



## **PA Criteria**

<b>Prior Authorization Group</b>	ADAGEN
<b>Drug Names</b>	ADAGEN
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Adagen® is NOT covered for members with the following criteria: A. Patient has diagnosis of severe thrombocytopenia B. Patient with bone marrow transplantation
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	initiated and monitored by a specialist well-versed in management of ADA deficiency.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approved for patients who are not suitable candidates for or who have failed bone marrow transplantation. Not intended as a replacement for HLA identical bone marrow transplant therapy or to replace continued close medical supervision and the initiation of appropriate diagnostic tests and therapy (eg, antibiotics, nutrition, oxygen, gammaglobulin) as indicated for intercurrent illnesses.
<b>Prior Authorization Group</b>	AFINITOR
<b>Drug Names</b>	AFINITOR
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	

A Health Plan with a Medicare Contract

A Coordinated Care Plan with a Medicare Advantage contract and a contract with the state Medicaid program.

<b>Prior Authorization Group</b>	ALDURAZYME
<b>Drug Names</b>	ALDURAZYME
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Aldurazyme® is NOT covered for members with the following criteria: A. The patient has laronidase hypersensitivity.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Therapy must be initiated and monitored by a specialist well-versed in management of this condition.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	ALZHEIMER'S MEDICATIONS
<b>Drug Names</b>	EXELON, RIVASTIGMINE TARTRATE
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Alzheimer's medications are NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: breast-feeding, GI bleeding, jaundice, renal failure or carbamate hypersensitivity. B. If the patient is taking dofetilide.
<b>Required Medical Information</b>	Neurology reports documenting diagnosis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	AMITIZA
<b>Drug Names</b>	AMITIZA
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Amitiza® is NOT covered for members with the following criteria: A. The patient has diarrhea. B The patient has a GI obstruction.
<b>Required Medical Information</b>	Documentation showing trial and failure of conventional formulary agents (lactulose and PEG 3350). If female, documentation showing patient is on a reliable form of contraception.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	AMPYRA
<b>Drug Names</b>	AMPYRA
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Patient has documented difficulty walking, no history of seizure disorder, renal function Creatinine Clearance 50mL/min-
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 month approval
<b>Other Criteria</b>	Diagnosis of multiple sclerosis and has documented difficulty walking, no history of seizure disorder, renal function Creatinine Clearance 50mL/min
<b>Prior Authorization Group</b>	ANAGRELIDE
<b>Drug Names</b>	ANAGRELIDE HYDROCHLORIDE
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Anagrelide is NOT covered for members with the following criteria: A. Severe hepatic impairment B.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Must be prescribed by a hematologist.
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	ARALAST
<b>Drug Names</b>	ARALAST NP
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Aralast is NOT covered for members who meet the following criteria: members with selective IgA deficiencies and who have known antibody against IgA
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Therapy must be initiated by a specialist well-versed in treating Alpha1-PI deficiency.
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	ARANESP
<b>Drug Names</b>	ARANESP ALBUMIN FREE
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Uncontrolled hypertension, use in patients with nonmetastatic or curable cancer, use in myeloid cancer, hemoglobin at or exceeding 13 g/dL
<b>Required Medical Information</b>	Patients with low iron stores require concomitant iron supplementation, pretreatment hemoglobin level less than 10 g/dL (or less than 11 g/dL with clinical symptoms of anemia). Cancer patients with anemia must be currently receiving myelosuppressive chemotherapy. Patients with myelodysplastic syndrome (MDS) may receive drug for symptomatic anemia provided the MDS is not associated with del(5q) cytogenetic abnormality and serum EPO is less than or equal to 500 mU/mL. Once on therapy, the patient must show an objective clinical response to treatment (ie, rise in hemoglobin or hematocrit from baseline). If hemoglobin increases significantly (eg, more than 1 g/dL in any 2 week period) or exceeds 12 g/dL, the prescriber must reduce dose. Patients must report any signs or symptoms of cardiovascular or thrombotic adverse events to the prescriber.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 weeks?
<b>Other Criteria</b>	

**Prior Authorization Group** ARCALYST  
**Drug Names** ARCALYST  
**Covered Uses** All FDA approved indications not otherwise excluded from Part D  
**Exclusion Criteria** Active or chronic infection. Concurrent therapy with other biologics.  
**Required Medical Information**  
**Age Restrictions** 12 years of age and older  
**Prescriber Restrictions**  
**Coverage Duration** Plan Year  
**Other Criteria**

**Prior Authorization Group** ARIXTRA  
**Drug Names** ARIXTRA  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria**  
**Required Medical Information** Patient has adequate renal function (creatinine clearance 30 mL/min). Patient's body weight is great then 50kg. Patient's liver function tests are within normal limits (ALT and AST less then35 U/L).  
**Age Restrictions** Minimum of 18 years of age  
**Prescriber Restrictions**  
**Coverage Duration** up to 32 days per incident  
**Other Criteria**

**Prior Authorization Group**

**Drug Names**

B VS. D

A-METHAPRED, ABILIFY, ACTEMRA, AMINOSYN, AMINOSYN 7%/ELECTROLYTES, AMINOSYN 8.5%/ELECTROLYTE, AMINOSYN II, AMINOSYN II 3.5%/DEXTROSE, AMINOSYN II 3.5%/DEXTROSE, AMINOSYN II 4.25%/DEXTROSE, AMINOSYN II 5%/DEXTROSE 25, AMINOSYN II 8.5%/ELECTROL, AMINOSYN II M 3.5%/DEXTRO, AMINOSYN M, AMINOSYN-HBC, AMINOSYN-HF, AMINOSYN-PF, AMINOSYN-PF 7%, AMPICILLIN SODIUM, AMPICILLIN-SULBACTAM, AZITHROMYCIN, BLEOMYCIN SULFATE, CALCITRIOL, CAMPATH, CANCIDAS, CARBOPLATIN, CEFAZOLIN SODIUM, CEFEPIME, CEFOXITIN SODIUM, CEFTRIAZONE SODIUM, CELLCEPT, CHORIONIC GONADOTROPIN, CUBICIN, CYCLOSPORINE MODIFIED, DAUNOXOME, ELITEK, ERYTHROCIN LACTOBIONATE, GANCICLOVIR, GENTAMICIN SULFATE/0.9% S, GENTAMICIN SULFATE/SODIUM, HECTOROL, HEPARIN SODIUM, HEPARIN SODIUM/D5W, HEPARIN SODIUM/NACL 0.45%, HEPARIN SODIUM/SODIUM CHL, ISOTONIC GENTAMICIN, ISTODAX, LEVOCARNITINE, LIDOCAINE/PRILOCAINE, METHYLPREDNISOLONE ACETAT, METHYLPREDNISOLONE SODIUM, MIACALCIN, MORPHINE SULFATE, MYCOPHENOLATE MOFETIL, NAFCILLIN SODIUM, NOVAREL, OCTREOTIDE ACETATE, PREGNYL W/DILUENT BENZYL, PRIMAXIN IV, PROGRAF, PROLEUKIN, RELISTOR, REMICADE, SOLU-CORTEF, TACROLIMUS, TAXOTERE, TESTOSTERONE CYPIONATE, TESTOSTERONE ENANTHATE, TOBI, TOPOSAR, TREANDA, TRELSTAR MIXJECT, TYGACIL, VANCOMYCIN HCL, VELCADE, VIDAZA, VIMPAT, ZYVOX

**Covered Uses**

NA

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

NA

**Other Criteria**

**Prior Authorization Group** BANZEL  
**Drug Names** BANZEL  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE Banzel® is NOT covered for members who meet the following criteria: A. If the patient has short QT syndrome.  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 1 year  
**Other Criteria**

**Prior Authorization Group** BONIVA INJECTABLE  
**Drug Names** BONIVA  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE Boniva Injection is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: hypocalcemia or phosphonate hypersensitivity.  
**Required Medical Information** Documentation showing intolerance to oral Boniva.  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 12 months  
**Other Criteria**

**Prior Authorization Group** BUPHENYL  
**Drug Names** BUPHENYL  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE Buphenyl® is NOT covered for members with the following criteria: A. To treat acute hyperammonemia.  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions** Therapy must be initiated and monitored by a specialist well-versed in the management of these conditions  
**Coverage Duration** 12 months  
**Other Criteria**

**Prior Authorization Group** BYETTA  
**Drug Names** BYETTA  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.

**Exclusion Criteria**  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 12 months  
**Other Criteria**

**Prior Authorization Group** CAMPRAL  
**Drug Names** CAMPRAL  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.

**Exclusion Criteria** NON COVERAGE Campral® delayed-release tablets are NOT covered for members with the following criteria: A. If the patient has renal failure. B. Will not be approved for individuals who have not undergone detoxification and not achieved alcohol abstinence prior to Campral treatment.

**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions** Must be prescribed by someone involved with member's management program  
**Coverage Duration** 6 months  
**Other Criteria** Approved for patients who are abstinent at treatment initiation. Must be used as part of a comprehensive management program that includes psychosocial support.

**Prior Authorization Group** CAPASTAT  
**Drug Names** CAPASTAT SULFATE  
**Covered Uses** All FDA approved indications not otherwise excluded from Part D

**Exclusion Criteria**  
**Required Medical Information** The following copies of chart notes/laboratory reports are required: A. Culture and Sensitivity report showing susceptibility of bacteria to Capastat

**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 6 Months  
**Other Criteria**

<b>Prior Authorization Group</b>	CAYSTON
<b>Drug Names</b>	CAYSTON
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	CELEBREX
<b>Drug Names</b>	CELEBREX
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Celebrex is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: coronary artery bypass graft surgery (CABG), NSAID hypersensitivity, salicylate hypersensitivity or sulfonamide hypersensitivity.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	CEREZYME
<b>Drug Names</b>	CEREZYME
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Cerezyme® is NOT covered for members with the following criteria: A. If the patient is taking Miglustat.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Therapy must be initiated by a specialist well-versed in the treatment of this condition.
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	Approved for long-term enzyme replacement therapy for patients with a confirmed diagnosis of Type 1 Gaucher disease that results in 1 or more of the following conditions: 1) Anemia 2) Thrombocytopenia 3) Bone disease 4) Hepatomegaly or splenomegaly

<b>Prior Authorization Group</b>	CHANTIX
<b>Drug Names</b>	CHANTIX
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Concurrent Zyban use
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 weeks initial, 12 weeks additional upon renewal
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	EFFIENT
<b>Drug Names</b>	EFFIENT
<b>Covered Uses</b>	All FDA approved uses not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	ELAPRASE
<b>Drug Names</b>	ELAPRASE
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Prescriber to submit at least one of the following test results: " Screening test *Presence or absence of mucopolysaccharides (also called glycosaminoglycans or GAG) in the urine " Enzyme test *Measures I2S activity in serum, white blood cells, or fibroblasts from skin biopsy " DNA test *Detects the specific genetic changes that code for the missing enzyme. Dosage prescribed is within the FDA recommended dose of 0.5 mg/kg of body weight administered once weekly as an intravenous (IV) infusion.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	A specialist in the treatment of metabolic diseases.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Molina Healthcare will approve Elaprasedipyrone when the following medical necessity criteria are met: Criteria for Initiation of Therapy Elaprasedipyrone (Idursulfase) may be considered medically necessary for all Hunter Syndrome members who meet ALL of the following criteria: 1. Prescribed for treatment of Hunter Syndrome 2. A definitive diagnosis of Hunter Syndrome documented by laboratory exams and/or reports. 3. Dosage prescribed is within the FDA recommended dose of 0.5 mg/kg of body weight administered once weekly as an intravenous (IV) infusion. 4. Infusion will be given in a safe setting, with capacity to respond to anaphylactoid reactions

<b>Prior Authorization Group</b>	ELOXATIN
<b>Drug Names</b>	OXALIPLATIN
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Eloxatin® is NOT covered for members who meet the following criteria: A. If the patient is female and she is pregnant. B. Known platinum compound hypersensitivity. C. If the patient is receiving live vaccines.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Hematologist/Oncologist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

**Prior Authorization Group** EMEND  
**Drug Names** EMEND  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE Emend® is NOT covered for members with the following criteria: A. If the patient is taking/receiving any of the following: Astemizole, Cisapride, Pimozide or Terfenadine.  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 3 day treatment per round of chemotherapy  
**Other Criteria**

**Prior Authorization Group** EMSAM  
**Drug Names** EMSAM  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE EMSAM® is NOT covered for members with the following criteria: A. If the patient has any of the following contraindications: surgery, MAOI therapy or pheochromocytoma. B. If the patient is taking/receiving any of the following: Altretamine, Bupropion, Buspirone, Caffeine, Carbamazepine, Cocaine, Cyclobenzaprine, Dextromethorphan, Ethanol, Furazolidone, General Anesthetics, Green Tea, Guarana, Isoniazid, INH, Kava Kava, Piper methysticum, Linezolid, Local Anesthetics, Meperidine, Methadone, Methyldopa, Mirtazapine, Monoamine oxidase inhibitors (MAOIs), Oxcarbazepine, Propoxyphene, Psychostimulants, S-adenosyl-L-methionine, SAM-e, Selective norepinephrine reuptake inhibitors, Selective serotonin reuptake inhibitors (SSRIs), Serotonin norepinephrine reuptake inhibitors, Serotonin-Receptor Agonists, St. John's Wort, Hypericum perforatum, Sympathomimetics, Tramadol, Trazodone, Tricyclic antidepressants, Tryptophan, 5-Hydroxytryptophan or Yohimbine.  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions** guidance of a psychiatrist.  
**Coverage Duration** 12 months  
**Other Criteria** Approved for the treatment of major depressive disorder (MDD). The American Psychiatric Association recommends reserving MAOI therapy for patients who do not respond to other treatments.

<b>Prior Authorization Group</b>	EXJADE
<b>Drug Names</b>	EXJADE
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Exjade® is NOT covered for members with the following criteria A. If the patient is taking/receiving any of the following: Deferoxamine, Iron Dextran, Iron Salts, Iron Sucrose, Polysaccharide-Iron Complex or Sodium Ferric Gluconate Complex. B. Member has not failed or is not intolerant to Desferal
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Patients 2 years of age or older.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	FABRAZYME
<b>Drug Names</b>	FABRAZYME
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Fabrazyme® is NOT covered for members with the following criteria: A. Known hypersensitivity to mannitol.
<b>Required Medical Information</b>	Diagnosis is to be made utilizing alpha galactosidase assays and confirmed by molecular studies
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	FORTEO
<b>Drug Names</b>	FORTEO
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation showing bone mineral density that is 2.5 or more standard deviations below that of a "young normal" adult (T-score at or below -2.5). AND Documentation showing Actonel (risedronate) or Fosamax (alendronate) are not effective after at least a 24-month treatment period based on objective documentation except if: 1. Actonel or Fosamax are contraindicated based on current medical literature and objective documentation describing the contraindication is provided. OR 2. Actonel or Fosamax are not tolerated due to documented clinical side effects.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	2 years
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	FRAGMIN
<b>Drug Names</b>	FRAGMIN
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Fragmin is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: bleeding, GI bleeding, hemophilia, heparin hypersensitivity, heparin-induced thrombocytopenia (HIT), idiopathic thrombocytopenic purpura (ITP), porcine protein hypersensitivity or use prior/post lumbar puncture, epidural anesthesia or spinal anesthesia. B. If the patient is taking/ receiving any of the following: mifepristone.
<b>Required Medical Information</b>	Patient's liver function tests are within normal limits (ALT and AST less than 35 U/L).
<b>Age Restrictions</b>	Patient is 18 years of age.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 Months
<b>Other Criteria</b>	Patient has unstable angina or non-Q wave myocardial infarction AND is at risk for thromboembolic complications ONLY when concurrently administered with aspirin.

**Prior Authorization Group** GARDASIL  
**Drug Names** GARDASIL  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE Gardasil is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: elderly  
**Required Medical Information**  
**Age Restrictions** (ACIP) recommends that the human papillomavirus vaccine, quadrivalent be routinely given to girls when they are 11 to 12 years old. The ACIP recommendation also allows for vaccination of girls beginning at nine years old and vaccination of women 13 to 26 years old.  
**Prescriber Restrictions**  
**Coverage Duration** 12 months  
**Other Criteria**

**Prior Authorization Group** GEODON  
**Drug Names** GEODON  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE Geodon is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: acute MI, AV block, bundle-branch block, cardiac arrhythmias, congenital heart disease, heart failure, hypokalemia, hypomagnesemia, intravenous administration, MI, QT prolongation, torsade de pointes or dementia-related psychosis in elderly. B. If the patient is taking/ receiving any of the following: Alfuzosin, Amoxapine, Arsenic trioxide, Astemizole, Bepidil, Chloroquine, Cisapride, Clarithromycin, Class IA antiarrhythmics, Class III antiarrhythmics, Clozapine, Cocaine, Dasatinib, Dolasetron, Droperidol, Erythromycin, Flecainide, Gatifloxacin, Gemifloxacin, Grepafloxacin, Halofantrine, Haloperidol, Lapatinib, Levofloxacin, Levomethadyl, maprotiline, Methadone, Moxifloxacin, Nilotinib, Ondansetron, palonosetron, Pentamidine, Phenothiazines, pimozone, ProbucoPropafenone, Sertindole, Sparfloxacin, Sunitinib, Tacrolimus, Telithromycin, Terfenadine, Tricyclic antidepressants, Troleandomycin, vardenafil or Vorinostat.

**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 6 months  
**Other Criteria**

**Prior Authorization Group** GROWTH HORMONE  
**Drug Names** TEV-TROPIN  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE Growth hormones are NOT covered for the following criteria: A. If the patient meets any of the following contraindications: diabetic retinopathy, epiphyseal closure, neoplastic disease. B. Contraindicated for obese patients if indication is Prader-Willi Syndrome.

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** 12 months

**Other Criteria**

**Prior Authorization Group** HALOPERIDOL DECANOATE  
**Drug Names** HALOPERIDOL DECANOATE  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE Haloperidol decanoate is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: CNS depression, coma, parkinson's disease.

**Required Medical Information** Documentation showing patient has failed oral haloperidol therapy, or has demonstrated non compliance to oral therapy

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** Therapy must be initiated by psychiatry.

**Other Criteria** 12 months

**Prior Authorization Group** HOME INFUSION THERAPY - ACUTE CARE  
**Drug Names** FENTANYL CITRATE  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** Renewable every 6 months

**Other Criteria**

**Prior Authorization Group** HUMIRA

**Drug Names** HUMIRA, HUMIRA PEN-CROHNS DISEASE

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

**Exclusion Criteria** NON COVERAGE  
Humira® is NOT covered for members with the following criteria:  
A. If the patient has any of the following contraindications: infection, influenza or sepsis.  
B. If the patient is taking/receiving any of the following Abatacept, Anakinra, Etanercept, Infliximab or Riloncept.

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions** Rheumatologist, Dermatologist, Gastroenterologist

**Coverage Duration** 3 months

**Other Criteria**

**Prior Authorization Group** IGF DEFICIENCY MEDICATIONS

**Drug Names** INCRELEX

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

**Exclusion Criteria** NON COVERAGE IGF deficiency medications are not covered for members who meet the following criteria: A. If the patient has any of the following contraindications: benzyl alcohol hypersensitivity, epiphyseal closure, intravenous administration, neonates or neoplastic disease.

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** 12 months

**Other Criteria**

**Prior Authorization Group** IMMUNE GLOBULINS  
**Drug Names** GAMASTAN S/D, GAMMAGARD LIQUID, GAMUNEX  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE Immune globulin is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: IgA deficiency.  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 6 months  
**Other Criteria**

**Prior Authorization Group** INTERFERONS (NON-HEPC)  
**Drug Names** ACTIMMUNE  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria**  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 6 months  
**Other Criteria**

<b>Prior Authorization Group</b>	INVEGA
<b>Drug Names</b>	INVEGA, SAPHRIS
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Invega® is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: AV block, bundle-branch block, cardiac arrhythmias, QT prolongation, torsade de pointes or dementia. B. If the member is taking/receiving any of the following: Mesoridazine or Thioridazine.
<b>Required Medical Information</b>	The following copies of chart notes/laboratory reports are required: A.Documentation of diagnosis B.If diagnosis is schizophrenia: a.Documentation of previous trial/failure on two or more of the following: i.Clozapine ii.Risperidone iii.Seroquel iv.Zyprexa v.Abilify vi.Geodon
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	ISOTRETINOIN
<b>Drug Names</b>	AMNESTEEM, CLARAVIS, SOTRET
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Isotretinoin is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: pregnancy, papilledema, paraben or retinoid hypersensitivity.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

**Prior Authorization Group** ITRACONAZOLE  
**Drug Names** ITRACONAZOLE  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria**  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 6 months  
**Other Criteria**

**Prior Authorization Group** JALYN  
**Drug Names** JALYN  
**Covered Uses** All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** member currently on a strong inhibitor of CYP3A4  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 12 months  
**Other Criteria** failure on, contraindication to or intolerance to formulary alternatives finasteride and tamsulosin

**Prior Authorization Group** LETAIRIS  
**Drug Names** LETAIRIS  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE Letairis® is NOT covered for members with the following criteria: A. If the patient has any of the following contraindications: pregnancy or breast-feeding. B. Members with severe anemia.  
**Required Medical Information** Documentation of baseline liver function tests (ALT, AST) performed prior to initiation of therapy. If member is a woman of childbearing potential: Documentation of a baseline negative pregnancy test prior to initiation of therapy.  
**Age Restrictions**  
**Prescriber Restrictions** Pulmonologist or Cardiologist  
**Coverage Duration** 4 months  
**Other Criteria**

<b>Prior Authorization Group</b>	LEUKINE
<b>Drug Names</b>	LEUKINE
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For use following induction or consolidation chemotherapy in AML: there are less than 10% leukemic myeloid blasts in bone marrow or peripheral blood. For patients with nonmyeloid malignancies receiving myelosuppressive chemotherapy: Leukine may be used for the prevention of chemotherapy-induced neutropenia if the regimen has a 20% or more risk of neutropenia OR the patient experienced febrile neutropenia with a previous chemotherapy cycle. Patients without severe risk for neutropenia may also receive Leukine for prophylaxis if there is a risk for serious medical consequences due to febrile neutropenia and the intent of chemotherapy to prolong survival or cure the disease. Leukine is allowable for the treatment of febrile neutropenia in patients who have received prophylaxis with Leukine (or Neupogen) OR in patients at risk for infection-related complications. Leukine is allowable for patients with neutropenia due to myelodysplastic syndrome if they have a history or recurrent or resistant infections. All patients must receive baseline and regular monitoring of complete blood counts and platelet counts.

**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration**  
**Other Criteria**

6 months

<b>Prior Authorization Group</b>	LEUPROLIDE PRODUCTS
<b>Drug Names</b>	LEUPROLIDE ACETATE, LUPRON DEPOT, LUPRON DEPOT-PED
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Leuprolide is NOT covered for members with the following criteria: A. If the patient has any of the following contraindications: breast-feeding, females, or pregnancy.

**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration**  
**Other Criteria**

6 months

<b>Prior Authorization Group</b>	LOTRONEX
<b>Drug Names</b>	LOTRONEX
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Lotronex® is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: Colitis, Constipation, Crohn's disease, Diverticulitis, GI obstruction, GI perforation, Hepatic disease, Thrombophlebitis, Toxic megacolon, or Ulcerative colitis. B. If the member is taking/receiving the following medications: Apomorphine and Fluvoxamine.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Lotronex is prescribed only by physicians who have enrolled in prescribing program
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	Approved for female patients only

<b>Prior Authorization Group</b>	LOVENOX
<b>Drug Names</b>	ENOXAPARIN SODIUM, LOVENOX
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Lovenox is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: bleeding, GI bleeding, hemophilia, heparin hypersensitivity, heparin-induced thrombocytopenia (HIT), idiopathic thrombocytopenic purpura (ITP), procine protein hypersensitivity or use prior/post lumbar puncture, epidural anesthesia or spinal anesthesia. B. If the member is taking/receiving any of the following: Mifepristone.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Patient is greater than 18 years of age.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	30 days
<b>Other Criteria</b>	

**Prior Authorization Group** LYRICA  
**Drug Names** LYRICA  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.

**Exclusion Criteria**  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 6 months  
**Other Criteria**

**Prior Authorization Group** MOZOBIL  
**Drug Names** MOZOBIL  
**Covered Uses** All FDA approved indications not otherwise excluded from Part D  
**Exclusion Criteria** Concurrent diagnosis of leukemia  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 6 months  
**Other Criteria** Mozobil is given in combination with granulocyte-colony stimulating factor

**Prior Authorization Group** MULTIPLE SCLEROSIS  
**Drug Names** AVONEX, BETASERON, COPAXONE, REBIF, REBIF TITRATION PACK  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.

**Exclusion Criteria**  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 12 months  
**Other Criteria**

**Prior Authorization Group** MYOZYME  
**Drug Names** MYOZYME  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.

**Exclusion Criteria**  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 12 months  
**Other Criteria**

**Prior Authorization Group** NAGLAZYME  
**Drug Names** NAGLAZYME  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.

**Exclusion Criteria**  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** Renewable every 6 months  
**Other Criteria**

**Prior Authorization Group** NEUTROPENIA MEDICATIONS  
**Drug Names** NEUPOGEN  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.

**Exclusion Criteria** NON COVERAGE neutropenia medications are NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: E. coli hypersensitivity.

**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 6 months  
**Other Criteria**

**Prior Authorization Group** NEXAVAR  
**Drug Names** NEXAVAR  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria**  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions** Hematologist/Oncologist  
**Coverage Duration** 6 months  
**Other Criteria**

**Prior Authorization Group** NICOTINE  
**Drug Names** NICOTROL INHALER, NICOTROL NS  
**Covered Uses** All FDA approved indications not otherwise excluded from Part D  
**Exclusion Criteria** Nonsmokers, during immediate post-MI period, life-threatening arrhythmias, severe or worsening angina pectoris  
**Required Medical Information** Documentation that the patient has stopped smoking before starting medication B.  
Documentation that the patient is enrolled in a smoking cessation program  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 3 months  
**Other Criteria**

**Prior Authorization Group** NOVANTRONE  
**Drug Names** MITOXANTRONE HCL  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE Mitoxantrone is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: breast-feeding, intraarterial administration, intramuscular administration, intrathecal administration, subcutaneous administration or neutropenia.  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 6 months  
**Other Criteria**

<b>Prior Authorization Group</b>	NOXAFIL
<b>Drug Names</b>	NOXAFIL
<b>Covered Uses</b>	All FDA -approved indications not otherwise excluded from Part D. Also may be used for the treatment of serious fungal infections caused by Cryptococcus neoformans, Fusarium, Basidiomycetes, Blastomyces, Coccidioides, Histoplasma, Scedosporium, and Cryptococcus species, in patients intolerant of, or refractory to fluconazole, itraconazole or verconazole.
<b>Exclusion Criteria</b>	NON COVERAGE Noxafil® is NOT covered for members who meet the following criteria: A. If the member is taking/receiving any of the following: Astemizole, Cisapride, Ergot Alkaloids, halofantrine, Pimozide, Quinidine, Red yeast rice, Sirolimus or Terfenadine.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Patient is 13 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approved for the treatment of oropharyngeal candidiasis in patients who have failed treatment on ketoconazole, fluconazole, itraconazole or verconazole and for the prophylaxis of invasive Aspergillus and Candida infections in immunocompromised patients.

<b>Prior Authorization Group</b>	NUEDEXTA
<b>Drug Names</b>	NUEDEXTA
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	hypersensitivity to Quinidine, Quinine, Mefloquine or dextromethorphan. quinidine, quinine, or mefloquine or have a history of quinine, mefloquine, or quinidine-induced thrombocytopenia, hepatitis, bone marrow depression, lupus-like syn-drome. concurrent use of medications that prolong the QT interval or personal history of Prolonged QT interval. Congenital long QT syndrome. History of torsades de pointes. Heart failure. Use of an MAOI in the last 14 days
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	NUVIGIL
<b>Drug Names</b>	NUVIGIL
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Nuvigil® is NOT covered for members with the following criteria: A. If the patient is taking/receiving any of the following: Amphetamine, Dexmethylphenidate, Dextroamphetamine, Methylphenidate, Monoamine oxidase inhibitors (MAOIs), Pemoline or Procarbazine.
<b>Required Medical Information</b>	A. If diagnosis is OSA: A standard diagnostic nocturnal polysomnography (NPSG) test should confirm the diagnosis of OSA. B. If diagnosis is narcolepsy or circadian-rhythm disruption: Documentation showing patient trial and failure on methylphenidate or amphetamine is required.
<b>Age Restrictions</b>	Patient minimum age of 16 years
<b>Prescriber Restrictions</b>	Request must come from neurology or Requesting physician must be a board certified sleep specialist, ENT, neurologist, or pulmonologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	ORFADIN
<b>Drug Names</b>	ORFADIN
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Therapy must be initiated and monitored by a specialist well-versed in the management of this condition.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	OXSORALEN
<b>Drug Names</b>	OXSORALEN ULTRA
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Oxsoralen® is NOT covered for members who meet the following criteria: If the patient has any of the following contraindications: albinism, aphakia, melanoma, porphyria, skin photosensitivity disorder, systemic lupus erythematosus (SLE), xeroderma pigmentosum or current skin burns.
<b>Required Medical Information</b>	Melanoma has been ruled out by biopsy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	Approved for the symptomatic control of severe, recalcitrant, disabling psoriasis not responsive to other therapy. Oxsoralen must be administered only in conjunction with a schedule of controlled doses of long wave UV radiation.

<b>Prior Authorization Group</b>	PASER
<b>Drug Names</b>	PASER
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	The following copies of chart notes/laboratory reports are required: A. Culture and Sensitivity report showing susceptibility of bacteria to Paser
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 Months
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	PEG-INTRON
<b>Drug Names</b>	PEG-INTRON, PEG-INTRON REDIPEN
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Recent CBC, hepatic function panel, and renal function lab reports indicating elevated liver enzymes, normal renal function, and documentation of baseline CBC and platelet counts are required. Recent lab report documenting elevated HCV RNA are required, along with genotype. Liver biopsy results for patients with Genotype 1. Documentation of recent screening for psychiatric disorders, particularly depression and alcohol abuse. Full psychiatric evaluation for patients with current or positive history of depression or substance abuse.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Request is initiated by a GI or infectious disease specialist.
<b>Coverage Duration</b>	Initial authorization will be given for 12 weeks
<b>Other Criteria</b>	Combination treatment with SQ interferon and Oral Ribavirin is now the standard of care. FDA approved for treatment-naïve patients only.

<b>Prior Authorization Group</b>	PEGASYS
<b>Drug Names</b>	PEGASYS
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Recent CBC, hepatic function panel, and renal function lab reports indicating elevated liver enzymes, normal renal function, and documentation of baseline CBC and platelet counts are required. If diagnosis is for hepatitis C: Recent lab report documenting elevated HCV RNA are required, along with genotype. Liver biopsy results for patients with Genotype 1. Documentation of recent screening for psychiatric disorders, particularly depression and alcohol abuse. Full psychiatric evaluation for patients with current or positive history of depression or substance abuse.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Request is initiated by a GI or infectious disease specialist.
<b>Coverage Duration</b>	Initial authorization will be given for 12 weeks
<b>Other Criteria</b>	Combination treatment with SQ interferon and Oral Ribavirin is now the standard of care. FDA approved for treatment-naïve patients only.

**Prior Authorization Group** PRADAXA  
**Drug Names** PRADAXA  
**Covered Uses** All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria**  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 12 months  
**Other Criteria**

**Prior Authorization Group** PRISTIQ  
**Drug Names** PRISTIQ  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria**  
**Required Medical Information** Documentation showing failure on an adequate course of treatment with Effexor XR  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 6 months  
**Other Criteria**

<b>Prior Authorization Group</b>	PROCRIT
<b>Drug Names</b>	PROCRIT
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE EPO's are not covered for members who meet the following criteria: A. If the patient has any of the following contraindication, albumin hypersensitivity, benzyl alcohol hypersensitivity, hamster protein hypersensitivity, uncontrolled hypertension, or hemoglobin concentration greater than 13 g/dl.
<b>Required Medical Information</b>	Non-dialysis members with symptomatic anemia Hgb less than 10g/dL. Prescribed for treatment of anemia related to therapy with zidovudine (AZT) in HIV-infected patients. The endogenous serum erythropoietin level is less then or equal to 500 mUnits/mL. Dose of zidovudine is less then or equal to 4200 mg/week. Treatment of Anemia induced by Biologic Agents or Chemotherapy. Prescribed for treatment of anemia induced by chemotherapy or biologic agents, excluding members with a diagnosis of acute leukemia. Reduction of Allogeneic Blood Transfusion in Surgery Patients.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribing physician is a hematologist, oncologist, nephrologist, or infectious disease specialist, or prescribing initiated based upon a consult with one of these specialists.
<b>Coverage Duration</b>	Renewable every 6 months
<b>Other Criteria</b>	Approved for the treatment of Anemia due to End Stage Renal Disease (ESRD) or Chronic Renal Failure (CRF). Prescribed for treatment of anemia associated with CRF, including both patients on dialysis [end-stage renal disease (ESRD)], and patients not on dialysis. NOT approved for the treatment of anemia in HIV-infected patients due to other factors such as iron or folate deficiency, hemolysis, or gastrointestinal bleeding.

<b>Prior Authorization Group</b>	PROMACTA
<b>Drug Names</b>	PROMACTA
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	PROVIGIL
<b>Drug Names</b>	PROVIGIL
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A. If diagnosis is OSA: A standard diagnostic nocturnal polysomnography (NPSG) test should confirm the diagnosis of OSA. B. If diagnosis is narcolepsy or circadian-rhythm disruption: Documentation showing patient trial and failure on methylphenidate or amphetamine is required.
<b>Age Restrictions</b>	Patient minimum age of 16 years
<b>Prescriber Restrictions</b>	Request must come from neurology or Requesting physician must be a board certified sleep specialist, ENT, neurologist, or pulmonologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	PULMOZYME
<b>Drug Names</b>	PULMOZYME
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Pulmonologist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	If administered via machine in the home setting, would be billable under Medicare Part B.

**Prior Authorization Group** RANEXA  
**Drug Names** RANEXA  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE Ranexa is NOT covered for members with the following criteria: A. If the patient has any of the following contraindications: clinically significant hepatic impairment (Child-Pugh Classes A[mild], B[moderate] or C [severe]). B. If the patient is taking/ receiving any of the following: Barbiturates, Carbamazepine, Cerivastatin, Chloramphenicol, Clarithromycin, Conivaptan, Dalfopristin Quinupristin, Delavirdine, Fosphenytoin, Imatinib, STI-571, Indinavir, Isoniazid INH, Itraconazole, Ketoconazole, Miconazole, Nefazodone, Nelfinavir, Nevirapine, Nilotinib, Oxcarbazepine, Phenytoin, Rifabutin, Rifampin, Rifapentine, Ritonavir, Saquinavir, St. John's Wort, Hypericum perforatum, Voriconazole

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions** cardiologist

**Coverage Duration** 12 months

**Other Criteria** Documentation verifying the patient has tried, failed and/or been intolerant (continues to have angina that limits daily activities) to a 30-day trial of a) a nitrate AND either b) a beta blocker OR c) a calcium channel blocker. . a. Betablockers: (eg. Toprol XL®, atenolol, Coreg®, propranolol, bisoprolol, metoprolol, timolol, acebutolol, nadolol, propranolol). b. Calcium Channel Blocker: (eg. amlodipine, nifedipine, nisoldipine, isradipine, diltiazem, nifedipine, felodipine, verapamil, Norvasc®, Exforge®, Caduet®, Lotrel®, Azor®). c. Nitrate: (eg. isosorbide, Isordil®, Dilatrate SR®, Monoket®, Ismo®, Imdur®, nitroglycerin, Nitro-Time®).

**Prior Authorization Group** REGRANEX  
**Drug Names** REGRANEX  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE Regranex is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: cresol hypersensitivity, or paraben hypersensitivity.

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions** Ulcer must be less than 10cm<sup>2</sup>  
Must be prescribed by an orthopedic surgeon, podiatrist, or endocrinologist

**Coverage Duration** 5 months

**Other Criteria**

**Prior Authorization Group** RESTASIS  
**Drug Names** RESTASIS  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE Restasis® is NOT covered for members who meet the following criteria: A. If the patient has an active ocular infection.  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions** Patient is under the care of an ophthalmologist, optometrist, or rheumatologist  
**Coverage Duration** Renewable every 6 months  
**Other Criteria**

**Prior Authorization Group** REVATIO  
**Drug Names** REVATIO  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE Revatio is NOT covered for members with the following criteria: A. IF the patient has any of the following contraindications: current therapy with organic nitrates or known hypersensitivity to sildenafil.  
**Required Medical Information**  
**Age Restrictions** deny for pediatric patients 18 years of age  
**Prescriber Restrictions** Pulmonologist or Cardiologist  
**Coverage Duration** 4 months  
**Other Criteria**

**Prior Authorization Group** REVLIMID  
**Drug Names** REVLIMID  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE Revlimid® is NOT covered for members with the following criteria: A. The patient is a female patient of child bearing age that is pregnant or has plans for pregnancy/breast-feeding.  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions** Hematologist/Oncologist  
**Coverage Duration** 6 months  
**Other Criteria** Treatment of multiple myeloma in combination with dexamethasone in patients who have failed to respond to at least one prior therapy such as stem cell transplantation, thalidomide, dexamethasone, bortezomib, melphalan, and doxorubicin.

<b>Prior Authorization Group</b>	RIBAVIRIN
<b>Drug Names</b>	REBETOL, RIBASPHERE, RIBAVIRIN
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Ribavirin is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: breast-feeding, hemoglobinopathy, pregnancy, renal failure or impairment, sickle cell disease, thalassemia or cardiac disease. B. If the member is taking didanosine.
<b>Required Medical Information</b>	Recent CBC, hepatic function panel, and renal function lab reports indicating elevated liver enzymes, normal renal function (creatinine clearance greater than 50 ml/min), and documentation of baseline CBC and platelet counts are required. Recent lab report documenting elevated HCV RNA are required, along with genotype. Liver biopsy results for patients with Genotype 1.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Request is initiated by a GI or infectious disease specialist.
<b>Coverage Duration</b>	Initial authorization will be given for 12 weeks
<b>Other Criteria</b>	Approved for chronic Hepatitis C Virus (HCV), Combination treatment with SQ interferon and Oral Ribavirin is now the standard of care.

<b>Prior Authorization Group</b>	RISPERDAL CONST
<b>Drug Names</b>	INVEGA SUSTENNA, RISPERDAL CONSTA
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 MONTHS
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	RITUXAN
<b>Drug Names</b>	RITUXAN
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Rituxan® is NOT covered for members with the following criteria: A. If the patient has any of the following contraindications: abciximab hypersensitivity or murine protein hypersensitivity. B. If the patient is taking/receiving any of the following: Live vaccines.
<b>Required Medical Information</b>	Documentation of baseline CBC and platelet counts are required. Recent Hepatitis B test results.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Hematologist/Oncologist / rheumatologist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	ROTATEQ
<b>Drug Names</b>	ROTATEQ
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE RotaTeq® is NOT covered for members who meet the following criteria: A.If the medication is given by parenteral administration. B. If the patient is taking/receiving any of the following: Adalimumab, Anakinra, Antineoplastic Agents, Etanercept, Immunosuppressives or Infliximab.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approved for use in infants between the ages of 6 and 32 weeks of age
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	70 days
<b>Other Criteria</b>	Approved for use in infants to help prevent rotavirus gastroenteritis caused by the serotypes G1, G2, G3, and G4.
<b>Prior Authorization Group</b>	SABRIL
<b>Drug Names</b>	SABRIL
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	

**Prior Authorization Group** SANCUSO  
**Drug Names** SANCUSO  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE Sancuso® is NOT covered for members who meet the following criteria: A.If the patient has any of the following contraindications: benzyl alcohol hypersensitivity or neonate. B. If the patient is taking/receiving apomorphine.  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 1 year  
**Other Criteria**

**Prior Authorization Group** SEROMYCIN  
**Drug Names** SEROMYCIN  
**Covered Uses** All FDA approved indications not otherwise excluded from Part D  
**Exclusion Criteria** Seromycin is NOT covered for members who meet the following criteria: A. Patient has a seizure disorder B. Patient has history of major depression, anxiety, or psychosis  
**Required Medical Information** The following copies of chart notes/laboratory reports are required: A. Culture and Sensitivity report showing susceptibility of bacteria to Seromycin B. Documentation of absence of seizure disorder C. Documentation of absence of major depression, anxiety, or psychosis  
**Age Restrictions** Patient must be 18 years old or older  
**Prescriber Restrictions**  
**Coverage Duration** 14 Days  
**Other Criteria** COVERAGE POLICY Seromycin® is covered for members who meet the following criteria: A. Patient is diagnosed with bacteria that is susceptible to Seromycin. B. Patient has culture and sensitivity report that shows susceptibility of bacteria to Seromycin.

<b>Prior Authorization Group</b>	SOMAVERT
<b>Drug Names</b>	SOMAVERT
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Somavert is NOT covered for members with the following criteria: A. If the medications will be given by intravenous administration.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Therapy must be initiated by an endocrinologist or other specialist well-versed in the treatment of this condition.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	SPRYCEL
<b>Drug Names</b>	SPRYCEL
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Hematologist/Oncologist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	STELARA
<b>Drug Names</b>	STELARA
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Diagnosis of moderate to severe plaque psoriasis, must be a candidate for phototherapy or systemic therapy, trial/failure or intolerant to at least one corticosteroid, trial/failure or intolerant to methotrexate, trial/failure or intolerant to Enbrel or Humira, must be 18 yo or older, must have negative TB test or received treatment if tested positive

<b>Prior Authorization Group</b>	STREPTOMYCIN
<b>Drug Names</b>	STREPTOMYCIN SULFATE
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	The following copies of chart notes/laboratory reports are required: A. Culture and Sensitivity report showing susceptibility of bacteria to streptomycin B. Patient creatinine clearance within the past 60 days
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 Months
<b>Other Criteria</b>	COVERAGE POLICY Streptomycin is covered for members who meet the following criteria: A. Patient is diagnosed with bacteria that is susceptible to streptomycin. B. Patient has culture and sensitivity report that shows susceptibility of bacteria to streptomycin.
<b>Prior Authorization Group</b>	SUTENT
<b>Drug Names</b>	SUTENT
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Hematologist/Oncologist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	Treatment of gastrointestinal stromal tumor after disease progression on or intolerance to Gleevec and renal cell carcinoma uses

<b>Prior Authorization Group</b>	SYLATRON
<b>Drug Names</b>	SYLATRON
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D, chronic myelogenous leukemia (CML)
<b>Exclusion Criteria</b>	Autoimmune hepatitis, decompensated hepatic disease, uncontrolled major depression or severe mental illness
<b>Required Medical Information</b>	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 (eg, imatinib, dasatinib, or nilotinib) OR patient is post-transplant without remission or with relapse of CML.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	The patient is monitored and evaluated for signs and symptoms of depression and other psychiatric symptoms throughout treatment with Sylatron
<b>Prior Authorization Group</b>	SYMLIN
<b>Drug Names</b>	SYMLIN, SYMLINPEN 120, SYMLINPEN 60
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Symlin® is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: cresol hypersensitivity, gastroparesis or hypoglycemia unawareness. B. If the patient has poor compliance with prescribed self-blood glucose monitoring, HbA1c greater than 9%, recurrent severe hypoglycemia requiring assistance during past 6 months or if the patient requires the use of drugs that stimulate GI motility C. Pediatric patients
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	should be limited to physicians who specialize in diabetes management and are supported by diabetes care teams.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Therapy will only be approved for insulin-using patients with Type 1 or Type 2 Diabetes who have failed to achieve adequate glycemic control despite individualized insulin management

<b>Prior Authorization Group</b>	SYNAREL
<b>Drug Names</b>	SYNAREL
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Synarel® is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: breast-feeding, pregnancy, undiagnosed vaginal bleeding, or Gonadotropin-Releasing Hormone (GnRH) analogs hypersensitivity. B. If the patient is taking/receiving any of the following: Chasteberry, Chaste tree fruit or Vitex agnus-castus
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	For precocious puberty patient must be 10 years old or younger
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	TABLOID
<b>Drug Names</b>	TABLOID
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	TARCEVA
<b>Drug Names</b>	TARCEVA
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Hematologist/Oncologist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	TARGRETIN
<b>Drug Names</b>	TARGRETIN
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Targretin is NOT covered for members who meet the following criteria: A. If the patient is female and is pregnant.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Hematologist/Oncologist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	TASIGNA
<b>Drug Names</b>	TASIGNA
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Tasigna is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: hypokalemia, hypomagnesemia, or long QT syndrome.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Hematologist/Oncologist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	TESTOSTERONE REPLACEMENT
<b>Drug Names</b>	ANDRODERM
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

**Prior Authorization Group** THALOMID  
**Drug Names** THALOMID  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE Thalomid is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: breast-feeding, pregnancy  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions** Hematologist/Oncologist, Infectious Disease  
**Coverage Duration** 6 months  
**Other Criteria**

**Prior Authorization Group** TOPAMAX  
**Drug Names** TOPIRAMATE  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria**  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** 12 months  
**Other Criteria**

**Prior Authorization Group** TRACLEER  
**Drug Names** TRACLEER  
**Covered Uses** FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** NON COVERAGE Tracleer is NOT covered for members with the following criteria: A. A female patient of child bearing age that is pregnant or has plans for pregnancy, taking Cyclosporin A, Glyburide, or hypersensitivity to Tracleer.  
**Required Medical Information** Documentation of baseline liver function tests (ALT, AST) performed prior to initiation of therapy. If member is a woman of childbearing potential: Documentation of a baseline negative pregnancy test prior to initiation of therapy.  
**Age Restrictions**  
**Prescriber Restrictions** Pulmonologist or Cardiologist  
**Coverage Duration** 4 months  
**Other Criteria**

<b>Prior Authorization Group</b>	TRECATOR
<b>Drug Names</b>	TRECATOR
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Trecator is NOT covered for members who meet the following criteria: A. Patients with hepatic encephalopathy
<b>Required Medical Information</b>	The following copies of chart notes/laboratory reports are required: A. Culture and Sensitivity report showing susceptibility of bacteria to Trecator B. Documentation showing patient does NOT have encephalopathy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 Months
<b>Other Criteria</b>	COVERAGE POLICY Trecator® is covered for members who meet the following criteria: A. Patient is diagnosed with bacteria that is susceptible to Trecator. B. Patient has culture and sensitivity report that shows susceptibility of bacteria to Trecator.
<b>Prior Authorization Group</b>	TRETINOIN
<b>Drug Names</b>	AVITA, TRETINOIN
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Tretinoin is NOT covered for members with the following criteria: A. A patient with paraben hypersensitivity or retinoid hypersensitivity B. If the patient is taking/receiving any of the following: Retinoids or Vitamin A.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	TYKERB
<b>Drug Names</b>	TYKERB
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation showing prior therapy including an anthracycline, a taxane, and trastuzumab.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Hematologist/Oncologist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	TYZEKA
<b>Drug Names</b>	TYZEKA
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	serum aminotransferases (ALT or AST). Documentation showing previous trial and failure on Epivir HBV, Baraclude, or Hepsera.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	ULORIC
<b>Drug Names</b>	ULORIC
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	VFEND
<b>Drug Names</b>	VFEND, VFEND IV, VORICONAZOLE
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Vfend® is NOT covered for members who meet the following criteria: A. If the patient is taking/receiving any of the following: Astemizole, Atorvastatin, Barbiturates, Carbamazepine, Cisapride, Ergot Alkaloids, Pimozide, Quinidine, Ranolazine, Red Yeast Rice, Rifabutin, Rifampin, Rifapentine, Ritonavir, Sirolimus, St. John's Wort, Hypericum perforatum, Terfenadine or Vinca alkaloids.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	VICTRELIS
<b>Drug Names</b>	VICTRELIS
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D?
<b>Exclusion Criteria</b>	Failed previous therapy with a treatment regimen that includes a protease inhibitor (e.g., Incivek, Victrelis). Concomitant administration with a drug that is highly dependent on CYP3A4/5 for clearance or potent CYP3A4/5 inducer.
<b>Required Medical Information</b>	Hepatitis C virus (HCV) infection confirmed by presence of viral load in serum. HCV Genotype 1. HCV-RNA less than 100 IU/mL at week 12 of treatment. Undetectable HCV-RNA at week 24 of treatment.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Initial: 8 weeks. Renewal: Up to 44 weeks.?
<b>Other Criteria</b>	Must be given in combination with pegylated interferon (i.e., Pegasys or PegIntron) and ribavirin. Must receive 4 weeks of pegylated interferon and ribavirin prior to starting Victrelis.
<b>Prior Authorization Group</b>	VIMPAT
<b>Drug Names</b>	VIMPAT
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	The following copies of chart notes/laboratory reports are required: A. Documentation showing that Vimpat will be given as an adjunctive anticonvulsant B. Documentation showing that the patient has had a previous trial/failure/contraindication to two or more of the following: Carbamazepine, Divalproex, Gabapentin, Lamotrigine, Levetiracetam, Oxcarbazepine, Phenytoin, Pregabalin, Tiagabine, Topiramate, Valproic acid, or Zonisamide
<b>Age Restrictions</b>	Covered for 17 years and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	COVERAGE POLICY Vimpat® is covered for members who meet the following criteria: A.Patient will receive Vimpat as an adjunctive anticonvulsant.

<b>Prior Authorization Group</b>	VPRIV
<b>Drug Names</b>	VPRIV
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Patients taking miglustat (Zavesca)
<b>Required Medical Information</b>	Diagnosis confirmed by bone marrow histology, DNA testing or measurement of beta-glucocerebrosidase enzyme activity less than 30%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Patient must have at least one of the following conditions: anemia, thrombocytopenia, bone disease, hepatomegaly, splenomegaly. Patients who have previously received 24 months of VPRIV therapy must have a decrease in liver and spleen volume and/or increase in platelet count and/or increase in hemoglobin concentration for reauthorization.
<b>Prior Authorization Group</b>	XENAZINE
<b>Drug Names</b>	XENAZINE
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Xenazine® is NOT covered for members who meet the following criteria: A.If the patient has any of the following contraindications: hepatic disease or torsade de pointes. B. If the patient is taking/receiving any of the following: Monoamine oxidase inhibitors or Reserpine.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	XOLAIR
<b>Drug Names</b>	XOLAIR
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Xolair® is NOT covered for members with the following criteria: A. If the patient has any of the following contraindications: hamster protein hypersensitivity or omalizumab hypersensitivity.
<b>Required Medical Information</b>	Member has documented allergy to a perennial airborne allergen, confirmed by skin testing or in vitro activity to the allergen. Allergy tests are required to identify patients who may be candidates for Omalizumab therapy. The FDA advisory committee defines having allergic asthma as testing positive to at least one perennial aeroallergen according to either a skin test (e.g., prick/puncture test, intracutaneous test) or a blood test (e.g., RAST) and having an IgE level between 30 and 700 IU/mL. 6. Member has an FEV1 less than 80% predicted 7. Member has a pre-treatment serum IgE level equal to or greater than 30 IU/mL and less than or equal to 700 IU/mL. The use of Xolair® in patients with IgE levels less than 30 and greater than 700 IU/mL has not been adequately studied and should not be used. 8. Member weighs between 30 and 150 kg (approximately 66 to 330 pounds).
<b>Age Restrictions</b>	Member is 12 years of age or older
<b>Prescriber Restrictions</b>	Requesting or administering physician is an asthma specialist (allergist, immunologist, or pulmonologist) with significant training and experience in the diagnosis and treatment of asthma and allergies
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	XYREM
<b>Drug Names</b>	XYREM
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Xyrem is NOT covered for members with the following criteria: C. If the patient has any of the following contraindications: succinic semialdehyde dehydrogenase deficiency, B. If the patient is taking/receiving any of the following: Anxiolytics, Sedatives, and Hypnotics, Barbiturates, Benzodiazepines or Ethanol.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Must be older than 16 years of age
<b>Prescriber Restrictions</b>	Request must come from neurology
<b>Coverage Duration</b>	renewable every three months
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	ZAVESCA
<b>Drug Names</b>	ZAVESCA
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	NON COVERAGE Zavesca® is NOT covered for members with the following criteria: A. If the patient has any of the following contraindications: pregnancy, labor, obstetric delivery or renal failure. B. The efficacy and safety of Zavesca has not been evaluated in patients with severe type 1 Gaucher disease, defined as a hemoglobin concentration below 9g/dL, a platelet count below 50 X 10 <sup>9</sup> /L, or active bone disease.
<b>Required Medical Information</b>	Documentation showing patient is not a candidate for enzyme replacement therapy (eg, because of constraints such as allergy, hypersensitivity, or poor venous access).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Therapy must be initiated and monitored by a specialist well-versed in the management of this condition.
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	ZOLINZA
<b>Drug Names</b>	ZOLINZA
<b>Covered Uses</b>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	ZYTIGA
<b>Drug Names</b>	ZYTIGA
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year?
<b>Other Criteria</b>	Used in combination with prednisone. Received prior chemotherapy containing docetaxel.