUM BROMIDE, MYCOPHENOLATE, NEORAL, NEPHRAMINE, NOVAMINE, ONDANSETRON HCL, ONDANSETRON ODT, PREMASOL, PROCALAMINE, PROGRAF, PROSOL, PULMICORT, PULMOZYME, RAPAMUNE, RECOMBIVAX HB, RENAMIN, SANDIMMUNE, TETANUS TOXOID ADSORBED, TETANUS/DIPHTHERIA TOXOIDS-ADSORBED ADULT, TOBI, TRAVASOL, TROPHAMINE, VENTAVIS, XOPENEX

Covered Uses

This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Prior Authorization:

Standard Plan: pages 1 - 27

Dual Plus: pages 28 - 49

Prior Authorization Dual Plus

PA Criteria

Prior Authorization Group

ACNE

Drug Names

AVITA CREAM, AVITA GEL, RETIN-A MICR GEL, TRETINOIN CREAM, TRETINOIN GEL

Covered Uses

All FDA-approved indications not otherwise excluded from Part D, keratosis follicularis (Darier's disease, Darier-White disease)

Exclusion Criteria

Cosmetic use

Required Medical Information

Age Restrictions

Approve for those 12 years of age and older

Prescriber Restrictions

Coverage Duration

12 months

Other Criteria

Prior Authorization Group

AFINITOR

Drug Names

AFINITOR

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

6 months

Other Criteria

<i>Prior Authorization Group</i>	AMPHETAMINES
<i>Drug Names</i>	DEXTROAMPHETAMINE
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	MAOI concurrent use or within the last 14 days
<i>Required Medical Information</i>	Sleep studies for narcolepsy diagnosis
<i>Age Restrictions</i>	Approve for those 3 years of age and older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	Monitor for weight loss, decreased growth velocity in children, increased heart rate and blood pressure, appearance or worsening of aggressive behavior or hostility, sleep disturbances and long-term usefulness of the drug

Prior Authorization Group	CHANTIX
Drug Names	CHANTIX
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Concurrent Zyban use
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 weeks initial, 12 weeks additional upon renewal
Other Criteria	
Prior Authorization Group	CIMZIA
Drug Names	CIMZIA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patients are excluded if they have an active infection or on are on concurrent biologic response modifier. Patient must also be assessed for the risk of hepatitis B and if appropriate, be tested.
Required Medical Information	Patient must demonstrate inadequate response to at least 1 conventional therapy for Crohn's disease (i.e., prednisone, budesonide, sulfasalazine, azathioprine, mesalamine, infliximab or adalimumab)
Age Restrictions	Approve for those 18 years of age or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

Prior Authorization Group	DIFFERIN
Drug Names	DIFFERIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Cosmetic use
Required Medical Information	
Age Restrictions	Approve for those 12 years of age and older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

Prior Authorization Group	ENBREL
Drug Names	ENBREL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, reactive arthritis, inflammatory bowel disease arthritis
Exclusion Criteria	Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patients are excluded if they have an active infection or on are on concurrent biologic response modifier. Patient must also be assessed for the risk of hepatitis B and if appropriate, be tested.

Required Medical Information	Rheumatoid Arthritis/Juvenile Rheumatoid Arthritis - patient must demonstrate inadequate response to at least 1 DMARD or intolerance to 2 DMARDs. Psoriasis - patient must be a candidate for systemic therapy or phototherapy. Ankylosing spondylitis - patient must demonstrate inadequate response or intolerance to at least 2 NSAIDs. If the ankylosing spondylitis is predominantly peripheral arthritis, patient must demonstrate an inadequate response or intolerance to sulfasalazine only. Reactive arthritis - patient must demonstrate inadequate response or intolerance to at least 2 of the following, NSAIDs, intra-articular steroid injections, or sulfasalazine, if indicated. IBDA - patient has to be refractory to at least 2 standard therapies.
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Age Restrictions	Psoriasis - Approve for those 18 years of age or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

<i>Prior Authorization Group</i>	EPO
<i>Drug Names</i>	PROCRIT
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	CRF, Hepatitis C, elective surgery, HIV/zidovudine - transferrin saturation less than 20% and patient not receiving iron supplementation where clinically appropriate. CRF, Hepatitis C, elective surgery, HIV/zidovudine, MDS, and anemia in patients with non-myeloid malignancies - hemoglobin level of the patient (not the result of a recent blood transfusion) greater than 13 g/dL. Lack of initial diagnosis of anemia (hematocrit less than 30% and/or hemoglobin less than 10 g/dL and/or symptomatic with hemoglobin 10-11g/dL).
<i>Required Medical Information</i>	CRF, Hepatitis C, elective surgery, HIV/zidovudine - iron status of the patient has been evaluated (serum transferrin saturation). CRF, Hepatitis C, elective surgery, HIV/zidovudine, and anemia of cancer - Hemoglobin level of the patient be monitored prior to each dose when initiating therapy, for dose changes, and at regular intervals when the dose is stabilized. Hemoglobin level of the patient will be monitored prior to each dose when initiating therapy, for dose changes, and at regular intervals when the dose is stabilized. Blood pressure of the patient will be monitored throughout therapy. Patient will be monitored for the occurrence of thrombotic events.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Initiation of therapy and/or dose changes - 6 weeks. Stable on therapy - 12 weeks.
<i>Other Criteria</i>	Once on therapy, compared to pretreatment baseline, the patient must show an objective clinical response (e.g., hemoglobin rise greater than 1 g/dL and/or hematocrit rise greater than 3%) to an appropriate dose/dose increase and duration of therapy.

<i>Prior Authorization Group</i>	GROWTH HORMONE
<i>Drug Names</i>	NORDITROPIN, SAIZEN, TEV-TROPIN
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Severe respiratory impairment or sleep apnea (Prader-Willi syndrome)
<i>Required Medical Information</i>	Growth hormone stimulation tests
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	6 months
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	HUMIRA
<i>Drug Names</i>	HUMIRA
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Patients are excluded if they have an active infection or on are on concurrent biologic response modifier.
<i>Required Medical Information</i>	Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patient must also be assessed for the risk of hepatitis B and if appropriate, be tested.
<i>Age Restrictions</i>	Rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, Crohn's disease, plaque psoriasis - Approve for those 18 years of age or older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	RA/JIA - patient must demonstrate inadequate response to at least 1 DMARD or intolerance to 2 DMARDs. Psoriasis - patient must be a candidate for systemic therapy or phototherapy. Ankylosing spondylitis - patient must demonstrate inadequate response or intolerance to at least 2 NSAIDs. If the ankylosing spondylitis is predominantly peripheral arthritis, patient must demonstrate an inadequate response or intolerance to sulfasalazine only. Crohn's disease - patient must demonstrate an inadequate response to 2 conventional therapies or Remicade.

<i>Prior Authorization Group</i>	INCRELEX
<i>Drug Names</i>	INCRELEX
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Closed epiphyses. Other secondary causes of growth failure. Pre-existing thyroid and/or nutritional deficits. Presence of active or suspected neoplasia.
<i>Required Medical Information</i>	Failure of a growth hormone stimulation test. Genetic testing for growth hormone gene deletion. Lab testing for neutralizing antibodies to growth hormone.
<i>Age Restrictions</i>	Approve for those 2 years of age or older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	Height of the patient greater than or equal to 3 standard deviations below the norm for children of the same age and gender prior to beginning Increlex therapy. Basal IGF-1 level greater than or equal to 3 standard deviations below the norm for children of the same age and gender prior to beginning Increlex therapy. Increase in height velocity of 2 cm/year within the first year of Increlex therapy.
<i>Prior Authorization Group</i>	INFERGEN
<i>Drug Names</i>	INFERGEN
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Patient must have compensated liver disease with detectable levels of hepatitis C virus RNA in the serum
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	3 to 9 months depending on genotype and initial vs. renewal therapy
<i>Other Criteria</i>	2-log decrease in viral load for renewals

Prior Authorization Group	IVIG
Drug Names	GAMMAGARD, GAMUNEX
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	HSCT - IVIG is to be used in patients that have developed severe hypogammaglobulinemia (IgG less than 400) within the first 100 days post transplant.
Age Restrictions	BMT - patients have to be 20 years of age or older. HIV - patient has to be younger than 13 years of age.
Prescriber Restrictions	
Coverage Duration	4 mos- CIDP, BMT, HSCT 6 mos - ITP, Kawasaki, Parvovirus B19 12 mos - remaining covered uses
Other Criteria	Kawasaki disease - IVIG is to be used in conjunction with high dose aspirin. BMT - IVIG is to be used within the first 100 days after BMT. Dermatomyositis - IVIG is to be used only if corticosteroid is not a therapeutic option. GBS - IVIG is to be used for patients who require aid to walk within 2 or 4 weeks from the onset of neuropathic symptoms. Hyperimmunoglobulinemia E syndrome - diagnosis has to be coincident with eczema and atopic dermatitis. RRMS - IVIG is to be used as 2nd line treatment.

Prior Authorization Group	LIDODERM
Drug Names	LIDODERM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Sensitivity to local anesthetics of the amide type (e.g., procaine, tetracaine, benzocaine), skin is broken or inflamed where the patch is to be applied.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

<i>Prior Authorization Group</i>	METHYLPHENIDATES
<i>Drug Names</i>	CONCERTA, METADATE CD, METHYLIN, METHYLPHENIDATE, RITALIN LA
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	MAOI concurrent use or within the last 14 days
<i>Required Medical Information</i>	Sleep studies for narcolepsy diagnosis
<i>Age Restrictions</i>	Approved for those 6 years of age or older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	Monitor for weight loss, decreased growth velocity in children, increased heart rate and blood pressure, appearance or worsening of aggressive behavior or hostility, sleep disturbances and long-term usefulness of the drug
<i>Prior Authorization Group</i>	NEULASTA
<i>Drug Names</i>	NEULASTA
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Neulasta treatment within the last 14 days. Treatment of acute afebrile neutropenia.
<i>Required Medical Information</i>	Current and periodic monitoring of WBC count at initiation of and during therapy.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	6 months
<i>Other Criteria</i>	Neulasta administration will be delayed a minimum of 24 hours after the administration of cytotoxic chemotherapy.

<i>Prior Authorization Group</i>	NEUTROPHIL
<i>Drug Names</i>	NEUPOGEN
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D, bone marrow transplantation failure or engraftment delay. Neutropenia AIDS associated with treatment or disease, myelodysplastic syndromes, drug-induced neutropenia.
<i>Exclusion Criteria</i>	Treatment of acute afebrile neutropenia. Patients not at high risk for infection-associated complications or not having prognostic factors that are predictive of poor clinical outcomes.
<i>Required Medical Information</i>	Current and periodic monitoring of WBC count at initiation of and during therapy.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	3 months
<i>Other Criteria</i>	Treatment to be halted in the event of excessive leukocytosis.
<i>Prior Authorization Group</i>	OCTREOTIDE
<i>Drug Names</i>	OCTREOTIDE
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	OSTEOPOROSIS
<i>Drug Names</i>	FORTEO
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Paget's disease, unexplained elevation of alkaline phosphatase, open epiphyses, bone cancer or cancer that has metastasized to the bone, history of breast cancer, prior radiation therapy involving the skeleton, hypercalcemia, treatment with Forteo for greater than or equal to 24 months, concurrent bisphosphonate therapy during treatment with Forteo
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	For diagnosis of primary osteoporosis or hypogonadal osteoporosis patient must have at least one of the following: history of osteoporotic fractures, multiple risk factors for fractures, OR has failed or is intolerant to traditional osteoporosis therapy

<i>Prior Authorization Group</i>	PEGASYS
<i>Drug Names</i>	PEGASYS
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	For chronic hepatitis C, patient must have compensated liver disease with detectable levels of HCV RNA in the serum. For chronic hepatitis B, patient must have a positive serum marker for HBV replication, persistently elevated aminotransferase levels greater than 2 times ULN, or signs of chronic hepatitis B on liver biopsy, or cirrhosis of the liver as evidenced by radiological or clinical data, or extrahepatic complications.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Chronic hepatitis C - 3 to 9 months. Chronic hepatitis B - 12 months.
<i>Other Criteria</i>	For chronic hepatitis C, patient must have 2-log decrease in viral load for renewals.
<i>Prior Authorization Group</i>	PEGINTRON
<i>Drug Names</i>	PEGINTRON
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Patient must have compensated liver disease with detectable levels of hepatitis C virus RNA in the serum
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	3 to 9 months depending on genotype and initial vs. renewal therapy
<i>Other Criteria</i>	2-log decrease in viral load for renewals

<i>Prior Authorization Group</i>	PROVIGIL
<i>Drug Names</i>	PROVIGIL
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	If diagnosis is narcolepsy require polysomnography, if diagnosis of OSAHS require polysomnography and whether pt using CPAP
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	REMICADE
<i>Drug Names</i>	REMICADE
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Patients are excluded if they have an active infection or moderate to severe CHF.
<i>Required Medical Information</i>	Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patient must also be assessed for the risk of hepatitis B and if appropriate, be tested.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	RA - patient must demonstrate inadequate response to at least 1 DMARD or intolerance to 2 DMARDs. Remicade is to be used in combination with methotrexate. Crohn's disease - patient must demonstrate an inadequate response to at least 2 first-line agents unless the patient has multiple draining enterocutaneous or rectovaginal fistulae. Ulcerative colitis - patient must demonstrate an inadequate response to at least 2 first-line agents such as oral or rectal 5-ASA products or glucocorticosteroids. Ankylosing spondylitis - patient must demonstrate inadequate response to at least 2 NSAIDs or intolerance to 2 NSAIDs. If the ankylosing spondylitis is predominantly peripheral arthritis, patient must demonstrate an inadequate response or intolerance to sulfasalazine only. Psoriasis - patient must be a candidate for systemic therapy or phototherapy. Reactive arthritis - patient must demonstrate inadequate response to at least 2 first-line agents such as NSAIDs or DMARDs. IBDA - patient must demonstrate an inadequate response to at least 2 first-line agents such as sulfasalazine, azathioprine, 6-mercaptopurine, MTX or oral steroids.

Prior Authorization Group	REVATIO
Drug Names	REVATIO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Concurrent nitrate therapy. PAH associated with any of the following: left heart disease, chronic thrombotic disease, embolic disease, compression of pulmonary vessels, lung diseases, hypoxemia, sarcoidosis
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	RIBAVIRIN
Drug Names	REBETOL SOLN, RIBAPAK, RIBASPHERE, RIBAVIRIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	History of unstable heart disease, hemoglobin less than 8.5, creatinine clearance less than 50, pregnancy, hemoglobinopathy.
Required Medical Information	Patient must have detectable levels of HCV RNA in the serum and be on an alfa interferon product concurrently.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	4 to 8 months, depending on genotype and initial vs. renewal therapy.
Other Criteria	2-log decrease in viral load for renewals
Prior Authorization Group	RITUXAN
Drug Names	RITUXAN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Chronic lymphocytic leukemia (CLL). Immune thrombocytopenic purpura (ITP). Waldenstrom's macroglobulinemia.
Exclusion Criteria	RA - Rituxan cannot be used concomitantly with another biologic DMARD.

Required Medical Information Prescriber has to assess the patient for the risk of hepatitis B, and if clinically indicated, test the patient for hepatitis B infection before initiation or continuation of therapy with Rituxan.

Age Restrictions

Prescriber Restrictions

Coverage Duration NHL, RA, CLL, Waldenstrom's macroglobulinemia - 12 months. ITP - 1 month.

Other Criteria For NHL, the diagnosis must fall into one of the following categories of CD20-positive B-cell NHL: - relapsed or refractory, low-grade or follicular - previously untreated follicular, in combination with CVP chemotherapy - low grade in patients with stable disease or who achieve a partial or complete response following first-line treatment with CVP chemotherapy - diffuse large B-cell, treated first line in combination with CHOP or other anthracycline-based chemotherapy - relapsed or refractory diffuse large B-cell lymphoma. For ITP, patient has to be refractory to first line treatment with corticosteroids and/or IVIG.

Prior Authorization Group SANDOSTATIN LAR

Drug Names SANDOSTATIN LAR

Covered Uses All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Required Medical Information Patient had prior therapy with sandostatin injection (not depot form) and treatment was effective and tolerated.

Age Restrictions

Prescriber Restrictions

Coverage Duration 12 months

Other Criteria

Prior Authorization Group	SOMATULINE DEPOT
Drug Names	SOMATULINE DEPOT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Either surgery and/or radiotherapy is not a therapeutic option for the patient or the patient has had inadequate response to surgery and/or radiotherapy

Prior Authorization Group	SOMAVERT
Drug Names	SOMAVERT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Monitor IGF-1 levels at 6 month intervals after IGF-1 levels stabilize within normal range. Monitor LFTs as recommended during therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Prior to initiation of therapy IGF-1 levels were above age and gender adjusted normal range. If patient has been on therapy for the past 6 months demonstration of significant decrease in IGF-1 levels required. Patients were considered for/received treatment with surgery, radiation therapy, or medical treatment for acromegaly but rejected as inappropriate or had inadequate response.

<i>Prior Authorization Group</i>	STEROIDS, ANABOLIC
<i>Drug Names</i>	OXANDROLONE
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Known or suspected carcinoma of the prostate or breast (in male patients), carcinoma of the breast in women with hypercalcemia, pregnancy, nephrosis (the nephrotic phase of nephritis), hypercalcemia.
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	6 months
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	STRATTERA
<i>Drug Names</i>	STRATTERA
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	MAOI concurrent use or within the last 14 days
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	Approved for those 6 years of age or older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	monitor for suicidality, clinical worsening, changes in behavior, blood pressure changes, heart rate changes, weight loss, decreased growth velocity in children, sleep disturbances, liver injury

Prior Authorization Group	TESTOSTERONES
Drug Names	ANDRODERM, ANDROGEL, TESTIM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Female, prostate cancer, breast cancer
Required Medical Information	Before the start of testosterone therapy patient has (or patient currently has) a confirmed low testosterone level (i.e. total testosterone less than 300 ng/dL, free or bioavailable, testosterone less than 5 ng/dL) or absence of endogenous testosterone
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	XENAZINE
Drug Names	XENAZINE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Actively suicidal, untreated or inadequately treated depression, impaired hepatic function, current use of monoamine oxidase inhibitors or reserpine.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	In patients who are taking reserpine, at least 20 days should elapse after stopping reserpine before initiation of Xenazine therapy.

<i>Prior Authorization Group</i>	XOLAIR
<i>Drug Names</i>	XOLAIR
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Xolair is not to be used as monotherapy.
<i>Required Medical Information</i>	Positive aeroallergen skin or blood test. Pre-treatment IgE level to be between 30 and 700 IU/mL
<i>Age Restrictions</i>	12 years of age and above
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	Patient must be inadequately controlled on inhaled corticosteroids.

Prior Authorization Group

B vs D

Drug Names

ACETYLCYSTEINE, ALBUTEROL SULFATE, ALBUTEROL SULFATE/IPRATROPIUM BROMIDE, AMINESS, AMINOSYN, AZASAN, AZATHIOPRINE, CELLCEPT, CHORIONIC GONADOTROPIN, CLIMIMIX , CLINISOL SF 15%, COLISTIMETHATE SODIUM, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, DECAVAC, DIPHTHERIA/TETANUS TOXOID PEDIATRIC, EMEND, ENGERIX-B, FREAMINE , GENGRAF, GRANISETRON HCL, GRANISOL, HEPATAMINE, HEPATASOL, INTRALIPID, IPRATROPIUM BROMIDE, MYCOPHENOLATE, NEORAL, NEPHRAMINE, NOVAMINE, ONDANSETRON HCL, ONDANSETRON ODT, PREMASOL, PROCALAMINE, PROGRAF, PROSOL, PULMICORT, PULMOZYME, RAPAMUNE, RECOMBIVAX HB, RENAMIN, SANDIMMUNE, TETANUS TOXOID ADSORBED, TETANUS/DIPHTHERIA TOXOIDS-ADSORBED ADULT, TOBI, TRAVASOL, TROPHAMINE, VENTAVIS, XOPENEX

Covered Uses

This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria