

## ***PA Criteria***

<b><i>Prior Authorization Group</i></b>	ACTEMRA
<b><i>Drug Names</i></b>	ACTEMRA
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	Active infection (including TB). Concurrent therapy with other biologic agent(s).
<b><i>Required Medical Information</i></b>	Screening for latent tuberculosis is required. If results are positive, patient must have completed treatment or must currently be receiving treatment for latent tuberculosis. Evaluate for HBV risk and initiate treatment if appropriate. Must have an inadequate response or intolerance/contraindication to one TNF antagonist therapy.

### ***Age Restrictions***

### ***Prescriber Restrictions***

### ***Coverage Duration***

### ***Other Criteria***

Plan Year

For renewals, patient must have responded to Actemra therapy (e.g., condition improved or stabilized).

### ***Prior Authorization Group***

### ***Drug Names***

### ***Covered Uses***

### ***Exclusion Criteria***

### ***Required Medical Information***

### ***Age Restrictions***

### ***Prescriber Restrictions***

### ***Coverage Duration***

### ***Other Criteria***

ACTIMMUNE

ACTIMMUNE

All FDA approved indications not otherwise excluded from Part D

Plan Year

### ***Prior Authorization Group***

### ***Drug Names***

### ***Covered Uses***

### ***Exclusion Criteria***

### ***Required Medical Information***

### ***Age Restrictions***

### ***Prescriber Restrictions***

### ***Coverage Duration***

### ***Other Criteria***

ADAGEN

ADAGEN

All FDA approved indications not otherwise excluded from Part D

Severe thrombocytopenia. Use in preparation for or in support of bone marrow transplantation.

Plan Year

Use for direct replacement for deficient enzyme (no benefit achieved in patients with immunodeficiency due to other causes).

<i>Prior Authorization Group</i>	ADCIRCA
<i>Drug Names</i>	ADCIRCA
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Nitrate therapy
<i>Required Medical Information</i>	PAH been confirmed by right heart catheterization.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	ALDURAZYME
<i>Drug Names</i>	ALDURAZYME
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Diagnosis confirmed by measurement of alpha-L-iduronidase activity (enzymatic assay) or DNA testing. For Scheie form of MPS I, must have at least 2 moderate to severe symptoms. Must demonstrate improvement in lung function in patients who have received at least 26 weeks of Aldurazyme on re-authorization.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	ALPHA1-PROTEINASE INHIBITOR
<i>Drug Names</i>	ARALAST NP
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Patient has IgA deficiency with antibodies against IgA.
<i>Required Medical Information</i>	Alpha1-proteinase inhibitor concentration is less than 11 micromoles per liter. The FEV1 level is between 35% and 60% predicted OR greater than 60% predicted. If the FEV1 is greater than 60% predicted, then the patient has experienced a rapid decline in lung function (ie, reduction of FEV1 more than 120 mL/year) that warrants treatment.
<i>Age Restrictions</i>	18 years old and older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<b><i>Prior Authorization Group</i></b>	AMPHETAMINES
<b><i>Drug Names</i></b>	AMPHETAMINE/DEXTROAMPHETA, DEXTROAMPHETAMINE SULFATE
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	MAOI concurrent use or within the last 14 days except if prescriber is a psychiatrist with experience prescribing both MAOI and amphetamine/dextroamphetamine drugs.
<b><i>Required Medical Information</i></b>	Sleep studies for narcolepsy diagnosis
<b><i>Age Restrictions</i></b>	3 years of age and older
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	Consider benefits of use versus the potential risks of serious cardiovascular events

<b><i>Prior Authorization Group</i></b>	AMPYRA
<b><i>Drug Names</i></b>	AMPYRA
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	Moderate to severe renal impairment (CrCL less than or equal to 50 mL/min), history of seizures, Ampyra at doses exceeding 10 mg twice daily.
<b><i>Required Medical Information</i></b>	Patient must demonstrate sustained walking impairment, but with the ability to walk 25 feet (with or without assistance) prior to starting Ampyra.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	2 months, then plan year upon renewal
<b><i>Other Criteria</i></b>	To continue therapy, the patient must experience an improvement in walking speed or other objective measure of walking ability since starting Ampyra.

<b><i>Prior Authorization Group</i></b>	ANABOLIC STEROIDS
<b><i>Drug Names</i></b>	ANADROL-50, OXANDROLONE
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	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.
<b><i>Required Medical Information</i></b>	
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	6 months
<b><i>Other Criteria</i></b>	

<i>Prior Authorization Group</i>	ANAGRELIDE
<i>Drug Names</i>	ANAGRELIDE HYDROCHLORIDE
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Severe hepatic impairment
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	Oncologist or hematologist
<i>Coverage Duration</i>	6 months
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	ARANESP
<i>Drug Names</i>	ARANESP ALBUMIN FREE
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Uncontrolled hypertension, hemoglobin greater than or equal to 13 g/dL
<i>Required Medical Information</i>	All patients must meet the following criteria: 1) The pretreatment hemoglobin level is less than 10 g/dL (or less than or equal to 11 g/dL with clinical symptoms of anemia). 2) Once on therapy for 12 weeks, the hemoglobin must increase at least 1 g/dL in response to Aranesp. 3) Once on therapy, the hemoglobin should be maintained to a level below 12 g/dL and if the level exceeds 12 g/dL, the prescriber must reduce the dose. Patients with chronic kidney disease or those treated with myelosuppressive chemotherapy must have adequate iron stores or be receiving concomitant iron supplementation.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 weeks
<i>Other Criteria</i>	Patient is instructed by the prescriber to report any signs or symptoms of adverse cardiovascular or thrombotic events.

<i>Prior Authorization Group</i>	ARCALYST
<i>Drug Names</i>	ARCALYST
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Active or chronic infection. Concurrent therapy with other biologics.
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	12 years of age and older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	For renewal, patient's condition must have improved or stabilized.

<i>Prior Authorization Group</i>	AVONEX
<i>Drug Names</i>	AVONEX
<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>	Plan Year
<i>Other Criteria</i>	

*Prior Authorization Group  
Drug Names*

B VS. D

ACETYLCYSTEINE, ADRIAMYCIN, ALBUTEROL SULFATE, ALIMTA, AMIFOSTINE, AMINOSYN, AMINOSYN 8.5%/ELECTROLYTE, AMINOSYN II, AMINOSYN II 3.5%/DEXTROSE, AMINOSYN II 3.5%/DEXTROSE, AMINOSYN II 4.25%/DEXTROSE, AMINOSYN II 5%/DEXTROSE 25, AMINOSYN II 8.5%/ELECTROL, AMINOSYN II M 3.5%/DEXTRO, AMINOSYN M, AMINOSYN-HBC, AMINOSYN-HF, AMINOSYN-PF, AMINOSYN-PF 7%, AMIODARONE HCL, AMPHOTERICIN B, ASTRAMORPH, AVASTIN, AZASAN, AZATHIOPRINE, AZATHIOPRINE SODIUM, BICNU, BLEOMYCIN SULFATE, BONIVA, BUDESONIDE, BUSULFEX, CALCITRIOL, CAMPATH, CARBOPLATIN, CELLCEPT, CISPLATIN, CLADRIBINE, CLINIMIX 2.75%/DEXTROSE 5, CLINIMIX 4.25%/DEXTROSE 1, CLINIMIX 4.25%/DEXTROSE 2, CLINIMIX 4.25%/DEXTROSE 5, CLINIMIX 5%/DEXTROSE 15%, CLINIMIX 5%/DEXTROSE 20%, CLINIMIX 5%/DEXTROSE 25%, CLINIMIX E 2.75%/DEXTROSE, CLINIMIX E 4.25%/DEXTROSE, CLINIMIX E 5%/DEXTROSE 15, CLINIMIX E 5%/DEXTROSE 20, CLINIMIX E 5%/DEXTROSE 25, CLINISOL SF 15%, COLISTIMETHATE SODIUM, COSMEGEN, CROMOLYN SODIUM, CUBICIN, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE, DACARBAZINE, DAUNORUBICIN HCL, DAUNOXOME, DECAVAC, DEPO-PROVERA, DEXRAZOXANE, DIPHTHERIA/TETANUS TOXOID, DOXIL, DOXORUBICIN HCL, DURAMORPH, ELITEK, ELSPAR, EMEND, ENGERIX-B, EPIRUBICIN HCL, ETOPOSIDE, FASLODEX, FENTANYL CITRATE, FLUDARABINE PHOSPHATE, FLUOROURACIL, FREAMINE III, FREAMINE III 3%, GAMASTAN S/D, GANCICLOVIR, GEMCITABINE HCL, GENGRAF, GRANISETRON HCL, HEPARIN SODIUM, HEPARIN SODIUM/D5W, HEPARIN SODIUM/NACL 0.45%, HEPARIN SODIUM/SODIUM CHL, HEPATAMINE, HEPATASOL, HERCEPTIN, HYDROMORPHONE HCL, IDARUBICIN HCL, IFEX, IFOSFAMIDE, IFOSFAMIDE/MESNA, INTRALIPID, INTRON-A, INTRON-A W/DILUENT, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, ISTODAX, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVOCARNITINE, LIPOSYN II, LIPOSYN III, MELPHALAN HYDROCHLORIDE, MESNA, METHOTREXATE SODIUM, MIACALCIN, MITOMYCIN, MITOXANTRONE HCL, MORPHINE SULFATE, MUSTARGEN, MYCOPHENOLATE MOFETIL, MYFORTIC, NEORAL, NEPHRAMINE, ONDANSETRON HCL, ONDANSETRON ODT, ONTAK, OXALIPLATIN, PACLITAXEL, PENTOSTATIN, PERFOROMIST, PHOTOFRIN, PREMASOL, PROCALAMINE, PROGRAF, PROLEUKIN, PROSOL, PULMOZYME, RAPAMUNE, RECOMBIVAX HB, REMODULIN, SANDIMMUNE, TACROLIMUS, TAXOTERE, TETANUS TOXOID ADSORBED, TETANUS/DIPHTHERIA TOXOID, TOBI, TOPOSAR, TOPOTECAN HCL, TPN ELECTROLYTES, TRAVASOL, TREANDA, TRELSTAR DEPOT MIXJECT, TRELSTAR LA MIXJECT, TRELSTAR MIXJECT, TRISENOX, TROPHAMINE, VANCOMYCIN HCL, VELCADE, VIDAZA, VINBLASTINE SULFATE, VINCASAR PFS, VINCRISTINE SULFATE, VINOELBINE TARTRATE, ZEMPLAR, ZOMETA, ZORTRESS

**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** NA

**Other Criteria**

**Prior Authorization Group**

**Drug Names** BUPRENORPHINE

**Covered Uses** BUPRENORPHINE HCL, SUBOXONE  
All FDA approved indications not otherwise excluded from Part D

**Exclusion Criteria** Dose in excess of 4 units daily

**Required Medical Information** Documentation that the member is not receiving other opioids

**Age Restrictions** 16 years of age and older

**Prescriber Restrictions** Prescribers must be certified through CSAT (The Center for Substance Abuse Treatment) of SAMHSA (Substance Abuse and Mental Health Services Administration) to prescribe Suboxone and Subutex

**Coverage Duration** Buprenorphine - one month (12 months if pregnant). Buprenorphine-naloxone - 12 months.

**Other Criteria** Buprenorphine and buprenorphine-naloxone should be part of an overall treatment program. The patient should be monitored periodically.

**Prior Authorization Group**

**Drug Names** BYETTA

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

**Exclusion Criteria** History of pancreatitis

**Required Medical Information** A. The patient is diagnosed as having type-2 diabetes with an HbA1c level greater than 7. B. The patient has a creatinine clearance of greater than 30mL/minute or normal kidney function. C. The patient has had an inadequate treatment response, intolerance or contraindication to metformin or a sulfonylurea medication. D. If the patient has received previous Byetta therapy, the patient demonstrated a reduction in HbA1c since initiating Byetta therapy.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** Plan Year

**Other Criteria**

<b><i>Prior Authorization Group</i></b>	CAMPRAL
<b><i>Drug Names</i></b>	CAMPRAL
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	Renal failure.
<b><i>Required Medical Information</i></b>	A. Clinical diagnosis for alcohol dependence. B. AND clinical evidence indicated that the patient will be abstinent at least 5 days prior to treatment initiation. C. AND a trial of naltrexone (oral/injectable) has been attempted, at clinically significant dosage and duration. Or therapy is documented to be clinically inappropriate (hepatic insufficiency, chronic pain medication use). D. AND medication administration should be part of a comprehensive psychosocial treatment program.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	6 months
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	CAYSTON
<b><i>Drug Names</i></b>	CAYSTON
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Diagnosis of cystic fibrosis is confirmed by appropriate diagnostic or genetic testing. Confirmation of <i>P. aeruginosa</i> in cultures of the airways. For continuation of therapy in patients younger than 6 years of age, a clinical reason to continue therapy, such as symptomatic improvement, is required. For continuation of therapy in patients older than 6 years of age, pulmonary function tests have not deteriorated more than 10% from baseline or there is a clinical reason to continue therapy, such as symptomatic improvement.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

**Prior Authorization Group** CEREZYME  
**Drug Names** CEREZYME  
**Covered Uses** All FDA approved indications not otherwise excluded from Part D  
**Exclusion Criteria** Concurrent therapy with Zavesca.  
**Required Medical Information** Diagnosis confirmed by bone marrow histology, DNA testing, or b-glucocerebrosidase enzyme assay (enzyme activity less than 30 percent). Must have at least one of following conditions: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly. Must demonstrate a decrease in liver and spleen volume and/or increase in platelet count and/or increase in Hgb concentration in patients who have received at least 24 months of Cerezyme therapy on re-authorization.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** Plan Year

**Other Criteria**

**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** Evaluation for neuropsychiatric symptoms. If the patient is currently receiving Chantix, the patient's treatment, including the use of Chantix, has resulted in smoking cessation.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** 12 weeks initial, 12 weeks additional upon renewal

**Other Criteria** Member is participating in a smoking cessation program.

**Prior Authorization Group** COPAXONE  
**Drug Names** COPAXONE  
**Covered Uses** All FDA approved indications not otherwise excluded from Part D  
**Exclusion Criteria** Concurrent use of any of the following medications: Interferon-beta therapy (Avonex, Betaseron, Extavia, or Rebif), or mitoxantrone.

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** Plan Year

**Other Criteria** Patients with previous use (12 or more months) of Copaxone must demonstrate one of the following clinical responses: decrease in the frequency of relapses, slowing of disease progression, diminished MRI lesions, OR patient is stable on therapy.

<b>Prior Authorization Group</b>	DRONABINOL
<b>Drug Names</b>	DRONABINOL
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A. The diagnosis is documented as anorexia associated with weight loss in a patient with AIDS a. AND the patient has had an involuntary weight loss of greater than 10% of pre-illness baseline body weight or a body mass index (BMI) less than 20kg/m <sup>2</sup> in the absence of a concurrent illness or medical condition other than HIV that may cause weight loss b. AND the patient has failed to respond to a 30-day drug regimen of megestrol (Megace) c. AND if the patient has received previous dronabinol therapy, he/she must show a positive response to therapy by maintaining or increasing their initial weight and/or muscle mass before initiating dronabinol therapy. B. The diagnosis is documented as nausea and vomiting associated with cancer chemotherapy in a cancer patient a. AND the patient is receiving a chemotherapy or radiation regimen b. AND the patient has had a full trial and failure through at least one cycle of chemotherapy with IV ondansetron AND at least one of the following oral anti-emetic agents: metoclopramide, promethazine, prochlorperazine, meclizine, trimethobenzamide, oral 5-HT <sub>3</sub> receptor antagonists e. AND if the patient has received previous dronabinol therapy, he/she must show a positive response by showing a reduced incidence of emesis and/or nausea.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

6 months

**Other Criteria**

B vs D coverage determination per CMS guidelines

**Prior Authorization Group**

ELAPRASE

**Drug Names**

ELAPRASE

**Covered Uses**

All FDA approved indications not otherwise excluded from Part D

**Exclusion Criteria**

**Required Medical Information**

Diagnosis confirmed by DNA testing or enzymatic analysis (deficiency of iduronate 2-sulfatase enzyme activity).

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

<i>Prior Authorization Group</i>	ENBREL
<i>Drug Names</i>	ENBREL
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Concomitant use with another biologic, active infection (including TB).
<i>Required Medical Information</i>	Screening for latent TB infection and assessment for Hep B risk. For positive latent TB, patient must have completed treatment or is currently receiving treatment for LTBI. HBV infection ruled out or treatment initiated for positive infection. Rheumatoid arthritis - Must have one of following: 1) inadequate response to methotrexate (MTX), 2) inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX, 3) intolerance or contraindication to at least 2 nonbiologic DMARDs or, 4) use Enbrel as first-line therapy with MTX for severely active RA. Polyarticular JIA - Must have an inadequate response to at least one nonbiologic DMARD or intolerance/contraindication to at least 2 nonbiologic DMARDs. Psoriatic arthritis with predominantly peripheral symptoms - Must have an inadequate response to at least an 8-week maximum tolerated dose trial of at least 1 nonbiologic DMARD unless contraindicated or intolerant to such therapy. Psoriatic arthritis with predominantly axial symptoms and ankylosing spondylitis Inadequate response or intolerance/contraindication to at least 2 NSAIDs. For plaque psoriasis - Must have more than 10% BSA affected or has crucial body areas (e.g., feet, hands, face) affected. Patient must have an inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., phototherapy, calcipotriene, MTX, acitretin) unless contraindicated or intolerant to such therapies. For psoriasis, patient must be 18 years of age or older
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	For continuation of therapy, patient's condition must have improved or stabilized.

<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>	Uncontrolled hypertension
<i>Required Medical Information</i>	For use in an anemic patient prior to surgery, the patient must also receive concomitant iron supplementation. For other indications, all of the following criteria are required: 1) The pretreatment Hgb is less than or equal to 10 g/dL for initial authorization. 2) The patient is receiving concomitant iron supplementation if iron stores are inadequate. 3) The Hgb is maintained at or below 12 g/dL once on therapy. 4) Once on therapy for 12 weeks, the hemoglobin must increase at least 1 g/dL in response to epoetin alfa.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 weeks
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	EXJADE
<i>Drug Names</i>	EXJADE
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Creatinine clearance less than 40 mL/min or evidence of overt proteinuria, platelet count less than 50 x 10 <sup>9</sup> /L, advanced malignancy, high-risk myelodysplastic syndrome (MDS) with poor performance status, or concurrent use of deferoxamine or iron-containing products.
<i>Required Medical Information</i>	The patient must meet all of the following criteria: 1) Diagnosis of transfusion-dependent anemia with chronic iron overload due to blood transfusions, 2) Pretreatment serum ferritin level within the last 60 days of at least 1,000 mcg/L, and 3) Patient will have baseline and monthly monitoring of serum ferritin, serum creatinine, creatinine clearance, serum transaminases, and bilirubin. For patients already receiving Exjade, the prescriber will consider temporary interruption of Exjade when serum ferritin is less than 500 mcg/L.
<i>Age Restrictions</i>	2 years of age and older
<i>Prescriber Restrictions</i>	Hematologist
<i>Coverage Duration</i>	3 months
<i>Other Criteria</i>	

<b><i>Prior Authorization Group</i></b>	EXTAVIA
<b><i>Drug Names</i></b>	EXTAVIA
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	Concurrent use of any of the following medications: Interferon-beta therapy (Avonex, Betaseron, or Rebif), glatiramer acetate, or mitoxantrone.
<b><i>Required Medical Information</i></b>	
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	Patients with previous use (12 or more months) of Extavia must demonstrate one of the following clinical responses: decrease in the frequency of relapses, slowing of disease progression, MRI lesions have diminished with therapy, OR patient is stable on therapy.
<b><i>Prior Authorization Group</i></b>	FABRAZYME
<b><i>Drug Names</i></b>	FABRAZYME
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Diagnosis confirmed with an enzyme assay measuring a deficiency of alpha-galactosidase enzyme activity or DNA testing.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	GILENYA
<b><i>Drug Names</i></b>	GILENYA
<b><i>Covered Uses</i></b>	All FDA approved uses not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For new starts, patient had an inadequate response to a trial of a beta interferon agent or Copaxone unless contraindicated or not tolerated.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	NA

<i>Prior Authorization Group</i>	GONADOTROPIN
<i>Drug Names</i>	CHORIONIC GONADOTROPIN, NOVAREL, PREGNYL W/DILUENT BENZYL
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Female. For prepubertal cryptorchidism, presence of anatomic obstruction or precocious puberty. For hypogonadotropic hypogonadism, presence of prostatic carcinoma or other androgen-dependent neoplasm.
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<b><i>Prior Authorization Group</i></b>	GROWTH HORMONE
<b><i>Drug Names</i></b>	NORDITROPIN FLEXPOR, NORDITROPIN NORDIFLEX PEN
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	Active malignancy or history of malignancy in past 12 months, active proliferative or severe non-proliferative diabetic retinopathy, acute critical illness, concurrent use with Increlex, and closed epiphyses for pediatric patients. For PWS only: upper airway obstruction and severe respiratory impairment.
<b><i>Required Medical Information</i></b>	For pediatric GHD in neonate with hypoglycemia: patient has a randomly assessed GH level less than 20 ng/mL, other causes of hypoglycemia have been ruled out, and other treatments have been ineffective. For all pediatric patients: patients have short stature or slow growth velocity and have been evaluated for other causes of growth failure. For pediatric GHD, patient has delayed bone age. For pediatric GHD without pituitary disease, patient failed 2 stimulation tests. For pediatric GHD with a pituitary or CNS disorder, patient has clinical evidence of GHD and low IGF-1/IGFBP3. For TS and SHOX patients: diagnosis confirmed by genetic testing. For CRI patients: metabolic, endocrine and nutritional abnormalities have been treated or stabilized and patient has not had a kidney transplant. For SGA: patient has a low birth weight or length for gestational age. For ISS: pediatric GHD has been ruled out with one stimulation test. For adult GHD, patient was assessed for other causes of GHD-like symptoms. For adult GHD without pituitary disease, patient failed 2 stimulation tests. For adult GHD with at least 3 pituitary hormone deficiencies (PHD) or panhypopituitarism: have a low IGF-1. For adult GHD with less than 3 PHD, low IGF-1 and failed one stimulation test. For renewal for pediatric patients, growing more than 2 cm per year and for PWS only: improved body composition. For renewal for adult patients: patient has seen clinical improvement and IGF-1 will be monitored.
<b><i>Age Restrictions</i></b>	For Turner syndrome and SGA, 2 years of age and older. For Noonan syndrome and SHOX, 3 years of age and older.
<b><i>Prescriber Restrictions</i></b>	Endocrinologist, Pediatric Nephrologist, Gastroenterologist, Nutritional Support Specialist, Infectious Disease Specialist
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<i>Prior Authorization Group</i>	HEPSERA
<i>Drug Names</i>	HEPSERA
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D, prophylaxis against HBV infection with liver transplantation.
<i>Exclusion Criteria</i>	Renal impairment without dosing adjustment, if the patient is taking/receiving tenofovir or PMPA. Use of Hepsera as a first-line therapy in treatment-naïve patients with HBV.
<i>Required Medical Information</i>	A. The patient has been diagnosed with chronic hepatitis B. B. AND the patient has evidence of a positive HBsAg (+ or -) serological marker for greater than 6 months OR evidence by a liver biopsy showing chronic hepatitis. C. AND the patient has a Hepatitis B viral load greater than 20,000 IU/mL (100,000 copies per mL) except if for HBeAg-negative HBV, the viral load is greater than 2,000 IU per mL (10,000 copies per mL). D. AND the patient has elevations in liver aminotransferases (ALT or AST) that are two (2) times greater than normal OR normal liver aminotransferase (ALT or AST) levels with evidence of significant disease found on biopsy. E. AND the patient is not receiving Intron A. F. AND documented evidence of diagnosis, serological markers or liver biopsy, viral load and liver aminotransferases. G. If the patient has received previous Hepsera treatment, there is documented clinical improvement shown by a drop in viral load or reduction in the patient's liver aminotransferases.
<i>Age Restrictions</i>	12 years and older
<i>Prescriber Restrictions</i>	Gastroenterologist or infectious disease specialist or affiliated with an infectious disease or gastroenterology practice, or a primary care physician with experience in treating HBV.
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	HRM EDITS
<i>Drug Names</i>	CARISOPRODOL, CHLORZOXAZONE, CYCLOBENZAPRINE HCL, CYPROHEPTADINE HCL, DICYCLOMINE HCL, DIPHENOXYLATE/ATROPINE, DIPYRIDAMOLE, ESTROPIPATE, HYDROXYZINE HCL, HYDROXYZINE PAMOATE, METAXALONE, METHOCARBAMOL, ORPHENADRINE CITRATE ER, ORPHENADRINE COMPOUND DS, ORPHENADRINE/ASA/CAFFEINE, ORTHO-EST, PHENADOZ, PROMETHAZINE HCL, PROMETHAZINE VC, PROMETHEGAN, TRANSDERM-SCOP, TRIMETHOBENZAMIDE HCL
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Not covered for those who are 65 years of age and older
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	HUMIRA
<i>Drug Names</i>	HUMIRA, HUMIRA PEN-CROHNS DISEASE
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Active infection (including TB), concurrent use with other biologics.
<i>Required Medical Information</i>	Screening for latent TB infection and assessment for Hep B risk. For positive latent TB, patient must have completed treatment or is currently receiving treatment for LTBI. HBV infection ruled out or treatment initiated for positive infection. Rheumatoid arthritis - Must have one of following: 1) inadequate response to methotrexate (MTX), 2) inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX, 3) intolerance or contraindication to at least 2 nonbiologic DMARDs or, 4) use Humira as first-line therapy with MTX for severely active RA. Polyarticular JIA - Must have an inadequate response to at least one nonbiologic DMARD or intolerance/contraindication to at least 2 nonbiologic DMARDs. Psoriatic arthritis with predominantly peripheral symptoms - Must have an inadequate response to at least an 8-week maximum tolerated dose trial of at least 1 nonbiologic DMARD unless contraindicated or intolerant to such therapy. Psoriatic arthritis with predominantly axial symptoms and ankylosing spondylitis - Inadequate response or intolerance/contraindication to at least 2 non-steroidal anti-inflammatory drugs (NSAIDs). For plaque psoriasis - Must have more than 10% BSA affected or has crucial body areas (e.g., feet, hands, face) affected. Must have an inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., phototherapy, calcipotriene, MTX, acitretin) unless contraindicated or intolerant to such therapies. Crohn's disease - Must have an inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., sulfasalazine, mesalamine, azathioprine, corticosteroids) unless contraindicated or intolerant to such therapies OR an inadequate response or intolerance to either Remicade or Cimzia.
<i>Age Restrictions</i>	For psoriasis, patient must be 18 years of age and older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Initial: 3 months for Crohn's disease and plan year for all other indications Renewal: Plan Year
<i>Other Criteria</i>	For re-authorization, patient's condition must have improved or stabilized.

<b><i>Prior Authorization Group</i></b>	INCRELEX
<b><i>Drug Names</i></b>	INCRELEX
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	Epiphyseal closure, IV administration of Increlex, active malignancy, use in neonates, concurrent use with GH therapy, patient has secondary causes of IGF-1 deficiency.
<b><i>Required Medical Information</i></b>	Prior to starting therapy, a height greater than 3 SD below the mean for chronological age and sex, and an IGF-1 level greater than or equal to 3 SD below the mean for chronological age and gender. One stimulation test showing patient has a normal or elevated GH level. For continuation of therapy, patient grew more than 2.5 cm/year.
<b><i>Age Restrictions</i></b>	Between 2 and 20 years of age
<b><i>Prescriber Restrictions</i></b>	Endocrinologist
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	INFERGEN
<b><i>Drug Names</i></b>	INFERGEN
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	Decompensated liver disease. Autoimmune hepatitis.
<b><i>Required Medical Information</i></b>	Prior to initiating therapy, detectable levels of HCV RNA in the serum. For treatment naïve, patient must have tried and had intolerance to pegylated interferon based treatment regimen. Allow Infergen monotherapy for treatment naïve if patient has a contraindication or intolerance to ribavirin. For retreatment, must use in combination with ribavirin and must have tried and failed to respond to pegylated interferon and ribavirin. Allow only one time for retreatment. For Genotype 1 and 4: undetectable HCV RNA after 12 weeks of treatment OR at least 2 log decrease in HCV RNA after 12 weeks of therapy and undetectable HCV RNA after 24 weeks of treatment.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	ID specialist, gastroenterologist, or oncologist
<b><i>Coverage Duration</i></b>	12 weeks to a total of 72 weeks depending on genotype and initial vs. renewal therapy
<b><i>Other Criteria</i></b>	Monitored for evidence of depression.

<b><i>Prior Authorization Group</i></b>	ITRACONAZOLE
<b><i>Drug Names</i></b>	ITRACONAZOLE
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	A. ventricular dysfunction (e.g., congestive heart failure (CHF) or history of CHF) do not use for onychomycosis. B. If the patient is taking/receiving any of the following: concomitant use with drugs metabolized by CYP3A4 (e.g., cisapride, dofetilide, pimozide, quinidine)
<b><i>Required Medical Information</i></b>	Patients with a diagnosis of blastomycosis, pulmonary or extrapulmonary OR patients with a diagnosis of histoplasmosis, including chronic cavitory pulmonary disease or disseminated, non-meningeal histoplasmosis OR patients with a diagnosis of aspergillosis, pulmonary or extrapulmonary OR patients with a diagnosis of onychomycosis of the toenail, with or without fingernail involvement, due to dermatophytes (tinea unguium) OR patients with a diagnosis of onychomycosis of the fingernail due to dermatophytes (tinea unguium). For onychomycosis, diagnosis has been confirmed with a fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy).
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	12 weeks
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	IVIG
<b><i>Drug Names</i></b>	GAMMAGARD LIQUID, GAMUNEX
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	IgA deficiency with antibody formation and a history of hypersensitivity. History of anaphylaxis or severe systemic reaction to human immune globulin. Presence of risk factor(s) for acute renal failure, unless the patient will receive IGIV products at the minimum concentration available and at the minimum rate of infusion practicable OR Gamunex/Gamunex-C is administered SC for PID.
<b><i>Required Medical Information</i></b>	CIDP: presence of objective findings consistent with diagnosis. CLL: serum IgG level less than 500 mg/dL and recurrent bacterial infections. Kawasaki syndrome: use of IGIV in conjunction with high-dose aspirin.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	CIDP diagnosis by a neurologist
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	Gamunex/Gamunex-C: if administered SC outside of a controlled healthcare setting, appropriate treatment (eg, anaphylaxis kit) should be available for managing an acute hypersensitivity reaction.

<i>Prior Authorization Group</i>	KUVAN
<i>Drug Names</i>	KUVAN
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Blood phenylalanine (Phe) levels. Pretreatment blood phenylalanine (Phe) levels greater than 10mg/dL if the patient is older than 12 years of age or greater than 6mg/dL if less than or equal to 12 years of age. Response to a therapeutic trial (greater than or equal to a 30% reduction in blood Phe levels) is required for long-term authorization.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	1 month initial, plan year on renewal
<i>Other Criteria</i>	Blood Phe levels should be checked after 1 week of therapy and periodically up to one month during a therapeutic trial.
<i>Prior Authorization Group</i>	LETAIRIS
<i>Drug Names</i>	LETAIRIS
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Pregnancy
<i>Required Medical Information</i>	NYHA class II or III symptoms. PAH been confirmed by right heart catheterization.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	UD or two appropriate contraceptive methods will be used for women of childbearing potential.

<b><i>Prior Authorization Group</i></b>	LEUKINE
<b><i>Drug Names</i></b>	LEUKINE
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	Administration within 24 hours preceding or following chemotherapy or radiotherapy, hypersensitivity to yeast-derived products. For prophylaxis of febrile neutropenia: use to increase the chemotherapy dose intensity or dose schedule above established regimens. For treatment of febrile neutropenia, when patient receives Neulasta during the current chemotherapy cycle. For AML only, excessive (greater than or equal to 10%) leukemic myeloid blasts in the bone marrow or peripheral blood.
<b><i>Required Medical Information</i></b>	For patients with nonmyeloid malignancies receiving myelosuppressive chemotherapy: Leukine may be used for the prevention of chemotherapy-induced febrile neutropenia if the patient experienced febrile neutropenia with a prior chemotherapy cycle OR the patient is at high risk (greater than 20%) or intermediate risk (10-20%) for developing febrile neutropenia. Patients at low risk (less than 10%) for developing febrile neutropenia may also receive Leukine for prophylaxis if there is a significant risk for serious medical consequences due to febrile neutropenia and the intent of chemotherapy is to prolong survival or cure the disease. Leukine is allowable for the treatment of febrile neutropenia in patients who have received prophylaxis with Leukine (or Neupogen) OR in patients at risk for infection-related complications. All patients must receive baseline and regular monitoring of complete blood counts and platelet counts.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	6 months
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	LIDODERM
<b><i>Drug Names</i></b>	LIDODERM
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	Patient has a sensitivity to local anesthetics of the amide type (e.g., procaine, tetracaine, benzocaine. Dose in excess of 3 patches per day.
<b><i>Required Medical Information</i></b>	A. The diagnosis is documented as post-herpetic neuralgia B. The skin where the patch is to be applied is intact (not broken or inflamed). C. The patient has completed a documented one month trial and failure of the following two medications: gabapentin OR Lyrica D. OR the patient has a contraindication or demonstrated an adverse event to the prerequisite drugs.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	3 months
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	LUPRON
<b><i>Drug Names</i></b>	LEUPROLIDE ACETATE, LUPRON DEPOT, LUPRON DEPOT-PED
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	Pregnancy and breast feeding in female patients of childbearing potential For prostate cancer, use as neoadjuvant androgen deprivation therapy (ADT) for radical prostatectomy For endometriosis and fibroids, undiagnosed abnormal vaginal bleeding
<b><i>Required Medical Information</i></b>	For prostate cancer: 1) allow therapy for locally advanced, recurrent or metastatic disease, 2) allow initial long-term neoadjuvant/concurrent/adjuvant ADT in combination with radiation therapy for clinically localized disease with high risk of recurrence, 3) allow initial short-term neoadjuvant/concurrent/adjuvant ADT in combination with radiation therapy for clinically localized disease with intermediate risk of recurrence or with brachytherapy for clinically localized disease with high risk of recurrence, or 4) allow neoadjuvant therapy in conjunction with brachytherapy in patients with a large prostate to shrink the prostate to an acceptable size for brachytherapy For endometriosis: patient must have completed a trial and failure of at least 2 of the following therapies: oral contraceptives, medroxyprogesterone, or danazol.
<b><i>Age Restrictions</i></b>	For CPP, patient must be less than 12 years old if female and less than 13 years old if male.
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Prostate CA: 1 yr but 6 mos for short term use, Fibroids: 3 mos, Endometriosis: 6 mos, CPP: 1 yr
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	METHYLPHENIDATES
<b><i>Drug Names</i></b>	METADATE ER, METHYLIN, METHYLPHENIDATE HCL, METHYLPHENIDATE HCL SR, METHYLPHENIDATE HYDROCHLO
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	MAOI concurrent use or within the last 14 days
<b><i>Required Medical Information</i></b>	Sleep studies for narcolepsy diagnosis
<b><i>Age Restrictions</i></b>	6 years of age and older
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	Consider benefits of use versus the potential risks of serious cardiovascular events.

<i>Prior Authorization Group</i>	MOZOBIL
<i>Drug Names</i>	MOZOBIL
<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>	6 months
<i>Other Criteria</i>	Mozobil is given in combination with granulocyte-colony stimulating factor

<i>Prior Authorization Group</i>	MYOZYME
<i>Drug Names</i>	MYOZYME
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Diagnosis confirmed by DNA testing or an enzymatic assay showing a deficiency in acid alpha glucosidase.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	NAGLAZYME
<i>Drug Names</i>	NAGLAZYME
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Diagnosis confirmed by DNA testing or an enzymatic assay showing a deficiency in N-acetylgalactosamine activity. Patient must have at least one MPS VI symptom. For re-authorization of Naglazyme, patient must demonstrate improvement in walking and/or stair-climbing capacity.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	NEUPOGEN
<i>Drug Names</i>	NEUPOGEN
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Administration within 24 hours preceding or following chemotherapy or radiotherapy, E coli hypersensitivity. For prophylaxis of febrile neutropenia: use to increase the chemotherapy dose intensity or dose schedule beyond established regimen. For treatment of febrile neutropenia, when patient receives Neulasta during the current chemotherapy cycle.
<i>Required Medical Information</i>	For patients with nonmyeloid malignancies receiving myelosuppressive chemotherapy: Neupogen may be used for the prevention of chemotherapy-induced febrile neutropenia if the patient experienced febrile neutropenia with a prior chemotherapy cycle OR the patient is at high risk (greater than 20%) or intermediate risk (10-20%) for developing febrile neutropenia. Patients at low risk (less than 10%) for developing febrile neutropenia may receive Neupogen for prophylaxis if there is a significant risk for serious medical consequences due to febrile neutropenia and the intent of chemotherapy is to prolong survival or cure the disease. Neupogen is allowable for the treatment of febrile neutropenia in patients who have received prophylaxis with Neupogen (or Leukine) OR in patients at risk for infection-related complications. All patients must receive baseline and regular monitoring of complete blood counts and platelet counts.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	6 months
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	NICOTINE
<i>Drug Names</i>	NICOTROL INHALER, NICOTROL NS
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Documentation that the patient is enrolled in a smoking cessation program
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	6 months
<i>Other Criteria</i>	

<b><i>Prior Authorization Group</i></b>	NUEDEXTA
<b><i>Drug Names</i></b>	NUEDEXTA
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	Concomitantly taking other drugs containing quinidine, quinine, mefloquine, monoamine oxidase inhibitors (MAOIs), or drugs that both prolong QT interval and are metabolized by CYP2D6 (e.g., thioridazine and pimozone), patient has a prolonged QT interval, congenital long QT syndrome or a history suggestive of torsades de pointes, or heart failure, patient has complete atrioventricular (AV) block without implanted pacemaker, or is at high risk of complete AV block. Dose in excess of 2 capsules per day.
<b><i>Required Medical Information</i></b>	Patient has amyotrophic lateral sclerosis (ALS) OR multiple sclerosis (MS)
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	NUVIGIL
<b><i>Drug Names</i></b>	NUVIGIL
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	If diagnosis is narcolepsy require Sleep Lab Evaluation, if diagnosis of OSAHS require polysomnography and whether the patient is using CPAP or CPAP is contraindicated or ineffective. If diagnosis of Shift Work Sleep Disorder (work the night shift (at least 6 hours between the hours of 10pm and 8am permanently or work the night shift (at least 6 hours between the hours of 10pm and 8am) frequently (5 times or more per month) AND experience excessive sleepiness while working. If diagnosis of mild obstructive sleep apnea/hypopnea syndrome and whether patient is using and compliant with an oral appliance
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

*Prior Authorization Group* OCTREOTIDE  
*Drug Names* OCTREOTIDE ACETATE  
*Covered Uses* All FDA approved indications not otherwise excluded from Part D  
*Exclusion Criteria*  
*Required Medical Information*  
*Age Restrictions*  
*Prescriber Restrictions*  
*Coverage Duration* Plan Year  
*Other Criteria*

*Prior Authorization Group* ORAL FENTANYL  
*Drug Names* FENTANYL CITRATE ORAL TRA  
*Covered Uses* All FDA approved indications not otherwise excluded from Part D  
*Exclusion Criteria* Patients taking strong or moderate cytochrome P450 3A4 inhibitor(s) (e.g., aprepitant, clarithromycin, diltiazem, erythromycin, fosamprenavir, fluconazole, itraconazole, ketoconazole, nefazodone, nelfinavir, ritonavir, verapamil) who will not be monitored or have dosing adjustments made if necessary.  
*Required Medical Information*  
*Age Restrictions* 16 years of age and older (Actiq), 18 years of age and older all others  
*Prescriber Restrictions*  
*Coverage Duration* 6 months  
*Other Criteria*

<b><i>Prior Authorization Group</i></b>	ORAL TESTOSTERONES
<b><i>Drug Names</i></b>	ANDROXY
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	Male patients who have confirmed or suspected carcinoma of the prostate or breast.
<b><i>Required Medical Information</i></b>	For female patients being treated for inoperable metastatic breast cancer who are 1 to 5 years postmenopausal (either naturally or surgically) and who have had an incomplete response to other therapies for metastatic breast cancer. For male patients being treated for primary or secondary hypogonadism, a confirmed low testosterone level (morning total testosterone less than 300 ng/dL, morning free or bioavailable testosterone less than 5 ng/dL) or absence of endogenous testosterone. For male patients being treated for delayed puberty, bone development must be checked at least every 6 months.

***Age Restrictions***

***Prescriber Restrictions***

***Coverage Duration*** Plan Year

***Other Criteria*** Patients who have tried and failed or unable to tolerate non-oral forms of testosterone supplementation.

***Prior Authorization Group***

***Drug Names*** ORFADIN

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

***Exclusion Criteria***

***Required Medical Information*** Confirmation of diagnosis by either biochemical testing (e.g., detection of succinylacetone in urine) and appropriate clinical picture OR DNA testing (mutation analysis).

***Age Restrictions***

***Prescriber Restrictions***

***Coverage Duration*** Plan Year

***Other Criteria*** Protein-restricted diet that is low in phenylalanine and tyrosine.

<b><i>Prior Authorization Group</i></b>	OSTEOPOROSIS
<b><i>Drug Names</i></b>	FORTEO
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	Paget's disease of bone, unexplained elevations in alkaline phosphatase, open epiphyses, prior radiation therapy involving the skeleton, history of a skeletal malignancy or bone metastases, pre-existing hypercalcemia, metabolic bone disease other than osteoporosis, concurrent bisphosphonate use, or cumulative use of Forteo for more than 24 months lifetime.
<b><i>Required Medical Information</i></b>	Patient meets one of the following criteria: 1) Patient has experienced a prior fragility fracture, or 2) Patient had an inadequate response to an adequate trial of a bisphosphonate (one year) or patient has a contraindication or intolerance to bisphosphonate trial, or 3) Patient has 2 of the following risk factors for fracture: advanced age, parental history of fracture, low body mass index, current smoker, chronic alcohol use, rheumatoid arthritis, chronic steroid use, or other secondary cause of osteoporosis.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	OXSORALEN
<b><i>Drug Names</i></b>	OXSORALEN ULTRA
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	Aphakia, melanoma, or invasive squamous cell carcinoma
<b><i>Required Medical Information</i></b>	The patient must be diagnosed with cutaneous T-cell lymphoma OR psoriasis AND if the diagnosis is psoriasis, the patient must have previous must have previous inadequate treatment response or intolerance or contraindication to at least one topical steroid.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	Dermatologist or Oncologist or affiliated with a dermatologist/oncologist practice
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<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>	Decompensated liver disease. Autoimmune hepatitis. Concomitant administration of didanosine with ribavirin in patients coinfectd with HIV.
<i>Required Medical Information</i>	<p>HCV: Prior to initiating therapy, detectable levels of HCV RNA in the serum.</p> <p>For HCV treatment naïve, allow Pegasys monotherapy if patient has a contraindication or intolerance to ribavirin.</p> <p>For HCV retreatment, must use in combination with ribavirin and must have nonresponse or relapse with prior HCV therapy. Allow only one time for retreatment with pegylated interferon and ribavirin.</p> <p>For Genotype 1 and 4: undetectable HCV RNA after 12 weeks of treatment OR at least 2 log decrease in HCV RNA after 12 weeks of therapy and undetectable HCV RNA after 24 weeks of treatment.</p> <p>HBV: Must have been HBsAg positive for at least 6 months and have persistent or intermittently elevated ALT greater than 2x ULN or liver biopsy showing chronic hepatitis with moderate to severe necroinflammation. For HBeAg positive, must have serum HBV-DNA greater than 100,000 copies/mL or greater than 20,000 IU/mL. For HBeAg negative, must have serum HBV-DNA greater than 10,000 copies/mL or greater than 2,000 IU/mL.</p>
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	ID specialist, Gastroenterologist, Oncologist
<i>Coverage Duration</i>	HCV:12 weeks to 72 weeks total depending on genotype and initial vs. renewal therapy. HBV:48 weeks.
<i>Other Criteria</i>	Monitor for evidence of depression.

<i>Prior Authorization Group</i>	PEGINTRON
<i>Drug Names</i>	PEG-INTRON, PEG-INTRON REDIPEN
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Decompensated liver disease. Autoimmune hepatitis. Concomitant administration of didanosine with ribavirin in patients coinfecting with HIV.
<i>Required Medical Information</i>	HCV: Prior to initiating therapy, detectable levels of HCV RNA in the serum. For HCV treatment naïve, allow PegIntron monotherapy if patient has a contraindication or intolerance to ribavirin. For retreatment, must use in combination with ribavirin and must have nonresponse or relapse with prior HCV therapy. Allow only one time for retreatment with pegylated interferon and ribavirin. For Genotype 1 and 4: undetectable HCV RNA after 12 weeks of treatment OR at least 2 log decrease in HCV RNA after 12 weeks of therapy and undetectable HCV RNA after 24 weeks of treatment.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	ID specialist, Gastroenterologist, Oncologist
<i>Coverage Duration</i>	12 weeks to a total 72 weeks depending on genotype and initial vs. renewal therapy.
<i>Other Criteria</i>	Monitor for evidence of depression.
<i>Prior Authorization Group</i>	PROLIA
<i>Drug Names</i>	PROLIA
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Hypocalcemia
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	Patient will be adequately supplemented with calcium and vitamin D.

<b><i>Prior Authorization Group</i></b>	PROMACTA
<b><i>Drug Names</i></b>	PROMACTA
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For new starts, at the time of diagnosis of ITP one of the following are required: 1) a pretreatment platelet count less than 30,000/microL or 2) a platelet count less than or equal to 50,000/microL with significant mucous membrane bleeding or risk factors for bleeding. Patients must be evaluated for other causes of thrombocytopenia and have had an insufficient response or intolerance to corticosteroids, or immunoglobulins, or splenectomy. For continuation of therapy, one of the following are required: 1) an increase in platelet count to greater than or equal to 50,000/microL or 2) an increase in platelet level that is sufficient to avoid clinically important bleeding after at least 4 weeks of Promacta at the maximum dose. For all patients receiving Promacta therapy, if platelets increase above 200,000/microL, therapy will be adjusted to maintain the minimal platelet count needed to reduce the risk for bleeding. Liver function must be assessed pretreatment and regularly throughout therapy. To continue Promacta therapy, alanine aminotransferase levels must not be greater than or equal to 3 times the upper limit of normal with any of the following characteristics: progressive, persistent, accompanied by increased bilirubin or symptoms of liver injury or evidence of hepatic decompensation.

***Age Restrictions***

***Prescriber Restrictions***

***Coverage Duration***

6 month initial, 12 month renewal if adequate platelet response, 3 month w/o platelet response

***Other Criteria***

***Prior Authorization Group***

REBIF

***Drug Names***

REBIF, REBIF TITRATION PACK

***Covered Uses***

All FDA approved indications not otherwise excluded from Part D

***Exclusion Criteria***

***Required Medical Information***

***Age Restrictions***

***Prescriber Restrictions***

***Coverage Duration***

Plan Year

***Other Criteria***

<i>Prior Authorization Group</i>	RELISTOR
<i>Drug Names</i>	RELISTOR
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Mechanical gastrointestinal obstruction, known or suspected.
<i>Required Medical Information</i>	A. Relistor is being prescribed for treatment of opioid-induced constipation in patients with advanced illness who are receiving palliative care. B. patient must have previous trial/failure of polyethylene glycol.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	4 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>	Active infection (including TB), concurrent use with other biologics, unstable moderate to severe HF (NYHA Functional Class III/IV).
<i>Required Medical Information</i>	<p>Screening for latent TB infection and assessment for Hep B risk. For positive latent TB, patient must have completed treatment or is currently receiving treatment for LTBI. HBV infection ruled out or treatment initiated for positive infection.</p> <p>Rheumatoid arthritis - An inadequate response or intolerance to Enbrel or Humira and one of the following: 1) inadequate response to methotrexate (MTX), 2) inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX, 3) intolerance or contraindication to at least 2 nonbiologic DMARDs.</p> <p>Psoriatic arthritis with predominantly peripheral symptoms - Must meet both of the following: 1) have an inadequate response or intolerance to either Enbrel or Humira, and 2) have an inadequate response to at least an 8-week maximum tolerated dose trial of at least 1 nonbiologic DMARD unless contraindicated or intolerant to such therapy.</p> <p>Psoriatic arthritis with predominantly axial symptoms and ankylosing spondylitis - Must have an inadequate response or intolerance/contraindication to at least 2 non-steroidal anti-inflammatory drugs (NSAIDs).</p> <p>For plaque psoriasis - More than 10% BSA affected or has crucial body areas (e.g., feet, hands, face) affected. An inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., phototherapy, calcipotriene, MTX, acitretin) unless contraindicated or intolerant to such therapies.</p> <p>Crohn's disease - Must meet both of the following: 1) have an inadequate response to at least a 60-day trial of 1 conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine) unless contraindicated or intolerant to such therapy, and 2) have an inadequate response or intolerance to either Humira or Cimzia.</p> <p>Ulcerative colitis - An inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., corticosteroids, mesalamine) unless contraindicated or intolerant to such therapies.</p>
<i>Age Restrictions</i>	For plaque psoriasis, patient must be 18 years of age and older.
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Initial: 3 months for Crohn's disease and UC, plan year for all others. Renewal: plan year
<i>Other Criteria</i>	For continuation of therapy, patient's condition must have improved or stabilized.

<i>Prior Authorization Group</i>	REVATIO
<i>Drug Names</i>	REVATIO
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Nitrate therapy
<i>Required Medical Information</i>	Diagnosis of pulmonary arterial hypertension (PAH), (WHO Group 1). PAH been confirmed by right heart catheterization. If patient is an infant, PAH diagnosed by Doppler echocardiogram. The patient has had an inadequate response or intolerance to Adcirca.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	REVLIMID
<i>Drug Names</i>	REVLIMID
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Pregnancy
<i>Required Medical Information</i>	For active myeloma, patient meets one of the following: 1) Revlimid is used after at least one prior therapy or as salvage therapy. 2) Revlimid is used with dexamethasone as primary induction therapy or in combination with melphalan and prednisone in nontransplant candidates. 3) Revlimid is used as maintenance monotherapy following response to either stem cell transplant or primary induction therapy. For Low or Intermediate-1 Risk myelodysplastic syndrome (MDS): for those with 5q deletion, patients should have transfusion-dependent anemia or symptomatic anemia with clinically significant cytopenias. For those with non-5q deletion MDS and symptomatic anemia, patients should have failed to respond to epoetin alfa or darbepoetin or have a pretreatment serum erythropoietin levels greater than 500 mU/mL and a low probability of response to immunosuppressive therapy. For female patients of childbearing potential, pregnancy is excluded by 2 negative serum or urine pregnancy tests. For all patients, complete blood counts are monitored for hematologic toxicity while receiving Revlimid.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	Male and female patients of child-bearing potential should be instructed on the importance of proper utilization of appropriate contraceptive methods for Revlimid use. Patients should be monitored for signs and symptoms of thromboembolism.

<i>Prior Authorization Group</i>	RIBAVIRIN
<i>Drug Names</i>	REBETOL, RIBAPAK, RIBASPHERE, RIBAVIRIN
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Hemoglobin less than 8.5 g/dL. Hemoglobinopathy. History of unstable heart disease. Creatinine clearance less than 50 mL/minute and unwilling to use modified dose of ribavirin. Pregnancy (self or partner). Unwilling to use effective contraception. Coadministration with didanosine in HIV coinfecting patients.
<i>Required Medical Information</i>	<p>Prior to initiating therapy, detectable levels of HCV RNA in the serum.</p> <p>Must use in combination with interferon.</p> <p>For retreatment: patient must have nonresponse or relapse with prior HCV therapy. Allow only one time retreatment with pegylated interferon and ribavirin OR Infigen and ribavirin.</p> <p>For Genotype 1 and 4: undetectable HCV RNA after 12 weeks of treatment OR at least 2 log decrease in HCV RNA after 12 weeks of therapy and undetectable HCV RNA after 24 weeks of treatment.</p>
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	ID specialist, gastroenterologist, or oncologist
<i>Coverage Duration</i>	12 weeks to a total 72 weeks depending on genotype and initial vs. renewal therapy.
<i>Other Criteria</i>	Patient has been instructed to practice effective contraception during therapy and for six months after stopping ribavirin therapy.

<i>Prior Authorization Group</i>	RITUXAN
<i>Drug Names</i>	RITUXAN
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	History of severe skin or infusion reaction with Rituxan than cannot be appropriately managed, use in combination with another biologic agent
<i>Required Medical Information</i>	For rheumatoid arthritis (RA): an inadequate response to MTX or another nonbiologic DMARD if MTX is contraindicated or not tolerated except when RA is severely active and frontline Rituxan therapy is warranted AND an inadequate response to a TNF antagonist (unless contraindicated). For continuation of RA therapy, improvement in clinical symptoms (may include improvement in tender and swollen joint count, mobility, or stiffness, or delay in progression of disease) is required from the last treatment course, which was at least 16 weeks earlier. Hematologic malignancies must be positive for CD20. Rituxan must be used in combination with chemotherapy for mantle cell lymphoma (or other agents), Burkitt's lymphoma, lymphoblastic lymphoma, and AIDS-related B-cell lymphoma. Induction therapy for Burkitt's lymphoma. Prior to initiating therapy, prescriber must have assessed the patient's risk for hepatitis B and, if appropriate, ruled out or initiated treatment for hepatitis B.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	Monitored for pulmonary toxicity

<i>Prior Authorization Group</i>	SANDOSTATIN LAR
<i>Drug Names</i>	SANDOSTATIN LAR DEPOT
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Patient received initial treatment with Sandostatin Injection (not the Depot form) for at least 2 weeks and treatment with Sandostatin Injection was effective and tolerable.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	SOMATULINE DEPOT
<i>Drug Names</i>	SOMATULINE DEPOT
<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>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	SOMAVERT
<i>Drug Names</i>	SOMAVERT
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	IV administration of Somavert, concomitant use of Sandostatin or Somatuline.
<i>Required Medical Information</i>	Diagnosis of acromegaly was confirmed by an elevated IGF-1 level or elevated GH level with a glucose tolerance test. Patient has tried and failed at least a 3 month trial of Sandostatin or Somatuline. For renewal, reduction in IGF-1 level from baseline.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	Endocrinologist
<i>Coverage Duration</i>	Plan Year
<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>	6 years of age and older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	Monitor for suicidality, clinical worsening, changes in behavior, blood pressure changes, heart rate changes, liver injury.

<b><i>Prior Authorization Group</i></b>	SYMLIN
<b><i>Drug Names</i></b>	SYMLIN, SYMLINPEN 120, SYMLINPEN 60
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	Severe hypoglycemia that required assistance during the past 6 months, gastroparesis, patient requires drug therapy to stimulate gastrointestinal motility, the presence of hypoglycemia unawareness (i.e., inability to detect and act upon the signs or symptoms of hypoglycemia).
<b><i>Required Medical Information</i></b>	
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	The patient must have inadequate glycemic control (HbA1c greater than 7% but less than 9%) at initiation of therapy, patient currently receiving optimal mealtime insulin therapy. If taking Symlin in previous 6 months, patient demonstrated a reduction in HbA1c since initiating Symlin therapy

<b><i>Prior Authorization Group</i></b>	TESTOSTERONES
<b><i>Drug Names</i></b>	ANDRODERM, TESTIM
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	Female, prostate cancer, breast cancer.
<b><i>Required Medical Information</i></b>	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.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<i>Prior Authorization Group</i>	THALOMID
<i>Drug Names</i>	THALOMID
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Pregnancy
<i>Required Medical Information</i>	For active myeloma, patient meets one of the following: 1) Thalomid is used as salvage or palliative therapy. 2) Thalomid is used for newly diagnosed disease or as primary induction therapy in combination with dexamethasone or in combination with melphalan and prednisone in nontransplant candidates. 3) Thalomid is used as maintenance monotherapy following response to either stem cell transplant or primary induction therapy. For female patients of childbearing potential, pregnancy is excluded by a negative pregnancy test.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	Patients are monitored for signs and symptoms of thromboembolism. Male and female patients of child-bearing potential are instructed on the importance of proper utilization of appropriate contraceptive methods.

<i>Prior Authorization Group</i>	THIORIDAZINE
<i>Drug Names</i>	THIORIDAZINE HCL
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Not covered for those who are 65 years of age and older
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<b><i>Prior Authorization Group</i></b>	TOPICAL IMMUNOSUPPRESSANT
<b><i>Drug Names</i></b>	ELIDEL, PROTOPIC
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	A. The diagnosis is documented as atopic dermatitis or eczema. B. AND patients must be at least 2 years of age C. AND patients who have completed a documented trial and failure of at least two medium or higher potency topical steroids or have documented intolerance or unresponsiveness to medium or higher potency topical steroids D. AND patients have been advised that Elidel and Protopic should only be used to treat the immediate problem and then should be stopped when the condition improves.
<b><i>Age Restrictions</i></b>	2 years of age and older
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	TOPICAL-ULCERS
<b><i>Drug Names</i></b>	REGRANEX
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	Neoplasm(s) at site(s) of application
<b><i>Required Medical Information</i></b>	A. Must be used for treatment of lower-extremity diabetic ulcers B. AND the ulcer must extend into subcutaneous tissue or beyond C. AND the tissue must have an adequate blood supply D. AND the patient must have concurrent good ulcer treatment practices including ALL of the following: a. Debridement b. Pressure relief c. Infection relief E. AND the ulcer must be less than 10 cm <sup>2</sup> in size.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	10 weeks
<b><i>Other Criteria</i></b>	

<i>Prior Authorization Group</i>	TRACLEER
<i>Drug Names</i>	TRACLEER
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	AST/ALT level greater than 3 times upper limit of normal (ULN). Pregnancy. Concomitant use of cyclosporine A or glyburide.
<i>Required Medical Information</i>	PAH confirmed by right heart catheterization. NYHA Class II-IV symptoms.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	Female patients of childbearing potential must use more than one method of contraception concurrently.

<i>Prior Authorization Group</i>	TYZEKA
<i>Drug Names</i>	TYZEKA
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Use of Tyzeka as a first-line therapy in treatment-naïve patients with HBV
<i>Required Medical Information</i>	A. The patient has been diagnosed with chronic hepatitis B. B. AND the patient has evidence of a positive HBsAg (+ or -) serological marker for greater than 6 months OR evidence by a liver biopsy showing chronic hepatitis. C. AND the patient has a Hepatitis B viral load greater than 20,000 IU/mL (100,000 copies per mL) except if for HBeAg-negative HBV, the viral load is greater than 2,000 IU per mL (10,000 copies per mL). D. AND the patient has elevations in liver aminotransferases (ALT or AST) that are two (2) times greater than normal OR normal liver aminotransferase (ALT or AST) levels with evidence of significant disease found on biopsy. E. AND the patient has been tested for HIV and is negative. F. AND if the patient has received previous Tyzeka treatment, there is documented clinical improvement shown by a drop in viral load or reduction in the patient's liver aminotransferases. G. AND the patient is not receiving duplicate therapy that includes Baraclude, Epivir and/or Intron A. H. AND evidence of diagnosis, serological markers or liver biopsy, viral load, and liver aminotransferases is documented in patient's chart.
<i>Age Restrictions</i>	16 years of age and older
<i>Prescriber Restrictions</i>	Infectious Disease specialist or Gastroenterologist or affiliated with an infectious disease or gastroenterology practice or a primary care physician with experience in treating HBV
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<b><i>Prior Authorization Group</i></b>	VICTRELIS
<b><i>Drug Names</i></b>	VICTRELIS
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	Failed previous therapy with a treatment regimen that includes a protease inhibitor (e.g., Incivek, Victrelis). Concomitant administration with a drug that is highly dependent on CYP3A4/5 for clearance or potent CYP3A4/5 inducer.
<b><i>Required Medical Information</i></b>	Hepatitis C virus (HCV) infection confirmed by presence of viral load in serum. HCV Genotype 1. HCV-RNA less than 100 IU/mL at week 12 of treatment. Undetectable HCV-RNA at week 24 of treatment.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Initial: 8 weeks. Renewal: Up to 44 weeks.
<b><i>Other Criteria</i></b>	Must be given in combination with pegylated interferon (i.e., Pegasys or PegIntron) and ribavirin. Must receive 4 weeks of pegylated interferon and ribavirin prior to starting Victrelis.

<b><i>Prior Authorization Group</i></b>	VPRIV
<b><i>Drug Names</i></b>	VPRIV
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	Concomitant use of miglustat (Zavesca)
<b><i>Required Medical Information</i></b>	Diagnosis confirmed by bone marrow histology, DNA testing, or measurement of beta-glucocerebrosidase enzyme activity of less than 30 percent. Patient must have at least one of the following conditions as a result of Type 1 Gaucher disease: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly. Patients who have previously received 24 months of VPRIV therapy must have one of the following responses to continue therapy: 1) A decrease in liver and spleen volume 2) An increase in platelet count, or 3) An increase in hemoglobin concentration.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<i>Prior Authorization Group</i>	XENAZINE
<i>Drug Names</i>	XENAZINE
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Patients with untreated or inadequately treated depression or who are actively suicidal, history of hepatic disease, use in combination with MAO inhibitors or reserpine (or it has been less than 20 days since reserpine was discontinued).
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	XIFAXAN
<i>Drug Names</i>	XIFAXAN
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Hypersensitivity reaction to rifamycin antimicrobial agents. For hepatic encephalopathy, Xifaxan exceeding the recommended dose of two 550mg tablets daily.
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	18 years of age and older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Hepatic encephalopathy-6 months
<i>Other Criteria</i>	

<b><i>Prior Authorization Group</i></b>	XOLAIR
<b><i>Drug Names</i></b>	XOLAIR
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Patient must meet all of the following criteria for Xolair use: 1) Patient has evidence of reversible disease (demonstrates at least 20 percent improvement in PEF with a short-acting bronchodilator challenge). 2) Patient has experienced two or more asthma exacerbations per month within the last three months. 3) Patient had a positive skin test to at least one perennial aeroallergen. 4) Baseline IgE level at or above 30 IU/mL. 5) Patient's asthma is inadequately controlled despite adherent use of inhaled corticosteroids. 6) Patient had an inadequate response to a trial of a leukotriene modifier or long-acting beta2-agonist (unless patient demonstrates intolerance to the therapeutic trial).
<b><i>Age Restrictions</i></b>	12 years of age and older
<b><i>Prescriber Restrictions</i></b>	Pulmonologist, allergist or immunologist
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	To continue therapy, patients must demonstrate an improvement in asthma control with use of Xolair.

<b><i>Prior Authorization Group</i></b>	XYREM
<b><i>Drug Names</i></b>	XYREM
<b><i>Covered Uses</i></b>	All FDA approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	If the patient is taking/receiving any of the following: anxiolytics, sedatives, hypnotics, barbiturates, benzodiazepines or ethanol.
<b><i>Required Medical Information</i></b>	A. The diagnosis is documented as excessive daytime sleepiness with symptoms that limit their ability to perform normal daily activities. B. AND the diagnosis is documented as cataplexy (a condition characterized by weak or paralyzed muscles) in patients with narcolepsy. C. AND if the patient has received prior treatment with Xyrem, the patient must experience a decrease in daytime sleepiness and/or cataplexy in a narcoleptic patient.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	3 months
<b><i>Other Criteria</i></b>	

<i>Prior Authorization Group</i>	ZAVESCA
<i>Drug Names</i>	ZAVESCA
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Severe renal impairment. Pregnancy.
<i>Required Medical Information</i>	Diagnosis confirmed by bone marrow histology, DNA testing, or b-glucocerebrosidase enzyme assay (enzyme activity less than 30 percent). Trial of enzyme replacement therapy (ERT) or ERT is not a therapeutic option (eg, allergy, poor venous access). Female patients of childbearing age will use an effective method of contraception. Female patients of childbearing age will be educated about the potential hazards associated with Zavesca use in pregnancy (ie, potential harm to fetus). Must demonstrate a decrease in liver and spleen volume and/or increase in platelet count and/or increase in Hgb concentration in patients who received at least 24 months of Zavesca therapy.
<i>Age Restrictions</i>	18 years of age and older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	ZYTIGA
<i>Drug Names</i>	ZYTIGA
<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>	Plan Year
<i>Other Criteria</i>	Used in combination with prednisone. Received prior chemotherapy containing docetaxel.