

Prior Authorization Group Description	Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
5HT3 ANTI-NAUSEA AGENT BVD DETERMINATION	GRANISETRON HCL   GRANISOL   ONDANSETRON HCL   ONDANSETRON ODT	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.						
ADALIMUMAB	HUMIRA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D	INITIAL: RHEUMATOID ARTHRITIS/JUVENILE IDIOPATHIC ARTHRITIS: NO TRIAL/FAILURE/INTOLERABLE SIDE EFFECTS TO AT LEAST ONE DMARD THERAPY, FOR MODERATE TO SEVERE PLAQUE PSORIASIS COVERING 10% BSA OR LESIONS COVERING HANDS, FEET, OR GENITAL AREA: NO TRIAL/FAILURE OF PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE. CROHN'S DISEASE: NO TRIAL/FAILURE OF CORTICOSTEROID, AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE. RENEWAL: ACTIVE RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS/JUVENILE ARTHRITIS: NO LESS THAN 20% OR GREATER IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT. ANKYLOSING SPONDYLITIS: LESS THAN 50% IMPROVEMENT OR INCREASE IN 2 UNITS FROM BASELINE IN BASDAI. PLAQUE PSORIASIS: PATIENT HAS NOT ACHIEVED CLEAR OR MINIMAL DISEASE OR A DECREASE IN PASI OF 50% OR MORE.			RHEUMATOLOGIST, DERMATOLOGIST, GASTROENTEROLOGIST	INITIAL: 3 MO, EXCEPT PLAQUE PSORIASIS AND CROHN'S DISEASE IS 2 MO., RENEWAL: ALL DIAGNOSES 12 MO.	INITIAL: RHEUMATOID ARTHRITIS: TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, OR AURANOFIN). JUVENILE IDIOPATHIC ARTHRITIS: TRIAL OF AT LEAST ONE DMARD. PLAQUE PSORIASIS: TRIAL OF PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE. CROHN'S: TRIAL OF CORTICOSTEROIDS, AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE. RENEWAL: RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS FOR HUMIRA DOSE OF 40 MG EVERY WEEK: TRY/FAIL AT LEAST A 3 MONTH TRIAL OF HUMIRA 40MG EVERY OTHER WEEK.
ANTIEMETICS	SANCUSO	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NOT TRIED AND FAILED ANOTHER FORMULARY ANTIEMETIC DRUG, NOT ON MODERATE TO HIGHLY EMETOGENIC CHEMOTHERAPY.	CHEMOTHERAPY EMETOGENICITY			UP TO 12 MONTHS	PREVIOUS TRIAL OF ONDANSETRON ODT, ORAL GRANISETRON, OR ORAL DOLASETRON.
APREPITANT BVD DETERMINATION	EMEND	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.						
ATOMOXETINE	STRATTERA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NOT TRIED AND FAILED A STIMULANT MEDICATION	CONTRAINDICATION TO STIMULANT MEDICATIONS			12 MONTHS	
BECAPLERMIN	REGRANEX	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NON-DIABETIC. KNOWN NEOPLASM AT APPLICATION SITE. PRESSURE OR VENOUS STASIS ULCERS. ULCER DOES NOT EXTEND THROUGH DERMIS.			VASCULAR SURGEON, PODIATRIST, ENDOCRINOLOGIST OR PHYSICIAN PRACTICING IN A SPECIALTY WOUND CLINIC ONLY	3 MONTHS	
BENZYL ALCOHOL	ULESFIA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			6 MONTHS AND OLDER		1 MONTH	UP TO 2724 GRAMS
CALCINEURIN INHIBITORS	ELIDEL   PROTOPIC	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D	NOT TRIED/FAILED OR INTOLERABLE ADVERSE EFFECTS TO TOPICAL CORTICOSTEROIDS				12 MONTHS	
CERTOLIZUMAB PEGOL	CIMZIA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NO TRIAL/FAILURE OF ONE OR MORE CONVENTIONAL THERAPIES FOR CROHN'S DISEASE SUCH AS CORTICOSTEROIDS, AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE	FOR RHEUMATOID ARTHRITIS: ALLOW IF PRIOR USE OF AT LEAST ONE DMARD, SUCH AS METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, AURANOFIN.		DRUG BEEN PRESCRIBED BY OR IS IT CURRENTLY BEING SUPERVISED BY A GASTROENTEROLOGIST OR RHEUMATOLOGIST	12 MONTHS	
CHOLINESTERASE INHIBITORS FOR ALZHEIMER'S DISEASE	ARICEPT   ARICEPT ODT   EXELON	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	MINI MENTAL STATE EXAM (MMSE) SCORE GREATER THAN 26	MINI MENTAL STATE EXAM (MMSE) SCORE OF 26 OR LESS			12 MONTHS	
CYCLOSPORINE OPHTHALMIC	RESTATIS	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		KERATOCONJUNCTIVITIS SICCA (KCS) OR DRY EYE DISEASE		OPHTHALMOLOGIST, OPTOMETRIST, RHEUMATOLOGIST	12 MONTHS	
DALFAMPRIDINE	AMPYRA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D				NEUROLOGIST	12 MONTHS	

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DARBEPOETIN	ARANESP	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D	ANEMIA ASSOCIATED WITH CHRONIC RENAL FAILURE: HEMOGLOBIN GREATER THAN OR EQUAL TO 12G/DL. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CHEMOTHERAPY: HEMOGLOBIN GREATER THAN OR EQUAL TO 10G/DL				RENAL FAILURE:12 MONTHS CANCER CHEMOTHERPY:COURSE OF TREATMENT BASED ON CHEMOTHERAPY CYCLE.	
ELTROMBOPAG	PROMACTA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D	INITIAL: ADEQUATE RESPONSE TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR SUFFICIENT RESPONSE TO SPLENECTOMY, RENEWAL: NO CLINICAL RESPONSE AS DEFINED BY AN INCREASE IN PLATELET COUNT OF GREATER THAN OR EQUAL TO 50 X10 <sup>9</sup> /L AT THE MAX DOSE OF 75MG PER DAY FOR 4 WEEKS				INITIAL:1 MONTH RENEWAL: NO RESPONSE AFTER INITIAL:1 MONTH AT MAX DOSE, IF RESPONSE: 12 MONTHS.	
EPOETIN ALFA	EPOGEN   PROCRIT	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	CHRONIC RENAL FAILURE: HEMOGLOBIN EQUAL TO OR GREATER THAN 10 G/DL IF NOT UNDERGOING DIALYSIS OR GREATER THAN OR EQUAL TO 12 IF ON DIALYSIS. PATIENTS WITH ANEMIA RELATED TO AZT THERAPY: HEMOGLOBIN EQUAL TO OR GREATER THAN 12 G/DL. ANEMIA DUE TO CONCOMITANTLY ADMINISTERED CHEMOTHERAPY: HEMOGLOBIN EQUAL TO OR GREATER THAN 10 G/DL. PATIENTS SCHEDULED FOR ELECTIVE, NONCARDIAC SURGERY, NONVASCULAR SURGERY: HEMOGLOBULIN GREATER THAN 13 G/DL				ANEMIA FROM CHRONIC RENAL FAILURE/AZT/CHEMOTHERAPY:12 MONTHS, ANEMIA FROM ELECTIVE SURGERY: 21 DAYS	
ETANERCEPT	ENBREL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D	INITIAL: FOR RHEUMATOID ARTHRITIS OR JUVENILE ARTHRITIS: NO TRIAL/FAILURE OR EXPERIENCE WITH INTOLERABLE SIDE EFFECTS TO AT LEAST ONE DMARD AGENT. FOR MODERATE TO SEVERE PLAQUE PSORIASIS COVERING 10% BSA OR LESIONS COVERING HANDS, FEET, OR GENITAL AREA: NO TRIAL/FAILURE/INTOLERABLE SIDE EFFECTS TO AT LEAST ONE PREFERRED THERAPY. (PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE). RENEWAL: ACTIVE RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS/JUVENILE ARTHRITIS: NO LESS THAN 20% OR GREATER IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT. ANKYLOSING SPONDYLITIS: NO LESS THAN 50% IMPROVEMENT OR INCREASE IN 2 UNITS FROM BASELINE IN BASDAI. PLAQUE PSORIASIS: PATIENT HAS NOT ACHIEVED CLEAR OR MINIMAL DISEASE OR A DECREASE IN PASI OF 50% OR MORE.			RHEUMATOLOGIST OR DERMATOLOGIST ONLY	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS	INITIAL: RHEUMATOID ARTHRITIS/JUVENILE IDOPATHIC ARTHRITIS: TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOAMALATE, OR AURANOFIN). PLAQUE PSORIASIS: TRIAL OF PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE.
EXENATIDE	BYETTA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		TYPE II DIABETES: FAILURE TO REACH TREATMENT GOALS WITH EITHER METFORMIN, A SULFONYLUREA AGENT, OR A THIAZOLIDINEDIONE			12 MONTHS	
FENTANYL TRANSDERMAL PATCH	FENTANYL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	PATIENT ABLE TO TAKE OR HAS NOT FAILED ORAL LONG-ACTING OPIOID NARCOTIC ANALGESICS.	PATIENT IS RECEIVING DAILY, AROUND-THE-CLOCK PAIN MEDICATION FOR AT LEAST ONE WEEK			12 MONTHS	
FENTANYL TRANSMUCOSAL AGENTS	FENTANYL CITRATE   FENTORA   ONSOLIS	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		CANCER: ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE PAIN MEDICATION, AND EITHER A TRIAL AND FAILURE OF 1 IMMEDIATE-RELEASE ORAL PAIN AGENT OR DIFFICULTY SWALLOWING TABLETS/CAPSULES			6 MONTHS	
FONDAPARINUX	ARIXTRA	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ACUTE DVT/PE TREATMENT: IS STABILIZED ON WARFARIN AND HAS ESTABLISHED AN ORAL ANTICOAGULANT EFFECT WITH A THERAPEUTIC INR BETWEEN 2 TO 3.				HIP REPLACEMENT/FRACTURE SURGERY UP TO 33 DAYS KNEE/ABDOMINAL SURGERY/DVT/PE TREATMENT UP TO 14 DAYS	
GLP-1 ANALOGS	VICTOZA 3-PAK	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	DIAGNOSIS: NON TYPE 2 DIABETES. NO FAILURE TO REACH TREATMENT GOAL WITH METFORMIN, SULFONYLUREA, OR THIAZOLIDINEDIONE.	DIAGNOSIS: TYPE 2 DIABETES			12 MONTHS	

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GOLIMUMAB	SIMPONI	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D	INITIAL: FOR ALL DIAGNOSES; CONCURRENT USE WITH ORENCIA/ KINERET. ACUTE RHEUMATOID ARTHRITIS: NOT CURRENTLY ON METHOTREXATE AND NO TRIAL/FAILURE OR EXPERIENCE WITH INTOLERABLE SIDE EFFECTS TO AT LEAST ONE OTHER DMARD AGENT. PSORIATIC ARTHRITIS: NO TRIAL/FAILURE OR EXPERIENCE WITH INTOLERABLE SIDE EFFECTS TO AT LEAST ONE DMARD AGENT. RENEWAL: ACTIVE RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS: NO LESS THAN 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT. ANKYLOSING SPONDYLITIS: NO LESS THAN 20% IMPROVEMENT IN ANKYLOSING SPONDYLITIS (ASAS20) CRITERIA.		18 YEARS OR OLDER	RHEUMATOLOGIST OR DERMATOLOGIST ONLY	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS	INITIAL: RHEUMATOID/PSORIATIC ARTHRITIS: TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, OR AURANOFIN).
HEPATITIS A VACCINE (INACTIVATED) BVD DETERMINATION	HAVRIX   VAQTA	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.						
HEPATITIS B VACCINE BVD DETERMINATION	ENGERIX-B   RECOMBIVAX HB	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.						
IMIQUIMOD	IMIQUIMOD	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	PERIANAL GENITAL WARTS: PATIENT HAS NOT TRIED/FAILED CONDYLOX. NON-HYPERKERATOTIC, NON-HYPERTROPHIC ACTINIC KERATOSES ON THE FACE OR SCALP: HAS NOT TRIED/FAILED OR CONTRAINDICATION TO TOPICAL 5-FLUOROURACIL. SUPERFICIAL BASAL CELL CARCINOMA: GREATER THAN 2CM IN SIZE AND ON THE FACE		EXTERNAL GENITAL OR PERIANAL WARTS: GREATER THAN OR EQUAL TO 12 YEARS OF AGE. ACTINIC KERATOSIS: GREATER THAN OR EQUAL TO 18 YEARS OF AGE	ACTINIC KERATOSIS: DERMATOLOGIST ONLY. SUPERFICIAL BASAL CELL CARCINOMA: DERMATOLOGIST OR ONCOLOGIST ONLY.	4 MONTHS	CRITERIA APPLIES TO NEW STARTS ONLY
IMMUNE GLOBULIN BVD DETERMINATION	CARIMUNE NF NANOFILTERED   FLEBOGAMMA DIF   GAMASTAN S-D   GAMMAGARD LIQUID   GAMUNEX   OCTAGAM   POLYGAM S-D   PRIVIGEN   VIVAGLOBIN	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.						
IMMUNOSUPPRESSANT BVD DETERMINATION	AZATHIOPRINE   AZATHIOPRINE SODIUM   CELLCEPT   CYCLOSPORINE   CYCLOSPORINE MODIFIED   GENGRAF   MYCOPHENOLATE MOFETIL   MYFORTIC   ORTHOCLONE OKT-3   PROGRAF   RAPAMUNE   SIMULECT   TACROLIMUS   TORISEL   ZENAPAX	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.						
INFUSIBLE DRUG BVD DETERMINATION	ABELCET   ACYCLOVIR SODIUM   ADRIAMYCIN   AMBISOME   AMPHOTEC   AMPHOTERICIN B   BLEOMYCIN SULFATE   CLADRIBINE   CYCLOPHOSPHAMIDE   CYTARABINE   CYTOVENE   DOXIL   DOXORUBICIN HCL   FLUOROURACIL   FOSCARNET SODIUM   HERCEPTIN   IFOSFAMIDE   IFOSFAMIDE-MESNA   METHOTREXATE   MITOMYCIN   REMICADE   REMODULIN   VINBLASTINE SULFATE   VINCRISTINE SULFATE	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.						

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INTERFERON AGENTS, OTHER	INFERGEN   PEGASYS   PEGINTRON   PEGINTRON REDIPEN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		INITIAL: PATIENT WITH DETECTABLE PRETREATMENT HCV RNA LEVEL/VIRAL LOAD OF GREATER THAN OR EQUAL TO 50 IU/ML, AND EITHER RIBAVIRIN BEING USED IN COMBINATION WITH PEG-INTRON OR PEGASYS, OR CONTRAINDICATION TO COMBINATION (RIBAVIRIN + INTERFERON) THERAPY, AND GENOTYPE 1,2,3,4,5 OR 6. FOR PATIENTS WITH GENOTYPE 1,4,5, OR 6: PATIENT'S LIVER BIOPSY MUST SHOW CHRONIC HEPATITIS WITH SIGNIFICANT FIBROSIS (METAVIR SCORE GREATER THAN OR EQUAL TO 2 OR ISHAK SCORE GREATER THAN OR EQUAL TO 3), CHRONIC HEPATITIS C RENEWAL: UNLESS THERE IS A CONTRAINDICATION TO COMBINATION THERAPY, THE REQUEST IS FOR CONTINUING TREATMENT FOR COMBINATION THERAPY WITH RIBAVIRIN AND AN INTERFERON, PATIENT ACHIEVED A GREATER THAN OR EQUAL TO 2 LOG REDUCTION IN HCV RNA FROM BASELINE VALUE IN THE FIRST 12 WEEKS OF TREATMENT, GENOTYPE 1,4,5,6 HEPATITIS C		GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST) ONLY	HEP C GENOTYPE 1,4,5,6 INITIAL 16 WEEKS, RENEWAL 32 WEEKS, GENOTYPE 2, 3: 24 WEEKS	
INTERFERON ALFA-2A AND 2B MONOTHERAPY AGENTS	INTRON A	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	HEPATITIS C INITIAL: PRETREATMENT HCV RNA LEVEL/VIRAL LOAD LESS THAN 50 IU/ML, RIBAVIRIN NOT USED IN COMBINATION WITH INTRON A UNLESS THERE IS A CONTRAINDICATION TO RIBAVIRIN AND THE PATIENT'S LIVER BIOPSY SHOWS CHRONIC HEPATITIS WITH SIGNIFICANT FIBROSIS (METAVIR SCORE EQUAL TO OR GREATER THAN 2 OR ISHAK SCORE EQUAL TO OR GREATER THAN 3). IF USED IN COMBINATION, THE PATIENT OR THE PATIENT'S PARTNER IS PREGNANT, LIVER BIOPSY WITHOUT SIGNIFICANT FIBROSIS FOR GENOTYPE 1,4,5, OR 6. HEPATITIS C RENEWAL: PATIENT INFECTED WITH HEPATITIS C AND REQUEST IS FOR MONOTHERAPY UNLESS RIBAVIRIN IS CONTRAINDICATED, PATIENT DID NOT ACHIEVED A MINIMUM 2 LOG DECREASE IN VIRAL LOAD DURING THE FIRST 12 WEEKS OF TREATMENT, PATIENT INFECTED WITH GENOTYPE 2,3	DIAGNOSIS: HAIRY CELL LEUKEMIA, OR CONDYLOMATA ACUMINATA, OR AIDS-RELATED KAPOSI'S SARCOMA, OR CHRONIC HEPATITIS B, NON-HODGKIN'S LYMPHOMA, OR MALIGNANT MELANOMA OR CHRONIC PHASE, OR PHILADELPHIA CHROMOSOME (PH) POSITIVE CHRONIC MYELOGENOUS LEUKEMIA (CML) PATIENTS WHO ARE MINIMALLY PRETREATED (WITHIN 1 YEAR OF DIAGNOSIS), OR FOLLICULAR LYMPHOMA.	FOR HEPATITIS C DIAGNOSIS: EQUAL TO OR GREATER THAN 3 YEARS OF AGE	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST) ONLY	HEP C:GENOTYPE 1,4,5,6: INITIAL 16 WKS. RENEW: 32 WKS, GENOTYPE 2, 3: 24 WEEKS.	
LOW MOLECULAR WEIGHT HEPARIN AGENTS	FRAGMIN   INNOHEP   LOVENOX	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ALL LMWH: CURRENTLY ON WARFARIN AND SCHEDULED FOR MINOR SURGERY OR MAJOR SURGERY AND HAS A THERAPEUTIC INR (GREATER THAN 2 FOR AT LEAST 2 DAYS).	ALL AGENTS: PREGNANCY TEST, INR.			CANCER:LIFETIME HIP REPLACEMENT/FRACTURE SURGERY UP TO 30 DAYS OTHER FDA INDICATIONS UP TO 17 DAYS	
MEASLES VIRUS LIVE VACCINE BVD DETERMINATION	ATTENUVAX VACCINE WITH DILUENT	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.						
MEMANTINE	NAMENDA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	MINI MENTAL STATE EXAM (MMSE) SCORE GREATER THAN 19				12 MONTHS	
METHYLNALTREXONE	RELISTOR	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NOT ON PALLIATIVE CARE OR LIFE EXPECTANCY OF GREATER THAN 6 MONTHS	CONSTIPATION DUE TO OPIOIDS			UP TO 6 MONTHS	
MODAFINIL	PROVIGIL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CHRONIC FATIGUE SYNDROME RELATED TO MULTIPLE SCLEROSIS.	OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME: NO TRIAL OF CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP). NARCOLEPSY: NO TRIAL/FAILURE OR CONTRAINDICATION TO AMPHETAMINE, DEXTROAMPHETAMINE AND/OR METHYLPHENIDATE.				12 MONTHS	
OFATUMUMAB	ARZERRA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D	CHRONIC LYMPHOCYTIC LEUKEMIA: NO FAILED TREATMENT WITH FLUDARABINE AND ALEMTUZUMAB				6 MONTHS	

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OMALIZUMAB	XOLAIR	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		INITIAL: PATIENT MEETS THE CRITERIA OF MODERATE TO SEVERE ASTHMA, POSITIVE SKIN PRICK OR RAST TEST, NON-SMOKER, FEV1 LESS THAN 80%, DEMONSTRATED INADEQUATELY CONTROLLED SYMPTOMS ON INHALED CORTICOSTEROIDS AND SECOND ASTHMA CONTROLLER, BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30 IU/ML. RENEWAL: PATIENT REDUCED EXACERBATIONS BY AT LEAST 25% FROM BASELINE, REDUCTION IN ORAL OR INHALED CORTICOSTEROID USE FROM BASELINE.	PATIENT 12 YEARS OF AGE OR OLDER	SPECIALIST IN ALLERGY OR PULMONARY MEDICINE ONLY	12 MONTHS	
PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION	ADCIRCA   REVATIO	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		PULMONARY ARTERIAL HYPERTENSION: WHO CLASS I-IV SYMPTOMS		CARDIOLOGIST OR PULMONOLOGIST	12 MONTHS	2 TABLETS PER DAY PER MONTH
PLERIXAFOR	MOZOBIL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		USE IN COMBINATION WITH GRANULOCYTE-COLONY STIMULATING FACTOR (G-CSF) TO MOBILIZE HEMATOPOIETIC STEM CELLS TO THE PERIPHERAL BLOOD FOR COLLECTION AND SUBSEQUENT AUTOLOGOUS TRANSPLANTATION IN PATIENTS WITH NON-HODGKIN'S LYMPHOMA AND MULTIPLE MYELOMA		HEMATOLOGIST OR ONCOLOGIST	4 DOSES (UP TO 8 VIALS) FOR ONE FILL.	
PRAMLINTIDE	SYMLIN   SYMLINPEN 120   SYMLINPEN 60	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		TYPE I OR TYPE II DIABETES: REQUIRING INSULIN OR CONTINUOUS INSULIN INFUSION (INSULIN PUMP) FOR GLYCEMIC CONTROL			12 MONTHS	
QUININE SULFATE	QUALAQUIN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
RABIES VACCINE BVD DETERMINATION	IMOVAX RABIES VACCINE   RABAVERT	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.						
RANOLAZINE	RANEXA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	PATIENT HAS NOT TRIED/FAILED OR HAVE CONTRAINDICATION TO 1 ANTI-ANGINA AGENT (BETA-BLOCKER, AMLODIPINE, NIFEDIPINE, ISOSORBIDE, OR LONG ACTING NITROGLYCERIN).
SAPROPTERIN	KUVAN	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D	INITIAL: HAS NOT TRIED DIETARY MODIFICATIONS. RENEWAL: PATIENT HAS NOT ACHIEVED AT LEAST 20% REDUCTION IN BLOOD PHENYLALANINE WITH INITIAL TREATMENT			ENDOCRINOLOGIST ONLY	INITIAL: 4 WEEKS. RENEWAL: 6 MONTHS	
SILDENAFIL	REVATIO	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		PULMONARY ARTERIAL HYPERTENSION: WHO CLASS I-IV SYMPTOMS		CARDIOLOGIST OR PULMONOLOGIST ONLY	12 MONTHS	
SOMATROPIN	GENOTROPIN   HUMATROPE   NORDITROPIN   NORDIFLEX   NUTROPIN   NUTROPIN AQ   OMNITROPE   SAIZEN   SEROSTIM   TEV-TROPIN   ZORBTIVE	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ATHLETIC ENHANCEMENT OR ANTI-AGING PURPOSE. GROWTH FAILURE DUE TO CHRONIC RENAL INSUFFICIENCY(CR) IF PATIENT HAS HAD A RENAL TRANSPLANT	FOR GROWTH FAILURE DUE TO (CR): PATIENT HAS NOT UNDERGONE A RENAL TRANSPLANT, PATIENT'S HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER, LACK OF RESPONSE FROM PREVIOUS YEAR, PATIENT HAS REACHED 50TH PERCENTILE FOR TARGET HEIGHT FOLLOWING GROWTH HORMONE THERAPY. FOR HIV/WASTING: THE PATIENT ON ANTIRETROVIRAL THERAPY, MEETS CRITERIA OF WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, 7.5% OVER 6 MONTHS, 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN) OR 23% (WOMEN) OF TOTAL BODY WT. AND A BODY MASS INDEX (BMI) LESS THAN 27KG/M2, OR BMI LESS THAN 20KG/M2. IF CURRENTLY ON GROWTH HORMONE, PATIENT HAS SHOWN CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT OR IF NOT ON GROWTH HORMONE, PATIENT HAS HAD INADEQUATE RESPONSE TO PREVIOUS THERAPY. FOR SHORT-BOWEL SYNDROME: CURRENTLY ON SPECIALIZED NUTRITIONAL SUPPORT			HIV/AIDS: 3 MONTHS. SHORT BOWEL: 4 WEEK ONCE. ALL OTHER DIAGNOSES: 12 MONTHS.	

Prior Authorization Group Description	Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TERIPARATIDE	FORTEO	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		A PATIENT WITH EITHER A DIAGNOSIS OF SEVERE OSTEOPOROSIS (T-SCORE LESS THAN -2.5 WITH FRAGILITY FRACTURE) OR A T SCORE EQUAL TO OR LESS THAN -2.5 AND MULTIPLE RISK FACTORS FOR FRACTURE (E.G. HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS), OR FAILED AN ADEQUATE TRIAL OF BISPSPHONATES, IS INTOLERANT, OR HAS A CONTRAINDICATION TO BISPSPHONATES.			12 MONTHS	
TESTOSTERONE AGENTS	ANDRODERM   ANDROGEL   TESTOSTERONE   TESTOSTERONE CYPIONATE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	FEMALE, UNLESS DIAGNOSED WITH METASTATIC BREAST CANCER.	MALE HYPOGONADISM CONFIRMED BY EITHER: 1) LABORATORY CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL OF LESS THAN 250NG/DL (8.7NMOL/L) OBTAINED WITHIN 90 DAYS, OR 2) LABORATORY CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL BETWEEN 250NG/DL AND 350NG/DL (12NMOL/L) TOGETHER WITH A FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 50NG/L (174 PMOL/L) OR 3) MALE DELAYED PUBERTY NOT SECONDARY TO PATHOLOGY.			12 MONTHS	
TETANUS TOXOID VACCINE BVD DETERMINATION	TETANUS TOXOID ADSORBED	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.						
TOCILIZUMAB	ACTEMRA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NO FAILURE OF ENBREL, HUMIRA, REMICADE, SIMPONI OR CIMZIA	DIAGNOSIS: ACTIVE RHEUMATOID ARTHRITIS. RENEWAL: AT LEAST 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT.		RHEUMATOLOGIST	INITIAL: 6 MONTHS. RENEWAL: 6 MONTHS	
TOTAL PARENTARAL NUTRITION AGENT BVD DETERMINATION	AMINOSYN   AMINOSYN II   AMINOSYN II 3.5% M-DEXTROSE 5%   AMINOSYN II 3.5%-DEXTROSE 25%   AMINOSYN II 3.5%-DEXTROSE 5%   AMINOSYN II 4.25% M-DEXT 10%   AMINOSYN II 4.25%-DEXTROSE 25%   AMINOSYN II 5% IN 25% DEXTROSE   AMINOSYN II IN DEXTROSE   AMINOSYN II W/ELEC IN DEX W/CA   AMINOSYN M   AMINOSYN W/ELECTROLYTES   AMINOSYN-HBC   AMINOSYN-HF   AMINOSYN-PF   CLINIMIX   CLINIMIX E   CLINISOL   DEXTROSE 10%-1/4NS   DEXTROSE IN WATER   DEXTROSE WITH SODIUM CHLORIDE   FREAMINE HBC   FREAMINE III   FREAMINE III WITH ELECTROLYTES   HEPATAMINE   HEPATASOL   INTRALIPID   LIPOSYN II   LIPOSYN III   NEPHRAMINE   NOVAMINE   PREMASOL   PROCALAMINE   PROSOL   QUICK MIX WITH LYTES   RENAMIN   TRAVASOL   TRAVASOL W/ELECTROLYTES   TRAVASOL WITH DEXTROSE   TRAVASOL WITH ELECTROLYTES   TROPHAMINE	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.						
USTEKINUMAB	STELARA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D	INITIAL: PLAQUE PSORIASIS: LESS THAN 10% BODY SURFACE AREA OR PASI SCORE LESS THAN 12. NO TRIAL/FAILURE OF PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORIN. RENEWAL: PHYSICIAN'S GLOBAL ASSESMENT GREATER THAN 1 OR LESS THAN 50% DECREASE IN PASI SCORE.	WEIGHT GREATER THAN 100KG (220LBS).		DERMATOLOGIST OR RHEUMATOLOGIST	INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS	
VALGANCICLOVIR	VALCYTE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D	OVER 16 YEARS OF AGE AND ABLE TO TOLERATE ORAL MEDICATIONS	PREVENTION OF CYTOMEGALOVIRUS: FOLLOWING KIDNEY OR HEART TRANSPLANT OR TREATMENT OF CYTOMEGALOVIRUS RETINITIS: AIDS			6 MONTHS	
VARENICLINE	CHANTIX	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	INITIAL: NOT ENROLLED IN A SMOKING CESSATION PROGRAM. RENEWAL: NOT ABSTAINING FROM CIGARETTE USE DURING THE INITIAL 12 WEEKS OF TREATMENT				INITIAL: 12 WEEKS RENEWAL:12 WEEKS	