

PA Criteria

Prior Authorization Group	ABATACEPT
Drug Names	ORENCIA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of moderate to severe Rheumatoid Arthritis OR moderate to severe Juvenile Idiopathic Arthritis AND member must have a negative tuberculin skin test, or if positive, have initiated treatment for latent TB prior to treatment with Orencia, AND member does not have an active infection that would put the patient at risk if receiving Orencia. AND treatment will not be prescribed along with another biologic DMARD (i.e., Enbrel, Rituxan, Humira, Remicade, etc.), AND member has had an inadequate response to one or more nonbiologic disease modifying antirheumatic drugs OR member has had an inadequate response to one or more biologic disease modifying antirheumatic drugs.
Age Restrictions	Patient is 18 years of age or older for RA. Patient is 6-17 years of age for juvenile idiopathic arthritis.
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	ADALIMUMAB
Drug Names	HUMIRA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for use of Humira in combination with other biologics e.g., Enbrel, Kineret or Remicade.
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	ALEFACEPT
Drug Names	AMEVIVE
Covered Uses	All FDA-approved indications not otherwise excluded for Part D.
Exclusion Criteria	Patients using other immunosuppressive agents or patients diagnosed with HIV/AIDS

Required Medical Information The first and second treatment cycles, each consisting of 12 weeks, must be separated by at least a 12-week interval. Retreatment with the second 12-week course may be initiated provided the CD4+ T-cell count is within the normal range. The physician should monitor CD4+ T-cell counts during treatment, dosing should be withheld if the CD4+ T-cell count is less than 250 /mm³ and treatment should be discontinued if the count remains less than 250 /mm³ for one month. Per manufacturer guidelines, Amevive should not be used concomitantly with other immunosuppressive agents or in patients currently receiving phototherapy. Amevive is contraindicated in patients with HIV/AIDs because it reduces CD4+ T-cell counts and, thus, may accelerate progression of HIV infection or increase complications of the disease.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Patient must be 18 years or older

1 year, lifetime limit of 180 days

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

AMBRISANTAN

LETAIRIS

All FDA-approved indications not otherwise excluded for Part D.

Diagnosis of PAH (WHO Group I) in Class II or III patients. Coverage is not provided unless pregnancy has been excluded prior to start of therapy and will be prevented thereafter with reliable contraception

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Consultation with or prescription by pulmonologist or cardiologist

12 months

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

ANABOLIC STEROIDS

ANADROL-50

All FDA-approved indications not otherwise excluded for Part D.

Known or suspected carcinoma of the prostate or male breast, carcinoma of the breast in females with hypercalcemia, pregnancy, nephrosis, hypercalcemia, severe hepatic impairment

Approve if treatment is for: anemia caused by deficient red cell production (documented hematocrit less than 33 or hemoglobin less than 12), hereditary angioedema, involuntary weight loss following extensive surgery, chronic infections, or severe trauma, failure to gain or maintain at least 90% of ideal body weight without definite pathophysiologic reasons, chronic corticosteroid administration, osteoporosis related bone pain

Age Restrictions

Prescriber Restrictions

Coverage Duration

12 months

Other Criteria

Prior Authorization Group

ANAKINRA

Drug Names

KINERET

Covered Uses

All FDA-approved indications not otherwise excluded for Part D.

Exclusion Criteria

Required Medical Information

Diagnosis of moderate to severe Rheumatoid Arthritis AND patient must have neutrophil counts assessed prior to beginning therapy, monthly for 3 months and then quarterly thereafter for up to a year AND patient does not have an active infection AND treatment will not be prescribed with another biologic DMARD. Patient must also have had an inadequate response to at least one biologic and nonbiologic DMARD
Patient must be 18 years or older

Age Restrictions

Prescriber Restrictions

Coverage Duration

12 months

Other Criteria

Prior Authorization Group

B VS. D

Drug Names

ABRAXANE, ACETYLCYSTEINE, ADRIAMYCIN, ALBUTEROL SULFATE, ALIMTA, ALOXI, 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 M, AMINOSYN-HBC, AMINOSYN-HF, AMINOSYN-PF, AMINOSYN-PF 7%, ANZEMET, ARZERRA, ATGAM, AVASTIN, AZASAN, AZATHIOPRINE, AZATHIOPRINE SODIUM, BICNU, BLEOMYCIN SULFATE, BROVANA, BUSULFEX, CALCITRIOL, CAMPATH, CARBOPLATIN, CELLCEPT, CELLCEPT INTRAVENOUS, 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%, CLOLAR, COSMEGEN, CROMOLYN SODIUM, CUBICIN, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE, CYTARABINE AQUEOUS, DACARBAZINE, DAUNORUBICIN HCL, DEXRAZOXANE, DEXTROSE 10% FLEX CONTAIN, DEXTROSE 5%, DOCETAXEL, DOXIL, DOXORUBICIN HCL, DRONABINOL, ELITEK, ELLENCE, ELSPAR, EMEND, ENGERIX-B, EPIRUBICIN HCL, ETOPOPHOS, ETOPOSIDE, FASLODEX, FLUDARABINE PHOSPHATE, FLUOROURACIL, FREAMINE III, FREAMINE III 3%, GEMCITABINE HCL, GENGRAF, GRANISETRON HCL, GRANISOL, HECTOROL, HEPATAMINE, HEPATASOL, HERCEPTIN, IDAMYCIN PFS, IDARUBICIN HCL, IFEX, IFOSFAMIDE, IFOSFAMIDE/MESNA, IMOVAX RABIES (H.D.C.V.), INTRALIPID, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, IXEMPRA KIT, LEUCOVORIN CALCIUM, LEVOCARNITINE, LIPOSYN III, MELPHALAN HYDROCHLORIDE, MESNA, METHOTREXATE, MITOMYCIN, MITOXANTRONE HCL, MUSTARGEN, MYCOPHENOLATE MOFETIL, MYFORTIC, NEBUPENT, NEPHRAMINE, NOVANTRONE, NULOJIX, ONDANSETRON HCL, ONDANSETRON ODT, ONTAK, ORTHOCLONE OKT3, OXALIPLATIN, PACLITAXEL, PENTOSTATIN, PREMASOL, PROCALAMINE, PROGRAF, PROLEUKIN, PULMOZYME, RABAVERT, RAPAMUNE, RECOMBIVAX HB, SIMULECT, TACROLIMUS, TAXOTERE, TETANUS TOXOID ADSORBED, THIOTEPA, THYMOGLOBULIN, TOBI, TOPOSAR, TOPOTECAN HCL, TRAVASOL, TREANDA, TREXALL, TRISENOX, TROPHAMINE, TWINRIX, VANCOMYCIN HCL, VELCADE, VIDAZA, VINBLASTINE SULFATE, VINCASAR PFS, VINCRISTINE SULFATE, VINOELBINE TARTRATE, ZANOSAR, ZEMPLAR, ZOMETA, ZORTRESS

Covered Uses

NA

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

NA

Other Criteria

Prior Authorization Group

BECAPLERMIN

Drug Names

REGRANEX

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information

Patient has diagnosis of diabetes mellitus AND Patient has diabetic neuropathic ulcer(s) that extend into the subcutaneous tissue or beyond (Stages III and IV of the NPUAP/WOCN pressure ulcer staging) AND Patients diabetic ulcer(s) has an adequate blood supply (defined as transcutaneous oxygen tension (T_{cp}O₂) on limb where ulcer is located of greater than 30 mm Hg) AND Patient is receiving a program of good ulcer care (consisting of initial complete sharp debridement, a non-weight-bearing regimen, systemic treatment for wound-related infection if present, moist saline dressings changed twice a day, and additional debridement as necessary).

Age Restrictions

Patient is 16 years of age or older

Prescriber Restrictions

Coverage Duration

12 months

Other Criteria

Prior Authorization Group

BOSENTAN

Drug Names

TRACLEER

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information

Diagnosis of PAH (WHO Group I) in Class II, III or IV patients OR Eisenmengers syndrome, (WHO Group I) Class III PAH OR Chronic thromboembolic pulmonary hypertension (WHO GROUP IV) AND For patients diagnosed with idiopathic PAH (IPAH), AND For female patients, pregnancy has been excluded prior to the start of therapy and will be prevented thereafter with reliable contraception AND Patient is not on concomitant therapy with any of the following drugs: cyclosporine A or glyburide AND Appropriate baseline liver function tests have or will be performed prior to the start of therapy.

Age Restrictions

Prescriber Restrictions

Pulmonologist or cardiologist or documentation of consultation with pulmonologist or cardiologist

Coverage Duration

12 months

Other Criteria

Prior Authorization Group

CALCIPOTRIENE AND BETAMETHASONE

Drug Names	TACLONEX, TACLONEX SCALP
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of stable moderate to severe psoriasis vulgaris (plaque psoriasis) AND Patient has less than 30% body surface area affected AND Patient has tried adequate treatment (at least 2 weeks) with at least medium to high potency topical steroid products OR Patient has contraindications to utilizing topical steroids in absence of calcipotriene OR Patient has tried adequate treatment (at least 2 weeks) with vitamin D analogs (calcipotriene, calcitriol) OR Patient has tried adequate treatment (at least 2 weeks) with tazarotene OR Patient has contraindications to utilizing tazarotene
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	CELEBREX
Drug Names	CELEBREX
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Post-operative pain following CABG surgery.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months for JRA, 12 months for dysmenorrhea, OA, RA, AS, 1 month for acute pain
Other Criteria	
Prior Authorization Group	CERTOLIZUMAB
Drug Names	CIMZIA
Covered Uses	All FDA-approved indications not otherwise excluded for Part D.
Exclusion Criteria	
Required Medical Information	Approve for FDA approved indications AND patient does not have a documented active infection, patient has been evaluated for tuberculosis risk factors and tested for latent infection prior to initiation of therapy and will be assessed periodically during therapy AND patient has failed to achieve symptom control after an adherent trial to conventional therapy AND patient has failed Remicade or Humira for Crohn's disease or Enbrel and Humira for rheumatoid arthritis
Age Restrictions	Patient must be 18 years or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	DASATINIB
Drug Names	SPRYCEL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria	Coverage will not be provided when patient will concomitantly use an H2-receptor antagonist or proton pump inhibitor while taking dasatinib.
Required Medical Information	Patient has one of the following diagnoses: Patient is in the chronic phase, accelerated, or blast (myeloid or lymphoid) phase of Philadelphia chromosome positive chronic myelogenous leukemia or Patient has Philadelphia chromosome positive acute lymphoblastic leukemia
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	Prescriber is an oncologist or a healthcare provider highly familiar with prescribing and monitoring of oncology medications.
Coverage Duration	12 months
Other Criteria	Patient will have hypokalemia or hypomagnesemia corrected prior to administration of dasatinib, and levels will be monitored periodically during treatment AND Patient will have complete blood counts (CBCs) performed at baseline, weekly for the first 2 months, and monthly thereafter, or as clinically indicated.
Prior Authorization Group	DEGARELIX
Drug Names	FIRMAGON
Covered Uses	All FDA-approved indications not otherwise excluded for Part D.
Exclusion Criteria	Coverage not provided for females
Required Medical Information	Diagnosis of advanced or metastatic prostate cancer OR patient has as an intermediate to high risk of disease recurrence AND orchiectomy is not indicated or not acceptable to the patient AND estrogen therapy is not indicated or not acceptable to the patient
Age Restrictions	Patient must be at least 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	DICLOFENAC PATCH
Drug Names	FLECTOR
Covered Uses	All FDA-approved indications not otherwise excluded for Part D.
Exclusion Criteria	
Required Medical Information	Approve if used for the topical treatment of acute pain due to minor strains, sprains, and contusions AND documented trial and failure of an oral NSAID or documented swallowing disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	ELTROMBOPAG
Drug Names	PROMACTA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria	Coverage not provided for Concomitant use with other platelet-stimulating agents such as romiplostim or oprelvekin, Patient who has failed to respond to therapy with eltrombopag following at least 4 weeks at the maximum dose, Eltrombopag is being used to normalize platelet count rather than to reduce the risk of bleeding in patients with chronic ITP, Chemotherapy/drug-induced thrombocytopenia, Treatment of thrombocytopenia due to causes other than chronic ITP, Patients who have previously failed therapy with eltrombopag.
Required Medical Information	Patient has a diagnosis of relapsed/refractory chronic ITP (greater than 6 months) AND Prescriber and patient are enrolled in the Promacta Cares program (1-877-9-PROMACTA) AND Patients baseline platelet count is less than 50,000/mcL AND Patients degree of thrombocytopenia and clinical condition increases the risk for bleeding AND Patient is intolerant to splenectomy, and has had an insufficient response or is intolerant to corticosteroids and immune globulin OR Patient had a splenectomy with an inadequate response and had an insufficient response or is intolerant to corticosteroids and immune globulin.
Age Restrictions	Patient is 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	ERLOTINIB
Drug Names	TARCEVA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Dosing or Quantity Limit Exception Approval Criteria: The prescribing physician must document that the patient has failed or is unresponsive to the lower dose or that the length of therapy dose limit is not meeting the clinical needs or the patient AND the dose/quantity requested is supported by one of the three CMS accepted compendia (DrugDex, USP or AHFS). The supporting documentation in such literature must be specific to that indication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	ERYTHROPOIETINS
Drug Names	ARANESP ALBUMIN FREE, EPOGEN, PROCRIT
Covered Uses	All FDA-approved indications not otherwise excluded for Part D.
Exclusion Criteria	

Required Medical Information Pretreatment hemoglobin (Hgb) level must be less than 13 in anemic patients at high risk for perioperative blood loss and less than 10 for all other indications AND patient must have adequate iron stores prior to therapy AND patient must not have uncontrolled hypertension AND patient has not been diagnosed with antibody-mediated pure red cell aplasia AND other causes of anemia have been ruled out

Age Restrictions

Prescriber Restrictions

Coverage Duration

12 months

Other Criteria

Part B vs D Determination - if patient has end stage renal disease and is on dialysis, covered under Part B. Otherwise covered under Part D.

Prior Authorization Group

ETANERCEPT

Drug Names

ENBREL

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Coverage is not provided for use of Enbrel in combination with other biologics e.g., Humira, Kineret or Remicade.

Required Medical Information

Patient must have a negative tuberculin skin test, or if positive, have initiated treatment for latent TB prior to treatment with Enbrel AND active infection must be ruled out AND inadequate response to at least one nonbiologic disease modifying antirheumatic drug

Age Restrictions

Prescriber Restrictions

Coverage Duration

12 months

Other Criteria

Prior Authorization Group

EVEROLIMUS

Drug Names

AFINITOR

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Coverage is not provided for patients that will receive live vaccines during treatment.

Required Medical Information

Patient has a diagnosis of advanced/metastatic renal cell carcinoma AND has failed therapy (disease progressed) with sunitinib (SUTENT) or sorafenib (NEXAVAR) AND patient will have the following lab tests performed at baseline and monitored periodically during therapy with everolimus: Renal function- serum creatinine and blood urea nitrogen (BUN) AND Blood glucose/lipids- fasting serum glucose and lipid profile AND Hematologic parameters- complete blood count.

Age Restrictions

Patient must be greater than or equal to 18 years of age

Prescriber Restrictions

Prescriber is an oncologist or a healthcare provider highly familiar with prescribing and monitoring of oncology medications

Coverage Duration

12 months

Other Criteria

If patient has a pre-existing invasive fungal infection, fungal infection treatment will be completed prior to initiation of everolimus.

Prior Authorization Group

FENTANYL CITRATE BUCCAL

Drug Names	FENTORA
Covered Uses	All FDA-approved indications not otherwise excluded for Part D.
Exclusion Criteria	Coverage not provided in the management of acute or postoperative pain, opioid non-tolerant patients, patients with known intolerance or hypersensitivity to the drug or fentanyl
Required Medical Information	Diagnosis of cancer and use is for breakthrough cancer pain AND other formulary short acting narcotics have been ineffective, not tolerated, or contraindicated AND patient is opioid tolerant and taking at least 60 mg morphine/day or an equianalgesic dose of another opioid for a week or longer
Age Restrictions	Patient must be at least 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	FENTANYL, TRANSMUCOSAL
Drug Names	FENTANYL CITRATE ORAL TRA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient must have a diagnosis of cancer and fentanyl is being used for the management of breakthrough pain. Patient must already be receiving and is tolerant to around the clock opioid therapy for cancer pain. Tolerance is defined as patients no longer responding to around the clock medicine consisting of the following or an equianalgesic dose of another opioid daily for a week or longer: morphine 60mg orally daily, or at least 25 mcg/hr transdermal fentanyl, or at least 30mg of oxycodone daily, or at least 8mg of oral hydromorphone daily.
Age Restrictions	Patient must be at least 18 years of age
Prescriber Restrictions	Prescriber is an oncologist or pain management specialist or is skilled in the use of Schedule II opioids to treat cancer pain.
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	FILGRASTIM
Drug Names	NEUPOGEN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Additional covered off-labeled uses are Neutropenia due to other drugs, AIDS/HIV, and myelodysplasia.
Exclusion Criteria	Combination therapy with Neulasta and Neupogen or Leukine is not covered
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

Prior Authorization Group	FINGOLIMOD
Drug Names	GILENYA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for patients with an acute or chronic infection.
Required Medical Information	Patient is diagnosed with a relapsing form of MS AND Patient will be observed in a controlled setting, for signs and symptoms of bradycardia for 6 hours after the first dose AND Patient has had a complete blood count (CBC) taken within 6 months prior to starting GILENYA AND The patient will have an ophthalmologic evaluation performed at baseline and at 3 to 4 months following initiation of treatment with GILENYA AND Patient has had liver transaminase and bilirubin levels taken within 6 months prior to starting GILENYA.
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Only female patients of childbearing potential will agree to use effective contraception during and for 2 months after stopping GILENYA treatment.
Prior Authorization Group	GROWTH HORMONES
Drug Names	GENOTROPIN, GENOTROPIN MINIQUICK, HUMATROPE, HUMATROPE COMBO PACK, NORDITROPIN FLEXPOR, NUTROPIN, NUTROPIN AQ PEN, OMNITROPE, SAIZEN, SAIZEN CLICK.EASY, SEROSTIM, TEV-TROPIN, ZORBTIVE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	IBANDRONATE
Drug Names	BONIVA
Covered Uses	All FDA-approved indications not otherwise excluded for Part D.
Exclusion Criteria	
Required Medical Information	Patient has any of the following diagnoses: Osteoporosis in a postmenopausal female or Primary or hypogonadal osteoporosis in a male AND documented trial and failure of an oral bisphosphonate for six months, OR patient has documented contraindication, intolerant to oral bisphosphonate therapy, or unable to comply with appropriate administration recommendations AND patient must receive supplemental calcium and vitamin D therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months

Other Criteria

Prior Authorization Group	ILOPROST
Drug Names	VENTAVIS
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of Pulmonary Arterial Hypertension [PAH] (WHO Group I) in Class III or IV patients OR Diagnosis of PAH (WHO Group I) in Class II patients who do not respond adequately to or are unable to tolerate conventional therapy, such as REVATIO (sildenafil), ADCIRCA (tadalafil), TRACLEER (bosentan) or LETAIRIS (ambrisentan).
Age Restrictions	
Prescriber Restrictions	Pulmonologist or cardiologist or documentation of consultation with pulmonologist or cardiologist
Coverage Duration	12 months
Other Criteria	

Prior Authorization Group	IMATINIB
Drug Names	GLEEVEC
Covered Uses	All FDA-approved indications not otherwise excluded for Part D.
Exclusion Criteria	
Required Medical Information	Approve if diagnosed with Philadelphia chromosome positive chronic myelogenous leukemia, Philadelphia chromosome positive acute lymphoblastic leukemia, Gastrointestinal stromal tumor, Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic, Hypereosinophilic syndrome or chronic eosinophilic leukemia, Myelodysplastic syndrome or myeloproliferative disease associated with PDGFR gene rearrangements, Systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutational status unknown, Desmoid tumor. Patients at least 2 years of age, approve if diagnosed with Philadelphia chromosome positive chronic myelogenous leukemia AND prescriber is an oncologist experienced in the treatment of patients with hematologic malignancies or malignant sarcomas AND Patient will have complete blood counts (CBCs) performed at baseline, weekly for the first month, biweekly for the second month, and periodically thereafter as clinically indicated AND Patient will have liver function (transaminases, bilirubin, and alkaline phosphatase) monitored at baseline and monthly, or as clinically indicated AND Patient will be weighed at baseline and monitored regularly for signs and symptoms of fluid retention.
Age Restrictions	Patients at least 18 years of age for FDA approved indications in adults. Patients at least 2 years of age and older for Philadelphia chromosome positive chronic myelogenous leukemia.
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

Prior Authorization Group	IMMUNE GLOBULIN
Drug Names	CARIMUNE NANOFILTERED, GAMASTAN S/D, GAMMAGARD LIQUID, GAMUNEX, VIVAGLOBIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided in patients with selective IgA deficiency, history of anaphylactic reaction or hypersensitivity to immune globulin preparations
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	INCIVEK
Drug Names	INCIVEK
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	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 CYP3A for clearance or strongly induce CYP3A.
Required Medical Information	Hepatitis C virus (HCV) infection confirmed by presence of viral load in serum. HCV Genotype 1. HCV-RNA less than or equal to 1,000 IU/mL at week 4 of treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 weeks. Renewal: Up to 12 weeks.
Other Criteria	Must be given in combination with pegylated interferon (i.e., Pegasys or PegIntron) and ribavirin. Assess HCV RNA level at weeks 4, 12, and 24 of Incivek triple therapy.
Prior Authorization Group	INFLIXIMAB
Drug Names	REMICADE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for use in combination with Enbrel, Kineret, or Humira.
Required Medical Information	Diagnosis RA and PsA: Member has had an inadequate response to one nonbiologic disease modifying antirheumatic drugs (DMARDS), Diagnosis AS: Member has had an inadequate response to two NSAIDs or one nonbiologic disease modifying antirheumatic drugs (DMARDS), Diagnosis Plaque Psoriasis: Member must have tried a DMARD or UVA light therapy with oral or topical psoralens (PUVA) in the past year.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	INTERFERON ALFACON-1
Drug Names	INFERGEN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria	Coverage not allowed for any of the following contraindications to therapy: Uncontrolled depression, Solid organ transplant other than liver, Autoimmune hepatitis or other autoimmune condition known to be exacerbated by interferon and ribavirin, Untreated thyroid disease, Pregnant or unwilling to comply with adequate contraception, Severe concurrent medical disease such as severe hypertension, heart failure, significant coronary heart disease, poorly controlled diabetes, chronic obstructive pulmonary disease, Known hypersensitivity to interferons.
Required Medical Information	Patient is receiving treatment for hepatitis C infection AND Patient is considered a relapser/non-responder to combination treatment with peg-interferon and ribavirin AND Patient is receiving combination therapy with ribavirin, unless contraindicated.
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	Initial: 16 weeks. Renewal: Additional 32 weeks if early response at week 12.
Other Criteria	For Renewal: early virological response is defined as greater than or equal to 2 log reduction in HCV RNA is at week 12.
Prior Authorization Group	LAPATINIB
Drug Names	TYKERB
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis: Patient has advanced or metastatic breast cancer whose tumor overexpresses HER2, patient received prior therapy including an anthracycline, a taxane, and trastuzumab (HERCEPTIN), and lapatinib will be used in combination with capecitabine (XELODA) OR Patient is a postmenopausal woman with hormone receptor positive metastatic breast cancer that overexpresses HER2 receptor for whom hormonal therapy is indicated and lapatinib will be used in combination with letrozole (FEMARA).
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	Prescriber is an oncologist or a healthcare provider highly familiar with prescribing and monitoring of oncology medications.
Coverage Duration	12 months
Other Criteria	Patient will have hypokalemia or hypomagnesemia corrected prior to administration of lapatinib AND Patient will have liver function (transaminases, bilirubin, and alkaline phosphatase) monitored at baseline, every 4 to 6 weeks during treatment, and as clinically indicated.
Prior Authorization Group	LEUPROLIDE - LUPRON
Drug Names	ELIGARD, LEUPROLIDE ACETATE, LUPRON DEPOT, LUPRON DEPOT-PED
Covered Uses	All FDA-approved indications not otherwise excluded for Part D. Additional off label uses include breast cancer and ovarian cancer
Exclusion Criteria	

Required Medical Information	Prostate cancer diagnosis: approve if patient has advanced or metastatic prostate cancer OR patient has an intermediate to high risk of disease recurrence AND orchiectomy is not indicated or acceptable AND estrogen therapy is not indicated or acceptable. For other conditions, verify diagnosis.
Age Restrictions	Patient must be 18 years or older for all FDA approved indications except central precocious puberty, where patient must be less than 11 years if female and less than 12 years if male
Prescriber Restrictions	For prostate, breast, and ovarian cancer diagnosis, prescriber must be an oncologist or individual highly familiar with prescribing and monitoring oncology related medications
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	LIDODERM
Drug Names	LIDODERM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Additional coverage is provided for the off-label use of neuropathic pain.
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	LUPRON
Drug Names	LUPRON DEPOT-PED
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	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
Required Medical Information	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.
Age Restrictions	For CPP, patient must be less than 12 years old if female and less than 13 years old if male.
Prescriber Restrictions	

Coverage Duration	Prostate CA: 1 yr but 6 mos for short term use, Fibroids: 3 mos, Endometriosis: 6 mos, CPP: 1 yr
Other Criteria	
Prior Authorization Group	MECASERMIN
Drug Names	INCRELEX
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, Allergy to mecasecamin (ICF-1) or any component of the formulation, growth promotion in patients with closed epiphyses, active or suspected neoplasia
Required Medical Information	1) diagnosis of growth failure due to severe primary IGFD with (a)height standard deviation less than-3.0, (b) basal IGF-1 standard deviation scoreless than-3.0 and (c) normal or elevated growth hormone levels OR (2) diagnosis of growth failure due to growth hormone deletion with neutralizing antibodies to growth hormone AND (3) treating physician is an endocrinologist or has consulted with an endocrinologist AND (4) patient does NOT have any of the following conditions: growth hormone deficiency, malnutrition, hypothyroidism or chronic treatment with pharmacologic doses of anti-inflammatory steroids.
Age Restrictions	Patient must be a pediatric patient that is at least 2 years of age
Prescriber Restrictions	Prescribing physician must be an endocrinologist
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	METHYLNALTREXONE
Drug Names	RELISTOR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of opioid-induced constipation in patients with advanced illness AND patient is receiving palliative care AND documented trial and insufficient response to laxative therapy AND no known or suspected mechanical gastrointestinal obstruction (contraindication) AND no severe or persistent diarrhea (therapy should be discontinued in cases of severe or persistent diarrhea)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	4 months
Other Criteria	Use of methylnaltrexone in this diagnosis has not been studied beyond four months.
Prior Authorization Group	MILNACIPRAN
Drug Names	SAVELLA, SAVELLA TITRATION PACK
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	

Required Medical Information Patient has a diagnosis of fibromyalgia AND Patient does not have any of the following contraindications to milnacipran therapy: Use of monoamine oxidase inhibitors (MAOI) concomitantly or in close temporal proximity, Uncontrolled narrow-angle glaucoma.
Age Restrictions Patient is 17 years of age or older

Prescriber Restrictions

Coverage Duration 12 months

Other Criteria

Prior Authorization Group MODAFINIL

Drug Names PROVIGIL

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

Exclusion Criteria

Required Medical Information Diagnosis of excessive sleepiness associated with narcolepsy and at least one formulary/preferred treatment, such as methylphenidate, mixed amphetamine salts, or dextroamphetamine, has been ineffective or not tolerated OR Diagnosis of excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS) when both criteria 1 and 2 below are met: There is documentation of residual excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome AND There is documentation that the patient has been compliant with CPAP or BiPAP for at least 2 months. OR Diagnosis of excessive sleepiness associated with shift-work sleep disorder [SWSD] (also referred to as circadian rhythm sleep disorder) when all criteria 1 through 3 below are met: Sleep disturbance causes specific measurable functional impairment in social, occupational, or other important areas of functioning that has persisted at least 3 months AND Sleep disturbance is not due to otherwise reversible conditions. Other reversible conditions may include, but are not limited to, another sleep disorder, mental disorder, or physiological effects of another substance AND Non-pharmacologic therapies have been inadequate in improving functional impairments. Examples of non-pharmacologic therapies include, but are not limited to, planned sleep schedules and timed light exposure.

Age Restrictions Patient is 17 years of age or older

Prescriber Restrictions

Coverage Duration 12 months

Other Criteria

Prior Authorization Group NABILONE

Drug Names CESAMET

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

Exclusion Criteria

Required Medical Information Diagnosis of cancer with chemotherapy-induced nausea/vomiting AND failure to reach desired outcomes with use of two conventional antiemetics

Age Restrictions Patient must be at least 18 years of age

Prescriber Restrictions

Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	NILOTINIB
Drug Names	TASIGNA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient is in the chronic phase or accelerated phase of Philadelphia chromosome positive chronic myelogenous leukemia AND Patient does not have long QT syndrome AND Patient will have hypokalemia or hypomagnesemia corrected prior to administration of nilotinib, and levels will be monitored periodically during treatment AND Patient will have an electrocardiogram (ECG) performed at baseline, 7 days after initiation, periodically thereafter, and following any nilotinib dose-adjustments AND Patient will have complete blood counts (CBCs) performed at baseline, every 2 weeks for the first 2 months, and monthly thereafter AND Patient will have liver function (transaminases, bilirubin, and alkaline phosphatase) monitored at baseline and periodically during therapy AND Patient will have electrolyte abnormalities (hypo/hyperkalemia, hypocalcemia, hyponatremia) corrected prior to initiation of nilotinib, and monitored periodically during therapy AND Patient does not have rare hereditary problems with galactose intolerance, severe lactase deficiency with a severe degree of intolerance to lactose-containing products, or glucose-galactose malabsorption AND Concomitant therapy with strong inhibitors or inducers of CYP3A4 agents will be avoided or if unavoidable, a dose-reduction with nilotinib will be considered and the patients QT-interval will be closely monitored.
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	Oncologist experienced in the treatment of patients with hematologic malignancies
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	OMALIZUMAB
Drug Names	XOLAIR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	

Required Medical Information

Diagnosis of severe persistent allergic asthma AND Patient is 12 years of age or older and does not weigh more than 150 kg AND Patient has evidence of specific allergic sensitivity confirmed by positive skin test (i.e. prick/puncture test) or blood test (i.e. RAST) for a specific IgE or in vitro reactivity to a perennial allergen AND Patient has baseline serum IgE levels between 30 and 700 IU/mL AND Patients symptoms are not adequately controlled with a high dose of inhaled corticosteroid plus long-acting beta agonist for at least three months AND Patient has impairment in activities of daily living, exacerbations affecting activity and sleep AND Patient has two or more acute exacerbations while on controller medications within a 12 month period, including ER visits, hospitalizations, and treatment with high dose injectable or oral corticosteroids AND Patient is compliant with current asthma therapy AND Omalizumab will be administered by a physician or other licensed health care provider who has been trained to recognize and treat anaphylaxis and who has available appropriate medications, equipment, and staff to respond to anaphylaxis

Age Restrictions

Patient is 12 years of age or older

Prescriber Restrictions

Physician who specializes in allergy, immunology, or pulmonary medicine

Coverage Duration

12 months

Other Criteria

Prior Authorization Group

ONABOTULINUMTOXINA

Drug Names

BOTOX

Covered Uses

All FDA-approved indications not otherwise excluded for Part D.

Exclusion Criteria

Exclude for cosmetic indications (wrinkles, frown lines, aging neck, blepharoplasty (eyelid lift))

Required Medical Information

Approve for diagnosis of chronic migraine prophylaxis (defined as headaches on 15 or more days per month lasting four hours a day or longer) in patients who have experienced treatment failure with at least 2 first line therapies from 2 different therapeutic classes that have drugs approved for migrain prophylaxis (i.e. anticonfulsants, beta-blockers) OR Diagnosis of Focal dystonia in patients with ANY of the following types: Blepharospasm or Cervical (including spasmodic torticollis) OR Diagnosis of Axillary hyperhidrosis that significantly interferes with patient's daily activities and refractory to greater than 6 months treatment with topical aluminum chloride OR Diagnosis of Spasticity (upper limb) from ANY of the following causes: Cerebral palsy, Demyelinating disorders of the central nervous system, Hereditary paraplegia, Multiple sclerosis, Spinal cord injury, Stroke, Traumatic brain injury OR Diagnosis of Strabismus associated with dystonia, including facial nerve VII disorders.

Age Restrictions

Prescriber Restrictions

For diagnosis of Migraine, Prescriber must be a Neurologist or Pain Management Specialist

Coverage Duration

12 months

Other Criteria

Although similar in certain aspects, Botulinum toxin A and B are not interchangeable. They are chemically, pharmacologically, and clinically distinct. There is no established method to convert dosing with one neurotoxin to appropriate dosing with another neurotoxin.

Prior Authorization Group

PALIVIZUMAB

Drug Names

SYNAGIS

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information

Used for immunoprophylaxis of respiratory syncytial virus (RSV) during the peak mths of infection in the patients geographic region AND not for the treatment of RSV. Patient is younger than 2 yrs of age at beginning of RSV season with chronic lung disease (CLD) and required medical therapy (supplemental oxygen, bronchodilator, diuretic, or corticosteroid therapy) for CLD within 6 mths before the anticipated start of RSV season OR Patient is less than or equal to 12 mths of age at the start of RSV season and born at less than or equal to 28 wks gestation OR Patient is less than or equal to 6 mths of age at the start of RSV season and born between 28 wks, 1 day and 32 wks of gestation OR Patient is less than or equal to 24 mths of age with hemodynamically significant cyanotic or acyanotic congenital heart disease (CHD) OR Patient is 24 mths or younger with hemodynamically significant cyanotic and acyanotic congenital heart disease OR patient is younger than 12 months with congenital heart disease and is receiving medication to control congestive heart failure OR Has moderate to severe pulmonary hypertension OR Has cyanotic heart disease OR Patient is less than or equal to 3 months of age at the start of RSV season and born between 32 weeks, 0 days and 34 weeks, 6 days gestation with at least one of the following risk factors, Infant attends child care, defined as a home or facility where care is provided for any number of infants or young toddlers in the child care facility OR Infant has a sibling younger than 5 yrs of age AND The patient does not have hemodynamically insignificant heart disease such as: Secundum atrial septal defect, Small ventricular septal defect, Pulmonic stenosis, Uncomplicated aortic stenosis, Mild coarctation of the aorta, Patent ductus arteriosus AND patient does not have a lesion that was adequately corrected by surgery (not requiring medication for congestive heart failure) or mild cardiomyopathy that does not require medical therapy.

Age Restrictions

Patient is under 2 years of age at the start of an RSV season

Prescriber Restrictions

Coverage Duration

5 mths during RSV season OR until 3 months of age (max 3 monthly doses) for certain infants

Other Criteria

Prophylaxis against RSV should be initiated just before the onset of the RSV season and terminated at the end of the RSV season. In most seasons and in most regions of the Northern Hemisphere, the first dose should be administered at the beginning of November and the last dose, at the beginning of March, which will provide protection into April. Request for year-round dosing will be considered only when the Centers for Disease Control (CDC) guidance or regional health department recommendations are available. Individual requests must provide the following types of documents for clinical review, CDCs clinical data regarding RSV activity AND Clinical data regarding RSV activity from local health department.

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

PAZOPANIB

VOTRIENT

All FDA-approved indications not otherwise excluded from Part D.

Diagnosis of advanced renal cell carcinoma

Patient is 18 years of age or older

Prescriber is an oncologist or a healthcare provider highly familiar with prescribing and monitoring of oncology medications

12 months

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

PEGFILGRASTIM

NEULASTA

All FDA-approved indications not otherwise excluded for Part D.

Approve if anticipated that patient will require at least 10 days of white blood cell CSF therapy AND drug will be used as primary prophylaxis of febrile neutropenia associated with myelosuppressive chemotherapy OR patient's risk of febrile neutropenia is at least 20% or has risk factors if less than 20%, OR patient is receiving a dose density chemotherapy regimen OR patient had neutropenic complication from a prior cycle of chemotherapy OR patient had an autologous BMT or PBPC OR patient has diffuse aggressive lymphoma, is at least 65 years old, and being treated with curative chemotherapy OR patient is receiving radiation therapy, not on chemotherapy, and expected to have prolonged delays in treatment secondary to neutropenia

Patient is under the care of a physician with experience in prescribing pegfilgrastim

12 months

Prior Authorization Group

Drug Names

Covered Uses

PEGINTERFERON ALFA

PEG-INTRON, PEG-INTRON REDIPEN

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information

Diagnosis of Hepatitis C Viral Infection as monotherapy or in combination with ribavirin AND HCV RNA and ANC test results are documented

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

HCV 12 to 72 weeks depending on genotype and HCV RNA response.
Treatment of relapsers and non-responders: Retreatment with peginterferon plus ribavirin in patients who did not achieve an SVR after a prior full course of peginterferon plus ribavirin is not recommended, even if a different type of peginterferon is administered. Retreatment with peginterferon plus ribavirin can be considered for non-responders or relapsers who have previously been treated with non-pegylated interferon with or without ribavirin, or with peginterferon monotherapy, particularly if they have bridging fibrosis or cirrhosis. Maintenance therapy is not recommended for patients with bridging fibrosis or cirrhosis who have failed a prior course of peginterferon and ribavirin. Coverage Duration: If patient meets criteria for peginterferon alfa monotherapy or patient has HIV co-infection duration of approval is 48 weeks. If the aforementioned criteria does not apply and taking peg in combo with ribavirin, duration of approval depends on genotype. For genotype 2 and 3, approval is 24 weeks. For genotypes 4, 5, and 6 initial approval is 16 weeks and if early viral response is achieved or HCV RNA is undetectable, then additional approval = 32 weeks (total 48 weeks). For genotype 1, initial approval is 16 weeks and if complete viral response at week 12 (defined as HCV RNA undetectable [less than 50 IU/mL]), then additional approval = 32 weeks (total 48 weeks). If an early viral response is achieved (defined as greater than 2 log reduction in viral load at week 12), an additional 12 weeks is approved, recheck HCV RNA at week 24. If HCV RNA is undetectable at week 24 (less than 50 IU/mL), then additional approval = 44 weeks (total 72 weeks)..

Prior Authorization Group

Drug Names

PEGINTERFERON ALFA-2A

Covered Uses

PEGASYS

Exclusion Criteria

All FDA-approved indications not otherwise excluded from Part D.

Required Medical Information

Diagnosis of Hepatitis C Viral Infection as monotherapy or in combination with ribavirin AND HCV RNA and ANC test results are documented OR Diagnosis of Hepatitis B Viral Infection.

Age Restrictions

Prescriber Restrictions

Coverage Duration

HBV 48 weeks. HCV 12 to 72 weeks depending on genotype and HCV RNA response.

Other Criteria

Treatment of HCV relapsers and non-responders: Retreatment with peginterferon plus ribavirin in patients who did not achieve an SVR after a prior full course of peginterferon plus ribavirin is not recommended, even if a different type of peginterferon is administered. Retreatment with peginterferon plus ribavirin can be considered for non-responders or relapsers who have previously been treated with non-pegylated interferon with or without ribavirin, or with peginterferon monotherapy, particularly if they have bridging fibrosis or cirrhosis. Maintenance therapy is not recommended for patients with bridging fibrosis or cirrhosis who have failed a prior course of peginterferon and ribavirin. Coverage Duration: If patient meets criteria for peginterferon alfa monotherapy or patient has HIV co-infection duration of approval is 48 weeks. If the aforementioned criteria does not apply and taking peg in combo with ribavirin, duration of approval depends on genotype. For genotype 2 and 3, approval is 24 weeks. For genotypes 4, 5, and 6 initial approval is 16 weeks and if early viral response is achieved or HCV RNA is undetectable, then additional approval = 32 weeks (total 48 weeks). For genotype 1, initial approval is 16 weeks and if complete viral response at week 12 (defined as HCV RNA undetectable [less than 50 IU/mL]), then additional approval = 32 weeks (total 48 weeks). If an early viral response is achieved (defined as greater than 2 log reduction in viral load at week 12), an additional 12 weeks is approved, recheck HCV RNA at week 24. If HCV RNA is undetectable at week 24 (less than 50 IU/mL), then additional approval = 44 weeks (total 72 weeks).

Prior Authorization Group
Drug Names
Covered Uses
Exclusion Criteria
Required Medical Information

PEGVISOMANT
SOMAVERT
All FDA-approved indications not otherwise excluded from Part D.

Age Restrictions
Prescriber Restrictions

Patient is 18 years of age or older
Prescriber is an endocrinologist or an individual familiar with prescribing and monitoring acromegaly related medications

Coverage Duration
Other Criteria

12 months

Prior Authorization Group
Drug Names
Covered Uses
Exclusion Criteria

PENTAMIDINE
PENTAM 300
All FDA-approved indications not otherwise excluded from Part D.

Required Medical Information	Approve if: patient has confirmed or presumed severe Pneumocystis Pneumonia (PCP) AND patient has tried and failed or allergic/intolerant to Trimethoprim sulfamethoxazole OR patient has confirmed or presumed cutaneous leishmaniasis AND treatment with antimonial compounds have failed or the patient is intolerant to antimonial compounds OR patient has confirmed or presumed African trypanosomiasis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	PLERIXAFOR
Drug Names	MOZOBIL
Covered Uses	All FDA-approved indications not otherwise excluded for Part D.
Exclusion Criteria	
Required Medical Information	Patient is to undergo autologous stem cell transplantation for treatment of NHL or MM AND patient will concomitantly receive a daily dose of G-CSF for 4 days prior to the first evening dose of plerixafor and on each day prior to apheresis if female, patient is not pregnant or breastfeeding
Age Restrictions	Patient must be 18 years or older
Prescriber Restrictions	Patient must be under the care of a physician with experience in hematology/oncology and autologous stem cell transplantation
Coverage Duration	30 days
Other Criteria	
Prior Authorization Group	PREGABALIN
Drug Names	LYRICA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	QUININE SULFATE
Drug Names	QUALAQUIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for patients with any of the following contraindications to therapy: Prolongation of QT interval, Glucose-6-phosphate dehydrogenase (G6PD) deficiency, Myasthenia gravis, Known hypersensitivity to quinine, mefloquine, or quinidine, Optic neuritis.
Required Medical Information	Diagnosis: Patient is being treated for uncomplicated Plasmodium falciparum malaria OR Patient is being treated for babesiosis.

Age Restrictions	Patient is 16 years of age or older
Prescriber Restrictions	
Coverage Duration	Date of service only
Other Criteria	
Prior Authorization Group	RILONACEPT
Drug Names	ARCALYST
Covered Uses	All FDA-approved indications not otherwise excluded for Part D.
Exclusion Criteria	Coverage is not provided for use of Arcalyst in combination with TNF inhibitors or other IL-1 blockers
Required Medical Information	Diagnosis of Familial Cold Autoinflammatory Syndrome (FCAS) OR Muckle-Wells Syndrome (MWS), patient has been screened for latent tuberculosis and has been treated by standard medical practice for TB if tested positive, patient has received all recommended vaccinations
Age Restrictions	Patient must be at least 12 year of age
Prescriber Restrictions	Diagnosed by or upon consultation with an immunologist, allergist, dermatologist, rheumatologist, neurologist, or other medical specialist
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	SAPROPTERIN
Drug Names	KUVAN
Covered Uses	All FDA-approved indications not otherwise excluded for Part D.
Exclusion Criteria	
Required Medical Information	Therapeutic Trial (up to 2 months): Patient has diagnosis of Phenylketonuria (PKU) [Phe level required for documentation] AND Patient is, and will be maintained during sapropterin therapy, on a phenylalanine (Phe)-restricted diet AND Patient will have blood Phe levels measured after 1 week of therapy and periodically for up to 2 months of therapy to determine response - Continuation Therapy for Responders (after 2 months): Patient has diagnosis of Phenylketonuria (PKU) AND Patient is, and will be maintained during sapropterin therapy, on a phenylalanine (Phe)-restricted diet AND Patient has been determined to be a sapropterin responder (i.e., baseline Phe blood levels have decreased by greater than 30% from baseline level [documentation of baseline and current Phe levels are required] AND Patient will have blood Phe levels measured periodically during therapy. If the patient is a non-responder, continued therapy will not be authorized. Non-responders are those whose blood Phe levels do not decrease (i.e., by at least 30% from baseline level) after at least 1 month of therapy with a dose of 20 mg/kg/day.
Age Restrictions	Patient must be 4 years or older
Prescriber Restrictions	
Coverage Duration	Initially approve new patient 2 mths. If responder, then approve 12 months.
Other Criteria	

Prior Authorization Group	SARGRAMOSTIM
Drug Names	LEUKINE
Covered Uses	All FDA-approved indications not otherwise excluded for Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Physician with experience in prescribing sargramostim
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	SELEGILINE TRANSDERMAL
Drug Names	EMSAM
Covered Uses	All FDA-approved indications not otherwise excluded for Part D.
Exclusion Criteria	Coverage not provided for patients using Emsam in conjunction with SSRIs, SNRIs, TCAs, bupropion, buspirone, meperidine, tramadol, methadone, propoxyphene, pentazocine, dextromethorphan, St. John's Wort, mirtazaprine, cyclobenzaprine, oral selegiline, other MAOIs, oxcarbazepine, carbamazepine, and/or sympathomimetic amines
Required Medical Information	Diagnosis of major depressive disorder AND at least two oral antidepressants from differing classes OR patient is unable to take oral medications and able to adhere to dietary guidelines necessary for MAOI products
Age Restrictions	Patient must be at least 12 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	SILDENAFIL
Drug Names	REVATIO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of Pulmonary Arterial Hypertension [PAH] (WHO Group I, WHO/NYHA functional class II, III or IV) AND Patient is not taking any of the following drugs concomitantly: organic nitrates in any form, ritonavir or other potent CYP3A4 inhibitors, Viagra or any other PDE5 inhibitors
Age Restrictions	
Prescriber Restrictions	Prescription is written by a pulmonologist or cardiologist or documentation of consultation with pulmonologist or cardiologist
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	SODIUM OXYBATE
Drug Names	XYREM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria	Coverage is not provided for patients being treated with sedative hypnotic agents, patients with succinic semialdehyde dehydrogenase deficiency, a rare disorder is an inborn error of metabolism variably characterized by mental retardation, hypotonia, and ataxia.
Required Medical Information	Documented (i.e., multiple sleep latency test) diagnosis of narcolepsy with excessive daytime sleepiness, cataplexy, or both. For a diagnosis of fibromyalgia, patients must try/fail two FDA approved drugs used for the treatment of fibromyalgia.
Age Restrictions	Patients greater than 16 years of age.
Prescriber Restrictions	
Coverage Duration	Approval given for up to 3 years
Other Criteria	
Prior Authorization Group	SORAFENIB
Drug Names	NEXAVAR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has one of the following diagnoses: Advanced renal cell carcinoma OR Unresectable hepatocellular carcinoma.
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	Prescriber is an oncologist or a healthcare provider highly familiar with prescribing and monitoring of oncology medications.
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	SUNITINIB
Drug Names	SUTENT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis: Patient has one of the following diagnoses: Advanced renal cell carcinoma OR Gastrointestinal stromal tumor (GIST) after disease progression on or intolerance to imatinib (GLEEVEC).
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	Prescriber is an oncologist or a healthcare provider highly familiar with prescribing and monitoring of oncology medications.
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	SYLATRON
Drug Names	SYLATRON
Covered Uses	All FDA approved indications not otherwise excluded from Part D, chronic myelogenous leukemia.
Exclusion Criteria	Autoimmune hepatitis, decompensated hepatic disease, uncontrolled major depression or severe mental illness.

Required Medical Information	For melanoma, all of the following initial criteria are required: melanoma has microscopic or gross nodal involvement AND Sylatron is used following surgical resection of the tumor and complete lymphadenectomy AND Sylatron is being requested for use within 84 days (12 weeks) of the surgical resection. For CML, the patient meets one of the following criteria: patient is unable to tolerate a tyrosine kinase inhibitor (e.g., imatinib, dasatinib, or nilotinib) OR patient is post-transplant without remission or with relapse of CML.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	The patient is monitored and evaluated for signs and symptoms of depression and other psychiatric symptoms throughout treatment with Sylatron.
Prior Authorization Group	TAZAROTENE
Drug Names	TAZORAC
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of stable moderate to severe plaque psoriasis (psoriasis vulgaris) with less than 20% body surface area involvement OR Patient has a diagnosis of acne vulgaris of mild to moderate severity AND Patient has tried adequate treatment (at least 2 weeks) of two topical acne products (e.g., benzoyl peroxide, salicylic acid, clindamycin, erythromycin, adapalene, azelaic acid, and/or tretinoin) or two topical psoriasis products (e.g., medium to high potency corticosteroids and/or vitamin D analogs) OR Patient has contraindications to other topical acne or topical psoriasis medications AND Female patients of child-bearing potential are utilizing adequate birth-control measures (pharmacological and/or barrier) during therapy OR Female patients of child-bearing potential not utilizing adequate birth-control measures have a documented negative pregnancy test 2 weeks prior to initiation of tazarotene therapy AND All Female patients of child-bearing potential have been warned of the potential risk of using tazarotene
Age Restrictions	Patient is 12 years of age or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	TELITHROMYCIN
Drug Names	KETEK
Covered Uses	All FDA-approved indications not otherwise excluded for Part D.

Exclusion Criteria	Coverage is not provided in patients with myasthenia gravis, previous history of hepatitis and/or jaundice associated with the use of telithromycin, or any macrolide antibiotic, history of hypersensitivity to telithromycin and/or any components of telithromycin, or any macrolide antibiotic, currently taking cisapride or pimozone
Required Medical Information	Diagnosis
Age Restrictions	Patient must be 18 years or older
Prescriber Restrictions	
Coverage Duration	14 days
Other Criteria	
Prior Authorization Group	TESTOSTERONE
Drug Names	ANDRODERM, ANDROGEL, STRIANT, TESTIM, TESTOSTERONE CYPIONATE, TESTOSTERONE ENANTHATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Male patients with normal or above normal testosterone levels (normal equal to 270-1070 ng/dl or 9.3-37 mmol), breast cancer in males, hypersensitivity to testosterone or any component of the product, pregnancy, known or suspected prostate cancer, use of the gel or patch in women
Required Medical Information	Diagnosis and testosterone level less than 270 ng/dl or 9.3mmol
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year (AIDS wasting), as requested for hypogonadism
Other Criteria	
Prior Authorization Group	TETRABENAZINE
Drug Names	XENAZINE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient must not have any of the following contraindications to therapy: Actively suicidal, Untreated or inadequately treated depression, Impaired hepatic function, Concomitant use of monoamine oxidase inhibitors (e.g., MARPLAN [isocarboxazid], NARDIL [phenelzine], PARNATE [tranylcypromine], AZILECT [rasagiline], EMSAM [selegiline], ZELAPAR [selegiline], ELDEPRYL [selegiline]), Concomitant use of reserpine or within 20 days of discontinuing reserpine.

Required Medical Information	Patient is being treated for chorea associated with Huntingtons disease OR Patient is being treated for tardive dyskinesia OR Patient is being treated for Gilles de la Tourettes syndrome AND Any medication possibly contributing to the underlying symptoms of chorea and/or tardive dyskinesia has been discontinued (e.g. antipsychotics, metoclopramide, amphetamines, methylphenidate, dopamine agonists, etc.) unless cessation would be detrimental to the underlying condition AND Patient will be routinely monitored for signs/symptoms of depression and suicidality during therapy and subsequent treatment initiated if/when necessary, AND For patients requiring doses greater than 50 mg per day, patient will be genotyped for CYP2D6 to determine whether they are poor metabolizers (PMs) [do not express CYP2D6] or extensive or intermediate metabolizers (EMs or IMs) [express CYP2D6].
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	Initiated by or on recommendation/consultation of a neurologist or psychiatrist
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	TOPICAL RETINOID-TYPE PRODUCTS
Drug Names	ADAPALENE, ATRALIN, AVITA, DIFFERIN, RETIN-A MICRO, TRETINOIN, ZIANA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of mild to moderate acne vulgaris
Age Restrictions	Patients greater than 40 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	TREPROSTINIL-INJ
Drug Names	REMODULIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of Pulmonary Arterial Hypertension [PAH] (WHO Group I) in Class III - IV patients OR Diagnosis of PAH (WHO Group I) in Class II patients who do not respond adequately to or are unable to tolerate conventional therapy, such as REVATIO (sildenafil), ADCIRCA (tadalafil), TRACLEER (bosentan) or LETAIRIS (ambrisentan).
Age Restrictions	
Prescriber Restrictions	Prescription is written by a pulmonologist or cardiologist or documentation of consultation with pulmonologist or cardiologist
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	TRIPTORELIN
Drug Names	TRELSTAR DEPOT MIXJECT, TRELSTAR LA MIXJECT, TRELSTAR MIXJECT

Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for Females who are pregnant or lactating, Concomitant use with other LHRH agents.
Required Medical Information	Patient is male AND Patient has a diagnosis of advanced or metastatic prostate cancer OR Patient has as an intermediate to high risk of disease recurrence AND Orchiectomy is not indicated or not acceptable to the patient
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	Oncologist or an individual highly familiar with prescribing and monitoring of oncology related medications
Coverage Duration	12 months
Other Criteria	
Prior Authorization Group	WEIGHT LOSS ANTI-OBESITY
Drug Names	XENICAL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for Non-alcoholic steatohepatitis, Polycystic ovarian syndrome, Coronary arteriosclerosis, prophylaxis, Diabetes mellitus, prophylaxis, Diabetes mellitus type 2, Drug-induced obesity, Hyperlipidemia, Binge eating disorder, Obesity, pediatrics, except Xenical (Rx) which may be used in children greater than 12 years and Meridia which may be used in children greater than 16 years, Diabetic peripheral neuropathy, Peripheral neuropathic pain.
Required Medical Information	Diagnosis of obesity when the following criteria are met Documentation of BMI greater than or equal to 30 kg/m ² OR Documentation of BMI greater than 27 kg/m ² with one or more of the following obesity related risk factors Hypertension, Dyslipidemia, Type 2 diabetes mellitus, Sleep apnea, Coronary heart disease, AND Documentation indicating drug therapy is part of a comprehensive plan which includes diet, physical activity, and behavior therapy AND Medication will not be used in combination with another anti-obesity agent.
Age Restrictions	Xenical (Rx) may be used in children greater than 12 years and Meridia may be used in children greater than 16 years, for all other weight-loss meds patient is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year unless medications indicated for short term therapy will be approved for 12 weeks.
Other Criteria	
Prior Authorization Group	XALKORI
Drug Names	XALKORI
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of locally advanced or metastatic non-small cell lung cancer that is ALK-positive as detected by an FDA-approved test.

Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Prior authorization applies to new starts only. Refills will be approved unless use is not coverable under Part D per Medicare drug coverage policies.
Prior Authorization Group	ZELBORAF
Drug Names	ZELBORAF
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of unresectable or metastatic melanoma AND the tumor is positive for the BRAF V600E mutation as detected by an FDA-approved test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Prior authorization applies to new starts only. Refills will be approved unless use is not coverable under Part D per Medicare drug coverage policies.
Prior Authorization Group	ZOLEDRONIC ACID
Drug Names	ZOMETA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not allowed for any of the following contraindications to therapy or conditions for which zoledronic acid therapy: hypersensitivity to zoledronic acid or any of its components, severe renal impairment, pregnancy or lactation, history of or has reported osteonecrosis of the jaw (ONJ), severe, incapacitating muscle, joint or bone pain.
Required Medical Information	Diagnosis of one of the following: hypercalcemia of malignancy (HCM) or bone metastases of solid tumors (i.e., breast cancer, prostate cancer) in conjunction with standard antineoplastic therapy in patients with bone metastases associated with prostate cancer, zoledronic acid should be used as second-line therapy, being reserved for those with disease progression following at least one hormonal therapy (i.e., antiandrogen (bicalutamide, flutamide, nilutamide), LHRH agonist [leuprolide, goserelin], LHRH antagonists [degarelix]) or multiple myeloma (MM) with associated bone disease (defined as bone metastases, osteolytic lesions, osteopenia, etc) AND Zoledronic acid one-time dose does not exceed 4 mg AND Patient is not being treated with RECLAST (zoledronic acid).
Age Restrictions	Patient must be 18 years or older.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	