

Drugs That Require Prior Authorization (PA)
Before Being Approved for Coverage

<u>PRIOR AUTHORIZATION MEDICATIONS</u>	
<u>ACNE</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Approve for those 12 years of age and older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Drugs	AVITA, RETIN-A MICRO, TRETINOIN
<u>ADAPALENE</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Cosmetic use
Required Medical Info	
Age Restrictions	Approve for those 12 years of age and older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Drugs	ADAPALENE, DIFFERIN
<u>AMITIZA</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy, history of mechanical gastrointestinal obstruction (e.g., due to adhesions, tumors, hernias, cysts, abscess, etc.), severe diarrhea
Required Medical Info	If female of child bearing potential, pregnancy excluded by negative urine or serum pregnancy tests.
Age Restrictions	approved for those 18 years of age or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Drugs	AMITIZA
<u>AMPHETAMINES</u>	
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 Info	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
Drugs	ADDERALL XR, AMPHETAMINE/DEXTROAMPHETAMINE, DEXTROAMPHETAMINE SULFATE ER

<u>ARALAST NP</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	coverage is not provided in patients with lung disease in whom congenital alpha 1 antitrypsin deficiency has not been established.
Required Medical Info	Alpha-1 Antitrypsin (ATT) Deficiency as defined by clinically evident emphysema, and congenital deficiency of alpha 1 protease inhibitor, and serum ATT levels less than or equal to 11 Micromoles per Liter, or less than or equal to 80 mg/dL. Reauthorization: demonstration of clinical response to therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Drugs	ARALAST NP
<u>ARANESP</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Transferrin saturation less than 20% and patient not receiving iron supplementation where clinically appropriate. Hemoglobin level of the patient (not the result of a recent blood transfusion) greater than 12 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).
Required Medical Info	Iron status of the patient has been evaluated (serum transferrin saturation). 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. Blood pressure of the patient will be monitored throughout therapy. Patient will be monitored for the occurrence of thrombotic events.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initiation of therapy and/or dose changes - 6 weeks. Stable on therapy - 12 weeks.
Other Criteria	'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. If hemoglobin rise greater than 1 g/dL in a 2 week period then physician should consider stopping therapy and/or restarting at a reduced dose.
Drugs	ARANESP
<u>ARCALYST</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Drugs	ARCALYST
<u>BUTORPHANOL NASAL SPRAY</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for the treatment of migraine headache pain.
Exclusion Criteria	
Required Medical Info	Coverage for acute pain is provided in situations where the use of oral opioid therapy is not warranted or therapy with a rapid-acting agent is desirable. Coverage for migraine headache pain is provided in situations where the use serotonin agonists or ergotamine derivatives are not warranted as determined by the prescriber.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months for migraine pain / 3 month for acute pain
Other Criteria	
Drugs	BUTORPHANOL TARTRATE

CELEBREX	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Post-operative pain following CABG surgery, allergic-type reaction to aspirin, NSAIDs, or sulfonamides
Required Medical Info	Evaluation of cardiovascular disease or risk factors for cardiovascular disease
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months for FAP and JRA, 12 months for dysmenorrhea, OA, RA, AS, 1 month for acute pain
Other Criteria	
Drugs	CELEBREX
CHANTIX	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for Chantix (varenicline) use in combination with bupropion or other nicotine replacement products.
Required Medical Info	The patient must be enrolled in a behavioral support/ modification program (e.g., community program, manufacturer sponsored program, counseling by the physician, internet, or telephone quitline).
Age Restrictions	The patient must be 18 years of age or older
Prescriber Restrictions	
Coverage Duration	9 months lifetime
Other Criteria	
Drugs	CHANTIX STARTING MONTH PAK, CHANTIX
COLONY STIMULATING FACTORS (Leukine)	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for neutropenia due to other drugs, AIDS/HIV, myelodysplasia, and severe chronic neutropenia (i.e. Neutropenic disorder, cyclic neutropenia)
Exclusion Criteria	Combination therapy with Neulasta, Neupogen or Leukine.
Required Medical Info	Patient has experienced neutropenia from previous chemotherapy OR for patient is considered to be at high risk for the development of neutropenia. Absolute Neutrophil Count (ANC). That is, coverage is provided for: Myelodysplasia when ANC is less than or equal to 1000/mm ³ , Severe chronic neutropenia (i.e., Neutropenic disorder, cyclic neutropenia) when ANC is less than or equal to 1500/mm ³ , bone marrow transplant when ANC is less than or equal to 1000/mm ³
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Drugs	LEUKINE
CRINONE	
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Additional coverage for off-label use is provided to support established pregnancy
Exclusion Criteria	Coverage is not provided for infertility
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	9 months for support of established pregnancy, 12 months for secondary amenorrhea
Other Criteria	
Drugs	CRINONE

<u>DIFICID</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For C. difficile associated diarrhea pt must have experienced failure or intolerance to metronidazole or oral vancomycin
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	
Drugs	DIFICID
<u>EFFIENT</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active bleeding such as peptic ulcer or intracranial hemorrhage, prior transient ischemic attack or stroke, patients started on plavix and are transitioning to Effient in the absence of failure or intolerance to plavix.
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	'12 months
Other Criteria	'In patients greater than or equal to 75 years who have a higher risk of bleeding per the package insert, use will be approved if patients have history of diabetes and/or previous MI or if they have failed previous Plavix (Clopidrogel) therapy and the prescriber is aware of an increase risk of bleeding with Effient.
Drugs	EFFIENT
<u>ENBREL</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Patients are excluded if they have an active infection or on are on concurrent biologic response modifier e.g., Humira, Kineret or Remicade.
Required Medical Info	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. Patient who are identified as being high risk must be tested for hepatitis B prior to initiation of treatment (e.g. patients at high risk for hepatitis B include patients with early stage kidney disease or on dialysis, patients who received blood products for a medical condition etc). Reauthorization: demonstration of clinical response to therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	RA/JRA - patient must demonstrate inadequate response to at least 1 DMARD or intolerance to two DMARDs. Psoriasis - patient must be a candidate for phototherapy.
Drugs	ENBREL

EPO	
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for anemia associated with myelodysplastic syndromes, anemia of chronic disease (associated with rheumatoid arthritis or heart failure), anemia associated with management of chronic hepatitis C.
Exclusion Criteria	Transferrin saturation less than 20% and patient not receiving iron supplementation where clinically appropriate. For patients with anemia due to CKD and zidovudine treated HIV patients only: Hemoglobin level of the patient (not the result of a recent blood transfusion) greater than 12 g/dL. Lack of initial diagnosis of anemia (applies to all indications except elective surgery indication) (hematocrit less than 30% and/or hemoglobin less than 10 g/dL and/or symptomatic with hemoglobin 10-11g/dL).
Required Medical Info	Iron status of the patient has been evaluated (serum transferrin saturation). 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. Blood pressure of the patient will be monitored throughout therapy. Patient will be monitored for the occurrence of thrombotic events.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initiation of therapy and/or dose changes - 6 weeks. Stable on therapy - 12 weeks.
Other Criteria	Once on therapy, compared to pretreatment baseline, the patient must show an objective clinical response (e.g., hemoglobin rise greater than 1 g/dL).
Drugs	EPOGEN
GROWTH HORMONE	
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for (note - some growth hormone drugs may be labeled for 1 or more of these indications): adult growth hormone deficiency, growth failure in children small for gestational age or with intrauterine growth retardation, idiopathic short stature, GH deficiency associated with Turner Syndrome, growth failure secondary to chronic renal failure/insufficiency in children who have not received a renal transplant, short stature associated with Noonan Syndrome, short bowel syndrome, and for the treatment of Prader-Willi Syndrome.
Exclusion Criteria	Coverage is not provided for constitutional delayed growth
Required Medical Info	Pediatric GHD: epiphyses must be confirmed open in patients 10 years of age and older, AND 1. diagnosis confirmed by any 2 provocative tests or by both low IGF-1 and IGFBP-3 levels in patients who meet the height related conditions of coverage, 2. diagnosis confirmed by 2 provocative tests and both low IGF-1 and IGF-BP3 in patients not meeting height related coverage conditions, or 3. 3 pituitary hormone deficiencies in pt with irreversible hypothalamic-pituitary structural lesions or panhypopituitarism. Growth failure from CRF: PGHD criteria must be met without the provocative tests or IGF-1 and IGF-BP3 related conditions. Idiopathic Short Stature: epiphyses must be confirmed as open in patients greater than or equal 10 years of age, height must be less than or equal - 2.25 sds from the mean. Small for Gestational Age: failure to manifest catch up growth by age 2 defined as birth weight, birth length, or both that are more than 2 sds mean normal values following adjustment for age and gender. Turner's syndrome and Noonan Syndrome: epiphyses must be confirmed as open and when on therapy. Adult GHD: requires either 1. 1 negative GH provocative test when the AGHD is due to childhood onset GHD, pituitary or hypothalamic disease, surgery or radiation therapy, or trauma, OR 2. 3 pituitary hormone deficiencies and serum IGF-I levels below the age- and sex-appropriate reference range or 1 negative stimulation test response is required when the AGHD is due to irreversible hypothalamic-pituitary structural lesions or panhypopituitarism not acquired as a child, OR 3. 3 pituitary hormone deficiencies if adult panhypopit or irreversible hypothalamic-pituitary structural lesions are from childhood.
Age Restrictions	7 years of age or older for Idiopathic short stature
Prescriber Restrictions	Pediatric endocrinologist for ISS
Coverage Duration	1 month for short bowel syndrome, 12 months for other indications

Other Criteria	Height related conditions of coverage - height below the third percentile for their age and gender related height, growth velocity subnormal greater than or equal 2 standard deviations (sds) from the age related mean, delayed skeletal maturation greater than or equal 2 sds below the age/gender related mean. Renewals for PGHD, CFR, SGA, Turner's and Noonan Syndromes require growth response of greater than or equal 4.5 cm/yr (pre-pubertal) or greater than or equal 2.5 cm/yr (post-pubertal). Renewals for short bowel syndrome is provided in the presence of clinical benefit (such as, decreasing the patient's intravenous nutritional requirements). Renewals for Prader-Willi syndrome is provided if pt has increase in lean body mass or decrease in fat mass. Renewals for ISS is provided in the presence of a growth response of greater than or equal 1.5 cm/yr. Renewals for AGHD is provided in the presence of clinical benefit.
Drugs	GENOTROPIN MINIQUICK, GENOTROPIN, HUMATROPE, HUMATROPE COMBO PACK, NORDITROPIN FLEXPRO, NUTROPIN, NUTROPIN AQ PEN, SAIZEN, SAIZEN CLICK.EASY
<u>HUMIRA</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients are excluded if they have an active infection or are on concurrent biologic response modifier (e.g. Enbrel, Kineret or Remicade)
Required Medical Info	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. Patient who are identified as being high risk must be tested for hepatitis B prior to initiation of treatment (e.g. patients at high risk for hepatitis B include patients with early stage kidney disease or on dialysis, patients who received blood products for a medical condition etc). Reauthorization: demonstration of clinical response to therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	RA/JIA - patient must demonstrate inadequate response to at least 1 DMARD or intolerance to two DMARDs. Psoriasis - patient must be a candidate for systemic therapy or phototherapy. Crohn's disease - patient must demonstrate an inadequate response or intolerance to Remicade or one conventional therapy drug such as a corticosteroid, sulfasalazine, azathioprine, or mesalamine.
Drugs	HUMIRA, HUMIRA PEN-CROHNS DISEASESTARTER
<u>INCIVEK - HEP C - PROTEASE INHIBITORS</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Coverage is not provided for genotypes other than type 1. Duration of therapy longer than 3 months. Previous failure to Incivek or Victrelis.
Required Medical Info	Chronic Hep C, in patients with genotype 1 who have a quantifiable viral load. Must be used in combination with a pegylated interferon and ribavirin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Drugs	INCIVEK
<u>INCRELEX</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided in the presence of: concurrent treatment with growth hormone or pharmacologic doses of corticosteroids
Required Medical Info	Patient's height standard deviation score must be less than or equal -3.0 AND the basal IGF-1 score must be below the lower limits of normal for the
Age Restrictions	
Prescriber Restrictions	Coverage is provided in situations where the diagnosis of IGF-1 deficiency has been made by an endocrinologist.
Coverage Duration	12 months
Other Criteria	
Drugs	INCRELEX

INFERGEN	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient must have compensated liver disease with detectable levels of hepatitis C virus RNA in the serum
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 to 9 months depending on genotype and initial vs. renewal therapy
Other Criteria	2-log decrease in viral load for renewals
Drugs	INFERGEN
ITRACONAZOLE	
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for pityriasis versicolor, tinea corporis,
Exclusion Criteria	For onychomycosis only: Congestive heart failure, history of congestive heart failure, evidence of left ventricular dysfunction
Required Medical Info	LFTs, fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1, 2, 3, or 6 months depending on the diagnosis (see duration in parentheses in covered uses)
Other Criteria	
Drugs	ITRACONAZOLE
LETAIRIS	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	WHO Group II, III, IV, or V PAH. If female of childbearing potential, pregnancy must be excluded and patient must be advised to practice more than one method of contraception.
Required Medical Info	hemoglobin and hematocrit, monthly negative pregnancy test if a female of childbearing potential
Age Restrictions	
Prescriber Restrictions	Coverage is provided in situations where it is being prescribed under the care or referral of a cardiologist or pulmonologist.
Coverage Duration	12 months
Other Criteria	Coverage is provided for use in combination with two or more PAH therapies when treatment with one PAH agent failed to adequately control the patient's symptoms.
Drugs	LETAIRIS
LIDODERM	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for diabetic neuropathy.
Exclusion Criteria	
Required Medical Info	For diabetic neuropathy: the patient must have previous use and inadequate response or intolerance to any ONE neuropathic pain medication, including (but not limited to): tri-cyclic antidepressants, gabapentin, Lyrica, opioids, tramadol, venlafaxine, Cymbalta.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Drugs	LIDODERM

METHYLPHENIDATES	
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 Info	Sleep studies for narcolepsy diagnosis
Age Restrictions	Approved for those 6 years of age or 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
Drugs	CONCERTA, DEXMETHYLPHENIDATE HCL, METADATE ER, METADATE CD, METHYLIN, METHYLIN ER, METHYLPHENIDATE HYDROCHLORIDE, METHYLPHENIDATE HCL, RITALIN LA, METHYLPHENIDATE HCL SR, METHYLPHENIDATE HCL ER
MULTIPLE SCLEROSIS THERAPY- GILENYA	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Treatment of primary progressive MS is not covered. Combination therapy with a beta interferon product or Copaxone is not covered.
Required Medical Info	Patient must still either be able to walk at least a few steps or alternatively must have some functional arm/ hand use consistent with performing activities of daily living.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Drugs	GILENYA
NEULASTA	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Neulasta treatment within the last 14 days. Treatment of acute afebrile neutropenia.
Required Medical Info	Current and periodic monitoring of WBC count at initiation of and during therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Neulasta administration will be delayed a minimum of 24 hours after the administration of cytotoxic chemotherapy.
Drugs	NEULASTA
NEUMEGA	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has experienced severe thrombocytopenia (e.g., platelet count less than equal to 20,000/mcL) from previous chemotherapy OR for patient is
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Drugs	NEUMEGA
NEUTROPHIL (NEUPOGEN)	
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for drug-induced neutropenia, myelodysplastic syndrome, neutropenia associated with AIDS
Exclusion Criteria	Treatment of acute afebrile neutropenia. Patients not at high risk for infection-associated complications or not having prognostic factors that are
Required Medical Info	Current and periodic monitoring of WBC count at initiation of and during therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Drugs	NEUPOGEN

OCTREOTIDE	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Drugs	OCTREOTIDE ACETATE
ONSOLIS	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	coverage is not provided for opioid non-tolerant patients
Required Medical Info	Confirmed diagnosis of management of breakthrough cancer pain. Patient must be an Opioid tolerant patient (i.e. one who are already receiving and who is tolerant to opioid therapy)
Age Restrictions	The patient must be 18 years of age or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Drugs	ONSOLIS
ORENCIA - SUBCUTANEOUS	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Coverage is not provided for use in combination with other biologics e.g., Humira, Kineret, Remicade, etc
Required Medical Info	Coverage is provided in situations where the patient has been evaluated and screened for the presence of latent TB infection, where warranted, prior to initiating treatment. Coverage is provided in situations where the patient experienced intolerance/failure to Humira AND Enbrel.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	Renewal coverage is provided in situations where treatment has provided clinical benefit.
Drugs	ORENCIA
OSTEOPOROSIS (FORTEO)	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	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
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	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
Drugs	FORTEO

<u>OXYMETHOLONE</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Additional coverage for off-label use is provided for cachexia associated with AIDS
Exclusion Criteria	
Required Medical Info	Coverage is provided for anemia due to conditions such as acquired aplastic anemia, anemia of chronic renal failure, pure red cell aplasia, Fanconi's anemia or myelosuppression due to chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months for anemia or 5 years for cachexia/AIDS wasting
Other Criteria	
Drugs	ANADROL-50
<u>PAGET'S DISEASE AGENTS</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Drugs	ACTONEL, ALENDRONATE SODIUM
<u>PEGASYS</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For chronic hepatitis C, patient must have compensated liver disease with detectable levels of HCV RNA in the serum. For chronic hepatitis B, patient
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Chronic hepatitis C - 3 to 9 months. Chronic hepatitis B - 12 months.
Other Criteria	For chronic hepatitis C, patient must have 2-log decrease in viral load for renewals.
Drugs	PEGASYS, PEGASYS PROCLICK
<u>PEGINTRON</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient must have compensated liver disease with detectable levels of hepatitis C virus RNA in the serum
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 to 9 months depending on genotype and initial vs. renewal therapy
Other Criteria	2-log decrease in viral load for renewals
Drugs	PEG-INTRON REDIPEN, PEG-INTRON
<u>PROMACTA</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided when used in combination with Nplate.
Required Medical Info	Patients have had an inadequate response or have been intolerant to treatment with corticosteroids, immunoglobulins, or splenectomy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Renewal is provided for patients who continue to have a response to therapy (for example, platelet count has increased)
Drugs	PROMACTA

<u>PROVIGIL</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Coverage is provided for the off-label use of idiopathic hypersomnolence and depression associated with fatigue and/or sleepiness.
Exclusion Criteria	
Required Medical Info	For narcolepsy, require polysomnography. Coverage is provided for SWSD when: (1) Prescriber must confirm that the patient is a night worker and (2) has complaints of persistent and frequent excessive sleepiness and/or falling asleep while at work and (3) any medical conditions known to cause or contribute to sleepiness have been considered and treated. Coverage is provided for idiopathic hypersomnolence that is confirmed by polysomnography where excessive sleepiness is not due to other sleep disorders such as narcolepsy, obstructive sleep apnea or posttraumatic hypersomnia. If diagnosis of
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For OSAHS require polysomnography. Coverage is also provided for patients who are receiving nasal continuous positive airway pressure therapy (CPAP) or who are not candidates for CPAP. Coverage is provided for depression associated with fatigue and/or sleepiness when the patient is receiving antidepressant therapy
Drugs	PROVIGIL
<u>PULMONARY ARTERIAL HYPERTENSION</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent nitrate therapy.
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Drugs	REVATIO
<u>RELISTOR</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Drugs	RELISTOR
<u>REMICADE</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Remicade doses greater than 5 mg/kg in moderate to severe CHF
Required Medical Info	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. Patient who are identified as being high risk must be tested for hepatitis B prior to initiation of treatment (e.g. patients at high risk for hepatitis B include patients with early stage kidney disease or on dialysis, patients who received blood products for a medical condition etc). Reauthorization: demonstration of clinical response to therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	RA - patient must demonstrate inadequate response to at least 1 DMARD or intolerance to two DMARDs. Remicade is to be used in combination with methotrexate. Crohn's disease - patient must demonstrate an inadequate response or intolerance to one first-line agent such as corticosteroids, sulfasalazine, azathioprine, or mesalamine unless the patient has multiple draining enterocutaneous or rectovaginal fistulae. Ulcerative colitis - patient must demonstrate an inadequate response or intolerance to two first-line agents such as oral or rectal 5-ASA products or glucocorticosteroids. Psoriasis - patient must be a candidate for systemic therapy or phototherapy.
Drugs	REMICADE

REVLIMID	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy
Required Medical Info	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. Instruction regarding importance and proper utilization of appropriate contraceptive methods. Monitor CBC on regular basis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Drugs	REVLIMID
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 Info	'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	12 months
Other Criteria	
Drugs	REBETOL, RIBAPAK, RIBASPHERE, RIBAVIRIN
RITUXAN	
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Additional coverage for off-label use is provided for relapsed or refractory Waldenstrom's macroglobulinemia.
Exclusion Criteria	Coverage is not provided for use of Rituxan in combination with other biologics e.g., Humira, Kineret or Remicade, etc. Prescriber has not assessed
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month for rheumatoid arthritis, 12 months for other indications
Other Criteria	Assess the patient's risk for latent hepatitis B infection. For rheumatoid arthritis: inadequate response to at least one TNF inhibitor or been intolerant to treatment with at least two TNF inhibiting drugs.
Drugs	RITUXAN
SANDOSTATIN LAR	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	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	
Drugs	SANDOSTATIN LAR DEPOT

<u>SENSIPAR</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Additional off-label coverage is provided to normalize serum calcium and lower parathayroid hormone in primary hyperparathyroidism.
Exclusion Criteria	Primary hyperparathyroidism: unacceptable hepatic function and plasma parathyroid hormone concentration less than 45 pg/ml.
Required Medical Info	Plasma PTH level.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Patient has serum calcium, phosphorus, and iPTH levels monitored during therapy. For Primary hyperparathyroidism: not a surgical candidate or had unsuccessful parathyroidectomy. For CKD: receives regular dialysis treatments.
Drugs	SENSIPAR
<u>SOMATULINE DEPOT</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
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
Drugs	SOMATULINE DEPOT
<u>SOMAVERT</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Coverage is provided when patients have had an inadequate response to surgery, radiation, or other medical therapies or in situations where the patient is not a candidate for other therapies.
Drugs	SOMAVERT
<u>STEROIDS, ANABOLIC</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Drugs	OXANDROLONE
<u>TERBINAFINE</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	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	
Drugs	TERBINAFINE HCL

TESTOSTERONES	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Female, prostate cancer, breast cancer
Required Medical Info	Before the start of testosterone therapy patient has (or patient currently has) a confirmed low testosterone level (i.e. total testosterone less than 300)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Drugs	ANDRODERM, ANDROGEL, ANDROGEL PUMP, TESTIM
THALIDOMIDE	
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Additional coverage for off-label uses include Crohn's disease, aphthous ulcers in the presence of HIV or AIDS, prostate cancer, malignant melanoma, myelofibrosis, and myelodysplastic syndromes.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Drugs	THALOMID
TOPICAL-ULCERS	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Known neoplasm at site of application, drug not used as an adjunct to, but as a substitute for good ulcer practices like initial sharp debridement, pressure relief, infection control
Required Medical Info	Ulcer size after 10 weeks of therapy, does ulcer have adequate blood supply, ulcer extending into subcutaneous tissue or beyond
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months, then additional 2 months upon renewal
Other Criteria	
Drugs	REGRANEX
TRACLEER	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	'Patient currently taking cyclosporine A or glyburide. WHO Group II, III, IV, or V PAH. If female of childbearing potential, pregnancy must be excluded and patient must be advised to practice more than one method of contraception.
Required Medical Info	'Aminotransferase (AST, ALT) levels. Hemoglobin levels. Pregnancy status if female of childbearing potential.
Age Restrictions	
Prescriber Restrictions	Coverage is provided in situations where it is being prescribed under the care or referral of a cardiologist or pulmonologist.
Coverage Duration	12 months
Other Criteria	'Patient has hemoglobin levels monitored after one and three months of treatment and then every three months during therapy.
Drugs	TRACLEER

<u>VICTRELIS- HEP C - PROTEASE INHIBITORS</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Coverage is not provided for genotypes other than type 1. Duration of therapy longer than 11 months. Previous failure to Incivek or Victrelis.
Required Medical Info	Chronic Hep C, in patients with genotype 1 who have a quantifiable viral load. Must be used in combination with a pegylated interferon and ribavirin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	11 months
Other Criteria	
Drugs	VICTRELIS
<u>XIFAXAN</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Drugs	XIFAXAN
<u>XOLAIR</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Baseline IgE must be between 30 and less than or equal to 700 IU/mL. The patient is currently receiving therapy with an inhaled steroid or oral steroid unless the patient should not receive steroids AND either 1. The dose of inhaled or systemic steroid must be reduced to help control adverse side effects and addition of Xolair is the only option that may achieve the needed dosage reduction OR 2. The patient has moderate to severe asthma defined as having had two or more ER visits for an asthma exacerbation AND/OR more than 2 courses of short pulse oral or parenteral corticosteroids for exacerbations within the previous 12 months
Age Restrictions	Coverage is provided for patients 12 years of age and older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Coverage may be renewed in situations where treatment if providing clinical benefit as evidenced by a reduction in asthma exacerbations from baseline.
Drugs	XOLAIR
<u>XYREM</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Approved for those 16 years of age or older
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	limited distribution, physician and patient registry and education required. No more than 3 month supply for no more than 9 grams per day
Drugs	XYREM

The following drugs 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 Name	Route of Administration / Dosage Form
ACETYLCYSTEINE	INHALATION SOLUTION
ALBUTEROL SULFATE	INHALATION NEBULIZATION SOLUTION
AZASAN	ORAL TABLET
AZATHIOPRINE	ORAL TABLET
AZATHIOPRINE SODIUM	INJECTION SOLUTION RECONSTITUTED
BONIVA	ORAL TABLET
BROVANA	INHALATION NEBULIZATION SOLUTION
BUDESONIDE	INHALATION SUSPENSION
CALCITRIOL	ORAL CAPSULE
CALCITRIOL	INJECTION SOLUTION
CALCITRIOL	ORAL SOLUTION
CELLCEPT	ORAL SUSPENSION RECONSTITUTED
CHORIONIC GONADOTROPIN	INJECTION SOLUTION RECONSTITUTED
COLISTIMETHATE SODIUM	INJECTION SOLUTION RECONSTITUTED
CROMOLYN SODIUM	INHALATION NEBULIZATION SOLUTION
CUBICIN	INJECTION SOLUTION RECONSTITUTED
CYCLOPHOSPHAMIDE	ORAL TABLET
CYCLOSPORINE	ORAL CAPSULE
CYCLOSPORINE	INJECTION SOLUTION
CYCLOSPORINE MODIFIED	ORAL CAPSULE
CYCLOSPORINE MODIFIED	ORAL SOLUTION
DECAVAC	INJECTION INJECTABLE
DIPHThERIA/TETANUS TOXOID PEDIATRIC	INJECTION INJECTABLE
EMEND	ORAL CAPSULE
ENGERIX-B	INJECTION SUSPENSION
FOSCARNET SODIUM	INJECTION SOLUTION
GAMMAGARD LIQUID	INJECTION SOLUTION
GAMUNEX	INJECTION SOLUTION
GENGRAF	ORAL CAPSULE
GENGRAF	ORAL SOLUTION
GRANISETRON HCL	ORAL TABLET
GRANISOL	ORAL SOLUTION
HECTOROL	ORAL CAPSULE
HECTOROL	INJECTION SOLUTION
IPRATROPIUM BROMIDE	INHALATION SOLUTION
IPRATROPIUM BROMIDE/ALBUTEROL SULFATE	INHALATION SOLUTION
LEVALBUTEROL	INHALATION NEBULIZATION SOLUTION
LEVOCARNITINE	INJECTION SOLUTION
LEVOCARNITINE	ORAL SOLUTION
LEVOCARNITINE	ORAL TABLET
MIACALCIN	INJECTION SOLUTION
MYCOPHENOLATE MOFETIL	ORAL CAPSULE
MYCOPHENOLATE MOFETIL	ORAL TABLET
MYFORTIC	ORAL TABLET DELAYED RELEASE

NEORAL	ORAL CAPSULE
NEORAL	ORAL SOLUTION
NULOJIX	INJECTION SOLUTION RECONSTITUTED
ONDANSETRON HCL	ORAL SOLUTION
ONDANSETRON HCL	ORAL TABLET
ONDANSETRON ODT	ORAL TABLET DISPERSIBLE
PERFORMIST	INHALATION NEBULIZATION SOLUTION
PROGRAF	INJECTION SOLUTION
PULMICORT	INHALATION SUSPENSION
PULMOZYME	INHALATION SOLUTION
RAPAMUNE	ORAL SOLUTION
RAPAMUNE	ORAL TABLET
RECOMBIVAX HB	INJECTION SUSPENSION
SANDIMMUNE	ORAL CAPSULE
SANDIMMUNE	ORAL SOLUTION
TACROLIMUS	ORAL CAPSULE
TETANUS TOXOID ADSORBED	INJECTION SOLUTION
TETANUS/DIPHThERIA TOXOIDS-ADSORBED ADULT	INJECTION SUSPENSION
TOBI	INHALATION NEBULIZATION SOLUTION
VANCOMYCIN HCL	INJECTION SOLUTION RECONSTITUTED
VENTAVIS	INHALATION SOLUTION
XOPENEX	INHALATION NEBULIZATION SOLUTION
ZORTRESS	ORAL TABLET