

## **PA Criteria**

<b>Prior Authorization Group</b>	ACNE
<b>Drug Names</b>	AVITA, TRETINOIN
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Cosmetic use
<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>	ACTEMRA
<b>Drug Names</b>	ACTEMRA
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Active infection (including TB). Concurrent therapy with other biologic agent(s).
<b>Required Medical Information</b>	Screening for latent tuberculosis is required. If results are positive, patient must have completed treatment or must currently be receiving treatment for latent tuberculosis. Evaluate for HBV risk and initiate treatment if appropriate.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Must have an inadequate response to at least one nonbiologic DMARD or intolerance/contraindication to at least 2 nonbiologic DMARDs. Must have an inadequate response or intolerance/contraindication to one TNF antagonist. For renewals, patient must have responded to Actemra therapy (e.g., condition improved or stabilized).
<b>Prior Authorization Group</b>	ACTIMMUNE
<b>Drug Names</b>	ACTIMMUNE
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Hypersensitivity to E.coli-derived products and/or interferon gamma.
<b>Required Medical Information</b>	Patient has no history of myelosuppression, complete blood count within normal limits, platelet count within normal limits, liver function tests within normal limits. Monitoring of complete blood count, platelet count, and liver function tests every 3 months is required.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	ADAGEN
<b>Drug Names</b>	ADAGEN
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D

<b>Exclusion Criteria</b>	Severe thrombocytopenia. Use in preparation for or in support of bone marrow transplantation.
<b>Required Medical Information</b>	Bone marrow transplantation failure or patient is not a suitable candidate for bone marrow transplantation.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Endocrinologist, ID specialist, Allergist, Immunologist, Clinical or Biochemical Geneticist, Hematologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Use for direct replacement for deficient enzyme (no benefit achieved in patients with immunodeficiency due to other causes).
<b>Prior Authorization Group</b>	ADCIRCA
<b>Drug Names</b>	ADCIRCA
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Nitrate therapy
<b>Required Medical Information</b>	Diagnosis of pulmonary arterial hypertension (PAH), (WHO Group 1). PAH been confirmed by right heart catheterization. If patient is an infant, PAH diagnosed by Doppler echocardiogram.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	ALDURAZYME
<b>Drug Names</b>	ALDURAZYME
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis confirmed by diagnostic method, enzymatic assay or DNA testing.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For Scheie syndrome: must have at least 2 moderate to severe symptoms. Must demonstrate improvement in lung function in patients who has previously received at least 26 weeks of Aldurazyme on re-authorization.
<b>Prior Authorization Group</b>	ALPHA1-PROTEINASE INHIBITOR
<b>Drug Names</b>	ARALAST NP
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Patient has IgA deficiency with antibodies against IgA.
<b>Required Medical Information</b>	Alpha1-proteinase inhibitor concentration is less than 11 micromoles per liter. The FEV1 level is between 35% and 60% predicted OR greater than 60% predicted. If the FEV1 is greater than 60% predicted, then the patient has experienced a rapid decline in lung function that warrants treatment.

<b>Age Restrictions</b>	18 years old and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	AMPHETAMINES
<b>Drug Names</b>	AMPHETAMINE/DEXTROAMPHETA, DEXTROAMPHETAMINE SULFATE
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	MAOI concurrent use or within the last 14 days except if prescriber is a psychiatrist with experience prescribing both MAOI and amphetamine/dextroamphetamine drugs
<b>Required Medical Information</b>	Sleep studies for narcolepsy diagnosis
<b>Age Restrictions</b>	3 years of age and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Consider benefits of use versus the potential risks of serious cardiovascular events
<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>	Moderate to severe renal impairment, history of seizures, Ampyra at doses exceeding 10 mg twice daily.
<b>Required Medical Information</b>	Patient must be able to walk 25 feet with or without assistance.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	2 months, then plan year upon renewal
<b>Other Criteria</b>	Patient must demonstrate sustained walking impairment prior to starting Ampyra. To continue therapy, the patient must experience an improvement in walking speed or other objective measure of walking ability since starting Ampyra.
<b>Prior Authorization Group</b>	ANABOLIC STEROIDS
<b>Drug Names</b>	OXANDROLONE
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Known or suspected carcinoma of the prostate or breast (in male patients), carcinoma of the breast in women with hypercalcemia, pregnancy, nephrosis (the nephrotic phase of nephritis), hypercalcemia.
<b>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>	ANAGRELIDE
<b>Drug Names</b>	ANAGRELIDE HYDROCHLORIDE

<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Severe hepatic impairment.
<b>Required Medical Information</b>	A. If the diagnosis is chronic myelogenous leukemia: a. persistent granulocyte count greater than or equal to 50,000/mcL without infection b. absolute basophil count greater than or equal to 100/mcL c. evidence of hyperplasia of the granulocytic line in the bone marrow d. presence of the Philadelphia chromosome e. leukocyte alkaline phosphatase less than or equal to lower limit of the lab range. B. If the diagnosis is polycythemia vera (either all three major criteria or first two major criteria and two minor criteria): major criteria: increase red cell mass (in men, greater than or equal to 36 mL/kg and in women, greater than or equal to 32 mL/kg), normal arterial oxygen saturation (greater than or equal to 92%), splenomegaly. minor criteria: platelet count greater than or equal to 400,000/mcL without iron deficiency or bleeding, white blood cell count greater than or equal to 12,000/mcL without infection, leukocyte alkaline phosphatase greater than or equal to 100 mcL, serum B12 greater than 900 pcg/mL. C. If the diagnosis is thrombocytosis: a. platelet count greater than or equal to 900,000/mcL b. profound megakaryocytic hyperplasia in bone marrow c. absence of Philadelphia chromosome d. normal red cell mass c. normal serum iron and ferritin and normal marrow iron stores d. pre-treatment cardiovascular examination.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Oncologist or Hematologist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	ARCALYST
<b>Drug Names</b>	ARCALYST
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Active or chronic infection. Concurrent therapy with other biologics.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	AVONEX
<b>Drug Names</b>	AVONEX
<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>	



## Drug Names

ACETYLCYSTEINE, ADRIAMYCIN, ALBUTEROL SULFATE, ALIMTA, AMIFOSTINE, 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%, AMIODARONE HCL, AMPHOTERICIN B, ASTRAMORPH, AVASTIN, AZASAN, AZATHIOPRINE, AZATHIOPRINE SODIUM, BICNU, BLEOMYCIN SULFATE, BONIVA, BUDESONIDE, BUSULFEX, CALCITRIOL, CAMPATH, CARBOPLATIN, CELLCEPT, CISPLATIN, CLADRIBINE, CLINIMIX 2.75%/DEXTROSE 5, CLINIMIX 4.25%/DEXTROSE 1, CLINIMIX 4.25%/DEXTROSE 2, CLINIMIX 4.25%/DEXTROSE 5, CLINIMIX 5%/DEXTROSE 15%, CLINIMIX 5%/DEXTROSE 20%, CLINIMIX 5%/DEXTROSE 25%, CLINIMIX E 2.75%/DEXTROSE, CLINIMIX E 4.25%/DEXTROSE, CLINIMIX E 5%/DEXTROSE 15, CLINIMIX E 5%/DEXTROSE 20, CLINIMIX E 5%/DEXTROSE 25, CLINISOL SF 15%, COLISTIMETHATE SODIUM, COSMEGEN, CROMOLYN SODIUM, CUBICIN, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE, DACARBAZINE, DAUNORUBICIN HCL, DAUNOXOME, DECAVAC, DEPO-PROVERA, DEXRAZOXANE, DIPHTHERIA/TETANUS TOXOID, DOXIL, DOXORUBICIN HCL, DURAMORPH, ELITEK, ELSPAR, EMEND, ENGERIX-B, EPIRUBICIN HCL, ETOPOSIDE, FASLODEX, FENTANYL CITRATE, FLUDARABINE PHOSPHATE, FLUOROURACIL, FREAMINE HBC 6.9%, FREAMINE III, FREAMINE III 3%, GAMASTAN S/D, GANCICLOVIR, GEMZAR, GENGRAF, GRANISETRON HCL, HEPARIN SODIUM, HEPARIN SODIUM/D5W, HEPARIN SODIUM/NACL 0.45%, HEPARIN SODIUM/SODIUM CHL, HEPATAMINE, HEPATASOL, HERCEPTIN, HYCAMTIN, HYDROMORPHONE HCL, IDARUBICIN HCL, IFEX, IFOSFAMIDE, IFOSFAMIDE/MESNA, INTRALIPID, INTRON-A, INTRON-A W/DILUENT, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, ISTODAX, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVOCARNITINE, LIDOCAINE/PRILOCAINE, LIPOSYN II, LIPOSYN III, MELPHALAN HYDROCHLORIDE, MESNA, METHOTREXATE SODIUM, MIACALCIN, MITOMYCIN, MITOXANTRONE HCL, MORPHINE SULFATE, MUSTARGEN, MYCOPHENOLATE MOFETIL, MYFORTIC, NEORAL, NEPHRAMINE, NOVAMINE, ONCASPAR, ONDANSETRON HCL, ONDANSETRON ODT, ONTAK, OXALIPLATIN, PACLITAXEL, PENTOSTATIN, PHOTOFRIN, PREMASOL, PROCALAMINE, PROGRAF, PROLEUKIN, PROSOL, PULMOZYME, RAPAMUNE, RECOMBIVAX HB, RENAMIN, SANDIMMUNE, TACROLIMUS, TAXOTERE, TETANUS TOXOID ADSORBED, TETANUS/DIPHTHERIA TOXOID, TOBI, TOPOSAR, TOPOTECAN HCL, TPN ELECTROLYTES FTV, TRAVASOL, TREANDA, TRELSTAR DEPOT MIXJECT, TRELSTAR LA MIXJECT, TRELSTAR MIXJECT, TRISENOX, TROPHAMINE,

VANCOMYCIN HCL, VELCADE, VIDAZA, VINBLASTINE SULFATE, VINCASAR PFS, VINCRISTINE SULFATE, VINOURELBINE TARTRATE, ZEMPLAR, ZORTRESS

**Covered Uses**

This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

NA

**Other Criteria**

**Prior Authorization Group**

BETASERON

**Drug Names**

BETASERON

**Covered Uses**

All FDA approved indications not otherwise excluded from Part D

**Exclusion Criteria**

Albumin hypersensitivity, concurrent use of any of the following medications: Interferon-beta therapy (Avonex, Extavia, or Rebif), glatiramer acetate, or mitoxantrone  
MRI has been performed and has features suggestive of MS (evidence of lesion)

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

Neurologist

**Coverage Duration**

Plan Year

**Other Criteria**

Patients with previous use (12 or more months) of Betaseron must demonstrate 1 of the following clinical responses: decrease in the frequency of relapses, slowing of disease progression, MRI lesions have diminished with therapy, OR patient is stable on therapy.

**Prior Authorization Group**

BUPRENORPHINE

**Drug Names**

BUPRENORPHINE HCL, SUBOXONE

**Covered Uses**

All FDA approved indications not otherwise excluded from Part D

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

16 years of age and older

**Prescriber Restrictions**

Prescribers must be registered with the Substance Abuse and Mental Health Services Administration

**Coverage Duration**

Buprenorphine - one month. Buprenorphine-naloxone - 12 months.

**Other Criteria**

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

**Prior Authorization Group**

BYETTA

**Drug Names**

BYETTA

**Covered Uses**

All FDA approved indications not otherwise excluded from Part D

**Exclusion Criteria**

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

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

**Prior Authorization Group**

CAMPRAL

**Drug Names**

CAMPRAL

**Covered Uses**

All FDA approved indications not otherwise excluded from Part D

**Exclusion Criteria**

Renal failure.

**Required Medical Information**

A. Clinical diagnosis for alcohol dependence. B. AND clinical evidence indicated that the patient will be abstinent at least 5 days prior to treatment initiation. C. AND a trial of naltrexone (oral/injectable) has been attempted, at clinically significant dosage and duration. Or therapy is documented to be clinically inappropriate (hepatic insufficiency, chronic pain medication use). D. AND medication administration should be part of a comprehensive psychosocial treatment program.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

6 months

**Other Criteria**

**Prior Authorization Group**

CAYSTON

**Drug Names**

CAYSTON

**Covered Uses**

All FDA approved indications not otherwise excluded from Part D

**Exclusion Criteria**

**Required Medical Information**

Diagnosis of cystic fibrosis is confirmed by appropriate diagnostic or genetic testing. Confirmation of *P. aeruginosa* in cultures of the airways. Upon renewal, patients 6 years of age or older who have diminished pulmonary function tests by greater than 10% while receiving Cayston therapy should have a clinical reason to continue Cayston therapy. Upon renewal, patients younger than 6 years of age should have a clinical reason to continue Cayston therapy.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

**Prior Authorization Group**

CELEBREX

<b>Drug Names</b>	CELEBREX
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Post-operative pain following CABG surgery.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months for FAP and JRA, 12 months for dysmenorrhea, OA, RA, AS, 1 month for acute pain
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	CEREZYME
<b>Drug Names</b>	CEREZYME
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Concurrent therapy with Zavesca.
<b>Required Medical Information</b>	Diagnosis confirmed by bone marrow histology, DNA testing or measurement of b-glucocerebrosidase enzyme activity less than 30 percent. Must have at least one of following conditions: anemia, thrombocytopenia, bone disease, hepatomegaly or splenomegaly. Must demonstrate a decrease in liver and spleen volume and/or increase in platelet count and/or increase in Hgb concentration in patients who has previously received 24 months of Cerezyme therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	
<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>	CIMZIA
<b>Drug Names</b>	CIMZIA
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Active infection (including TB).
<b>Required Medical Information</b>	Screening for latent TB infection and assessment for Hep B risk and be treated if positive.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Gastroenterologist or Rheumatologist

<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Rheumatoid arthritis - At least 8-week maximum tolerated dose trial/failure or contraindication /intolerance to at least one nonbiologic DMARD and trial/failure of either Enbrel or Humira. Crohn's Disease - Trial/failure or contraindication/intolerance to at least one oral corticosteroid and Humira. For re-authorization, demonstrate improvement in clinical symptoms.
<b>Prior Authorization Group</b>	COPAXONE
<b>Drug Names</b>	COPAXONE
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Mannitol hypersensitivity, concurrent use of any of the following medications: Interferon-beta therapy (Avonex, Betaseron, Extavia, or Rebif), or mitoxantrone. MRI has been performed and has features suggestive of MS.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Patients with previous use (12 or more months) of Copaxone must demonstrate one of the following clinical responses: decrease in the frequency of relapses, slowing of disease progression, MRI lesions have diminished with therapy, OR patient is stable on therapy.
<b>Prior Authorization Group</b>	DIFFERIN
<b>Drug Names</b>	ADAPALENE
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Cosmetic use
<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>	DRONABINOL
<b>Drug Names</b>	DRONABINOL
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	

**Required Medical Information**

A. The diagnosis is documented as anorexia associated with weight loss in a patient with AIDS a. AND the patient has had an involuntary weight loss of greater than 10% of pre-illness baseline body weight or a body mass index (BMI) less than 20kg/m<sup>2</sup> in the absence of a concurrent illness or medical condition other than HIV that may cause weight loss b. AND the patient has failed to respond to a 30-day drug regimen of megestrol (Megace) c. AND if the participant has received previous dronabinol therapy, he/she must show a positive response to therapy by maintaining or increasing their initial weight and/or muscle mass before initiating dronabinol therapy. B. The diagnosis is documented as nausea and vomiting associated with cancer chemotherapy in a cancer patient a. AND the participant is receiving a chemotherapy or radiation regimen b. AND if dronabinol is NOT being used as a full therapeutic replacement for an intravenous anti-emetic drug (e.g., ondansetron) c. AND if dronabinol is being used as a full therapeutic replacement for an intravenous anti-emetic drug (e.g., ondansetron) BUT dronabinol will NOT be within 48 hours of cancer therapy d. AND the patient has had a full trial and failure through at least one cycle of chemotherapy with IV ondansetron AND at least one of the following oral anti-emetic agents: metoclopramide, promethazine, prochlorperazine, meclizine, trimethobenzamide, oral 5-HT<sub>3</sub> receptor antagonists e. AND if the participant has received previous dronabinol therapy, he/she must show a positive response by showing a reduced incidence or emesis and/or nausea.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

6 months

B vs D coverage determination per CMS guidelines

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

ELAPRASE

ELAPRASE

All FDA approved indications not otherwise excluded from Part D

Diagnosis confirmed by either DNA testing or enzymatic analysis.

Plan Year

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

EPO

PROCRIT

All FDA approved indications not otherwise excluded from Part D

Uncontrolled hypertension. Red cell aplasia. Hgb greater than 12 g/dL (with the exception of surgery patients with Hgb greater than 13 g/dL).

**Required Medical Information** Following labs performed within 30 days of request: Hgb less than or equal to 10 g/dL OR Hct less than or equal to 30% for initial authorization. Hgb less than 12 g/dL OR Hct less than 36% for re-authorization. Transferrin saturation greater than or equal to 20% and ferritin level greater than or equal to 100 ng/mL. For chemo-induced anemia - have serum Epo level less than or equal to 200 mUnits/mL prior to therapy. For anemia secondary to MDS and in HIV-infected patients - have serum Epo level less than or equal to 500 mUnits/mL prior to therapy. Surgery patients - require Hgb level greater than 10 but less than or equal to 13 g/dL.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

12 weeks

For chemo-induced anemia - diagnosis is non-myeloid malignancy and receiving concomitant myelosuppressive chemotherapy regimen without an anticipated outcome of cure. For anemia in HIV-infected patient - must be on concurrent anti-retroviral therapy. Surgery patients - patient is at high risk for perioperative blood loss and must receive iron supplementation. Surgery is within 30 days of request. For re-authorization, must have an increase in Hgb of at least 1 g/dL or Hct of at least 3% since the initial Epo treatment.

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

EXJADE

EXJADE

All FDA approved indications not otherwise excluded from Part D

Creatinine clearance less than 40 mL/min or serum creatinine more than 2 times the age appropriate upper limit of normal, platelet count less than 50 x 10<sup>9</sup>/L, patients with high-risk MDS with poor performance status or an advanced malignancy, concurrent use of deferoxamine or iron-containing products.

**Required Medical Information**

The patient must meet all of the following criteria: diagnosis of transfusion-dependent anemia, patient has chronic iron overload due to blood transfusions, pretreatment serum ferritin level within the last 60 days of at least 1,000 mcg/L, and patient will have baseline and monthly monitoring of serum creatinine, creatinine clearance, serum transaminases and bilirubin. For reauthorization, if serum ferritin threshold is less than 500 mcg/L, prescriber should consider interrupting the dose of Exjade.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

2 years of age and older

Hematologist

3 months

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

EXTAVIA

EXTAVIA

All FDA approved indications not otherwise excluded from Part D

<b>Exclusion Criteria</b>	Albumin hypersensitivity, concurrent use of any of the following medications: Interferon-beta therapy (Avonex, Betaseron, or Rebif), glatiramer acetate, or mitoxantrone.
<b>Required Medical Information</b>	MRI has been performed and has features suggestive of MS (evidence of lesion).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Patients with previous use (12 or more months) of Extavia must demonstrate one of the following clinical responses: decrease in the frequency of relapses, slowing of disease progression, MRI lesions have diminished with therapy, OR patient is stable on therapy.
<b>Prior Authorization Group</b>	FABRAZYME
<b>Drug Names</b>	FABRAZYME
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis confirmed with an enzyme assay measuring a deficient activity of alpha-galactosidase enzyme or DNA testing.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	GILENYA
<b>Drug Names</b>	GILENYA
<b>Covered Uses</b>	All FDA approved uses not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For new starts, patient had an inadequate response to a trial of a beta interferon agent or Copaxone unless contraindicated or not tolerated.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For continuation, patient is benefiting from Gilenya therapy.
<b>Prior Authorization Group</b>	GONADOTROPIN
<b>Drug Names</b>	CHORIONIC GONADOTROPIN, NOVAREL, PREGNYL W/DILUENT BENZYL
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Female. In males: anatomic obstruction, precocious puberty, prostatic carcinoma or other androgen-dependent neoplasm.
<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>	GROWTH HORMONE
<b>Drug Names</b>	NORDITROPIN NORDIFLEX PEN, SAIZEN, SAIZEN CLICK.EASY, TEV-TROPIN
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Malignancy, diabetic retinopathy, acute critical illness, concurrent use with Increlex, closed epiphyses for all pediatric patients, upper airway obstruction for PWS only, and other cause of hypoglycemia have been ruled out for neonates with hypoglycemia, pediatric GHD has been ruled out for ISS with one stimulation test.
<b>Required Medical Information</b>	For neonate with hypoglycemia, patient has pediatric GHD, has a randomly assigned GH level of less than 20 ng/mL. For SBS: patient is receiving specialized nutritional support and patient has not received GH therapy for more than 8 weeks lifetime. For HIV wasting: patient is on antiretroviral therapy, has tried and failed alternative therapies such as dronabinol or megestrol, and alternative causes of wasting have been ruled out. To continue therapy for HIV wasting, BMI has improved or stabilized and it has been at least 4 weeks since completion of last round of GH therapy. For all pediatric patients: patients have short stature and have been evaluated for other causes of growth failure. For pediatric GHD, has delayed bone age and failed 2 stimulation tests. For pediatric GHD with a pituitary or CNS disorder: patient has clinical evidence of GHD and low IGF-1/IGFBP3. For Turner syndrome patient: diagnosis confirmed with karyotyping. For chronic renal insufficiency patients: metabolic, endocrine and nutritional abnormalities have been treated or stabilized, and patient has not had a kidney transplant. For SGA patients: has a low birth weight, and has failed to manifest catch up growth by age 2. For PWS patients: therapy will be discontinued if patient develops severe respiratory impairment. For SHOX patients: diagnosis confirmed by molecular or genetic testing. For adults: assessed for other causes of GHD-like symptoms and failed 2 stimulation tests. For adult GHD with at least 3 pituitary hormone deficiencies or panhypopituitarism: have a low IGF-1. For adult GHD with less than 3 pituitary hormone deficiencies, low IGF-1 and failed one stimulation test. To continue therapy for pediatric patients, growing more than 2 cm per year, open epiphyses, and for PWS only: improved body composition. To continue therapy for adult patients: clinical improvement and IGF-1 to confirm appropriateness of treatment. For Turner syndrome and SGA, 2 years of age and older. For Noonan syndrome and SHOX, 3 years of age and older.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Endocrinologist, Pediatric Nephrologist, Gastroenterologist, Nutritional Support Specialist, Infectious Disease Specialist
<b>Coverage Duration</b>	12 weeks for HIV wasting, 8 weeks lifetime for SBS, 12 months for all other indications
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	HEPSERA
<b>Drug Names</b>	HEPSERA
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D

<b>Exclusion Criteria</b>	Renal impairment without dosing adjustment, if the patient is taking/receiving tenofovir or PMPA.
<b>Required Medical Information</b>	A. The patient has been diagnosed with chronic hepatitis B. B. AND the patient has evidence of a positive HBsAg (+ or -) serological marker for greater than 6 months OR evidence by a liver biopsy showing chronic hepatitis. C. AND the patient has a Hepatitis B viral load greater than 20,000 IU/ml (100,000 copies per ml). D. AND the patient has elevations in liver aminotransferases (ALT or AST) that are two (2) times greater than normal OR normal liver aminotransferase (ALT or AST) levels with evidence of significant disease found on biopsy. E. AND the patient has been tested for HIV. (Hepsera therapy can cause HIV resistance in untreated HIV infection). F. AND the patient is not receiving duplicate therapy that includes Baraclude, Tyzeka, and/or Intron A. G. AND documented evidence of diagnosis, serological markers or liver biopsy, viral load and liver aminotransferases. H. If the patient has received previous Hepsera treatment, there is documented clinical improvement shown by a drop in viral load or reduction in the patient's liver aminotransferases.
<b>Age Restrictions</b>	12 years and older
<b>Prescriber Restrictions</b>	Gastroenterologist or Infectious Disease
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	HUMIRA
<b>Drug Names</b>	HUMIRA, HUMIRA PEN-CROHNS DISEASE
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Active infection (including TB, sepsis), concurrent use with other biologics.

<b>Required Medical Information</b>	LTBI screening, and if results are positive, patient must have completed treatment or must currently be receiving treatment for LTBI. HBV infection ruled out or treatment initiated. If moderate to severe psoriatic arthritis with predominantly peripheral symptoms or moderate to severe RA or JIA, patient has had at least an 8-week maximum tolerated dose trial and failure or has an intolerance or contraindication to at least 1 nonbiologic DMARD (e.g., methotrexate, cyclosporine, azathioprine, sulfasalazine, leflunomide, hydroxychloroquine). If psoriatic arthritis with predominantly axial symptoms or ankylosing spondylitis, patient has tried and failed to respond to 2 NSAIDs unless patient has a contraindication or intolerance to NSAIDs. For moderate to severe plaque psoriasis, affected area is greater than 10% of BSA OR an area that will affect crucial daily functions (e.g., feet, hands). For moderate to severe plaque psoriasis, patient has tried and failed or has an intolerance or contraindication to at least a 60-day trial of 2 conventional therapies including high potency topical steroid therapy, calcipotriene, phototherapy, retinoids, methotrexate, or cyclosporine. If Crohn's disease, patient has tried and failed or has a contraindication or intolerance to at least a 60-day trial of 2 of the following conventional therapies: sulfasalazine, balsalazide, mesalamine, azathioprine, cyclosporine, methotrexate, mercaptopurine, corticosteroids OR patient has had an inadequate response or intolerance to either Remicade or Cimzia.
<b>Age Restrictions</b>	For PP, 18 years of age and older
<b>Prescriber Restrictions</b>	Rheumatologist, Dermatologist or Gastroenterologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For continuation of therapy, patient must show an improvement in clinical symptoms or delay in progression of disease.
<b>Prior Authorization Group</b>	INCRELEX
<b>Drug Names</b>	INCRELEX
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Benzyl alcohol hypersensitivity, epiphyseal closure, IV administration of Increlex, active malignancy, use in neonates, concurrent use with GH therapy, secondary causes of IGF-1 deficiency.
<b>Required Medical Information</b>	Prior to starting therapy, a height greater than 3 SD below the mean for chronological age and sex, and an IGF-1 level greater than or equal to 3 SD below the mean for chronological age and gender. One stimulation test showing patient has a normal or elevated GH level.
<b>Age Restrictions</b>	Between 2 and 20 years of age
<b>Prescriber Restrictions</b>	Endocrinologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For continuation of therapy, there is an increase in height velocity by greater than 2.5 cm total growth in one year and patient has open epiphyses.

<b>Prior Authorization Group</b>	INFERGEN
<b>Drug Names</b>	INFERGEN
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Decompensated liver failure/disease. Autoimmune disease. Use for nonresponse or relapse.
<b>Required Medical Information</b>	Prior to initiating therapy, detectable levels of HCV RNA in the serum. Genotype 1,4: undetectable HCV RNA after 12 weeks of treatment OR at least 2 log decrease in HCV RNA after 12 weeks of therapy and undetectable HCV RNA after 24 weeks of treatment.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 to a total of 18 months depending on genotype and initial vs. renewal therapy
<b>Other Criteria</b>	Monitored for evidence of depression. If used as monotherapy, patient should have a contraindication or intolerance to ribavirin.
<b>Prior Authorization Group</b>	ITRACONAZOLE
<b>Drug Names</b>	ITRACONAZOLE
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	A. ventricular dysfunction (e.g., congestive heart failure (CHF) or history of CHF) do not use for onychomycosis. B. If the patient is taking/receiving any of the following: concomitant use with drugs metabolized by CYP3A4 (e.g., dofetilide, oral midazolam, nisoldipine, pimozide, quinidine), HMG CoA-reductase inhibitors (e.g., lovastatin, simvastatin), triazolam, or ergot alkaloids (dihydroergotamine, ergometrine (ergonovine), ergotamine, methylethergotamine (methylethergonovine)). C. pregnant women or women contemplating pregnancy do not use for onychomycosis.
<b>Required Medical Information</b>	Patients with a diagnosis of blastomycosis, pulmonary and extrapulmonary OR patients with a diagnosis of histoplasmosis, including chronic cavitary pulmonary disease and disseminated, non-meningeal histoplasmosis OR patients with a diagnosis of aspergillosis, pulmonary and extrapulmonary OR patients with a diagnosis of onychomycosis of the toenail, with or without fingernail involvement, due to dermatophytes (tinea unguium) OR patients with a diagnosis of onychomycosis of the fingernail due to dermatophytes (tinea unguium) documentation is required showing a positive culture of aspergillosis, blastomycosis, histoplasmosis, or onychomycosis of the toenail or fingernail.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 weeks
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	IVIG
<b>Drug Names</b>	GAMMAGARD LIQUID, GAMUNEX
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D

<b>Exclusion Criteria</b>	IgA deficiency with antibody formation. Intolerance to any of the components of immune globulin. Presence of risk factor for acute renal failure, unless the patient will receive IGIV products at the minimum concentration available and at the minimum rate of infusion practicable.
<b>Required Medical Information</b>	PID: history of infections with nonsustained response to antimicrobial therapy AND evidence of failed antibody development to established norms for vaccine stimulation. CIDP: presence of objective findings consistent with diagnosis. B-Cell CLL: history of recurrent bacterial infections.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	CIDP diagnosis by a neurologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	B vs D coverage determination per CMS guidelines
<b>Prior Authorization Group</b>	LETAIRIS
<b>Drug Names</b>	LETAIRIS
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	AST/ALT level greater than 3 times ULN, pregnancy for females.
<b>Required Medical Information</b>	Diagnosis of pulmonary arterial hypertension (PAH), (WHO Group 1). NYHA class II or III symptoms. PAH been confirmed by right heart catheterization. If patient is an infant, PAH diagnosed by Doppler echocardiogram.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	IUD or two appropriate contraceptive methods for women of childbearing potential.
<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>	Administration within 24 hours preceding or following chemotherapy or radiotherapy, hypersensitivity to yeast-derived products, treatment of acute afebrile neutropenia, use to increase the chemotherapy dose intensity or dose schedule above established regimens.

**Required Medical Information** 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

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

LEUPROLIDE DEPOT

LEUPROLIDE ACETATE, LUPRON DEPOT, LUPRON DEPOT-PED

All FDA approved indications not otherwise excluded from Part D

For endometriosis, fibroids, and ovarian cancer: pregnancy and breastfeeding.

For CPP, patient must be less than 12 years old if female and less than 13 years old if male.

**Prescriber Restrictions**

Obstetrician/Gynecologist, Oncologist, Endocrinologist. Urologist for diagnosis of prostate cancer.

**Coverage Duration**

Fibroids - 3 months, endometriosis - 6 months, ovarian cancer, prostate cancer, CPP - 12 months.

**Other Criteria**

For endometriosis only, patient must have completed a trial and failure of at least 2 of the following therapies: oral contraceptives, medroxyprogesterone, danazol. For ovarian CA, patient has recurrent or stage II to stage IV ovarian cancer. For prostate cancer, orchiectomy or estrogen therapy are unacceptable treatment options. For prostate cancer: used for initial treatment in advanced prostate cancer or when there is intermediate to high risk of recurrence. For prostate cancer, for adjuvant or neoadjuvant therapy.

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

LIDODERM

LIDODERM

All FDA approved indications not otherwise excluded from Part D

**Exclusion Criteria**

**Required Medical Information**

A. The diagnosis is documented as post-herpetic neuralgia B. The skin where the patch is to be applied is intact (not broken or inflamed). C. The patient has completed a documented one month trial and failure of the following two medications: gabapentin and Lyrica D. OR the patient has a contraindication or demonstrated an adverse event to the prerequisite drugs.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

3 months

**Other Criteria**

**Prior Authorization Group**

**Drug Names**

METHYLPHENIDATES  
DEXMETHYLPHENIDATE HCL, METHYLIN, METHYLPHENIDATE HCL,  
METHYLPHENIDATE HYDROCHLO

**Covered Uses**

All FDA approved indications not otherwise excluded from Part D

**Exclusion Criteria**

MAOI concurrent use or within the last 14 days

**Required Medical Information**

Sleep studies for narcolepsy diagnosis

**Age Restrictions**

6 years of age and older

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

Consider benefits of use versus the potential risks of serious cardiovascular events.

**Prior Authorization Group**

**Drug Names**

MOZOBIL  
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**

**Drug Names**

MYOZYME  
MYOZYME

**Covered Uses**

All FDA approved indications not otherwise excluded from Part D

**Exclusion Criteria**

**Required Medical Information**

Diagnosis confirmed by an enzymatic assay showing a deficiency in acid alpha glucosidase or DNA testing.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

<b>Prior Authorization Group</b>	NAGLAZYME
<b>Drug Names</b>	NAGLAZYME
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis confirmed by an enzymatic assay showing a deficiency in N-acetylgalactosamine activity or DNA testing.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Must have at least one MPS VI symptom. For re-authorization, must demonstrate improvement in walking and/or stair-climbing capacity.
<b>Prior Authorization Group</b>	NEUPOGEN
<b>Drug Names</b>	NEUPOGEN
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Administration within 24 hours preceding or following chemotherapy or radiotherapy, E coli hypersensitivity, use in acute afebrile neutropenia, use to increase the chemotherapy dose intensity or dose schedule above labeled use.
<b>Required Medical Information</b>	For patients with nonmyeloid malignancies receiving myelosuppressive chemotherapy: Neupogen may be used for the prevention of chemotherapy-induced neutropenia if the regimen is associated with 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 receive Neupogen 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. Neupogen is allowable for the treatment of febrile neutropenia in patients who have received prophylaxis with Neupogen (or Leukine) OR in patients at risk for infection-related complications. Neupogen 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	NICOTINE
<b>Drug Names</b>	NICOTROL INHALER, NICOTROL NS
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation that the patient is enrolled in a smoking cessation program
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	

<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<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>	Concomitantly taking other drugs containing quinidine, quinine, mefloquine, monoamine oxidase inhibitors (MAOIs), or drugs that both prolong QT interval and are metabolized by CYP2D6 (e.g., thioridazine and pimozide), patient has a prolonged QT interval, congenital long QT syndrome or a history suggestive of torsades de pointes, or heart failure, patient has complete atrioventricular (AV) block without implanted pacemaker, or is at high risk of complete AV block. Dose in excess of 2 capsules per day.
<b>Required Medical Information</b>	Patient has amyotrophic lateral sclerosis (ALS) OR multiple sclerosis (MS)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<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>	
<b>Required Medical Information</b>	If diagnosis is narcolepsy require sleep lab evaluation, if diagnosis of OSAHS require polysomnography and whether the patient is using CPAP.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	OCTREOTIDE
<b>Drug Names</b>	OCTREOTIDE ACETATE
<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>	ORFADIN
<b>Drug Names</b>	ORFADIN
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D

<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Confirmation of diagnosis by either biochemical testing (e.g., detection of succinylacetone in urine) and appropriate clinical picture OR DNA testing (mutation analysis).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Endocrinologist, Clinical or Biochemical Geneticist, Gastroenterologist, Hepatologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Protein-restricted diet that is low in phenylalanine and tyrosine.
<b>Prior Authorization Group</b>	OSTEOPOROSIS
<b>Drug Names</b>	FORTEO
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Paget's disease, elevated alkaline phosphatase, pre-existing hypercalcemia, skeletal malignancies, prior radiation of the skeleton, cumulative use of Forteo for more than 24 months lifetime, concurrent bisphosphonate use.
<b>Required Medical Information</b>	Patients treated with Forteo meet one of the following criteria for fracture risk: prior fragility fracture OR T score less than or equal to -2.5 and family history of fracture OR inadequate response to a bisphosphonate trial of a minimum of one year (unless bisphosphonate is contraindicated or patient was intolerant to bisphosphonate therapy).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	OXSORALEN
<b>Drug Names</b>	OXSORALEN ULTRA
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Albinism, aphakia, melanoma, porphyria, skin photosensitivity disorder, systemic lupus erythematosus (SLE), xeroderma pigmentosum, invasive squamous cell carcinoma or current skin burns.
<b>Required Medical Information</b>	The patient must be diagnosed with T-cell lymphoma OR psoriasis OR vitiligo AND if the diagnosis is psoriasis, the patient must have previous trial/failure or contraindication to at least one topical steroid.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Dermatologist or Oncologist or affiliated with a dermatologist/oncologist practice
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	PEGASYS
<b>Drug Names</b>	PEGASYS
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Current psychosis or a history of psychosis, severe depression, severe thrombocytopenia, decompensated cirrhosis, serious active infection.

<b>Required Medical Information</b>	HCV: HCV genotype, detectable HCV RNA within 90 days prior to starting therapy. HBV: HBsAg positive or liver biopsy showing chronic hepatitis AND appropriate HBV DNA levels for HBeAg status AND elevated liver enzymes. CML: unable to tolerate tyrosine kinase inhibitors or post-transplant if not in remission or with relapse.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	ID specialist, Gastroenterology, Oncologist
<b>Coverage Duration</b>	Chronic hepatitis C - 3 to 12 months total. Chronic hepatitis B - 12 months. CML - 12 months.
<b>Other Criteria</b>	HBV: Not receiving duplicate therapy. For reauthorization, clinical improvement. HCV: Retreatment allowed in those who did not receive optimal HCV treatment. For reauthorization at 12 weeks, early virologic response.
<b>Prior Authorization Group</b>	PEGINTRON
<b>Drug Names</b>	PEG-INTRON, PEG-INTRON REDIPEN
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Current psychosis or a history of psychosis, severe depression, severe thrombocytopenia, decompensated cirrhosis, serious active infection.
<b>Required Medical Information</b>	HCV: HCV genotype. Detectable HCV RNA within 90 days of initiating therapy. CML: unable to tolerate TKIs or post-transplant if not in remission or with relapse.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	ID specialist, Gastroenterology, Oncology
<b>Coverage Duration</b>	HCV - 3 months to 12 months. CML - 12 months.
<b>Other Criteria</b>	HCV: Retreatment allowed for those who did not receive optimal HCV treatment. For reauthorization at 12 weeks, early virologic response.
<b>Prior Authorization Group</b>	PROLIA
<b>Drug Names</b>	PROLIA
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Hypocalcemia
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Patient will be adequately supplemented with calcium and vitamin D.
<b>Prior Authorization Group</b>	PROMACTA
<b>Drug Names</b>	PROMACTA
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	

**Required Medical Information** For new starts, a pretreatment platelet count less than 30,000/microL or a platelet count less than or equal to 50,000/microL with significant mucous membrane bleeding or risk factors for bleeding are required. For continuation of therapy, an increase in platelet count to a level that is sufficient to avoid clinically important bleeding after at least 4 weeks of maximum dose therapy is required. For continuation of therapy, alanine aminotransferase levels must not be greater than or equal to 3 times the upper limit of normal and must not be progressive, persistent, or accompanied by increased bilirubin, symptoms of liver injury, or hepatic decompensation.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

6 mo initially, 12 mo renewal w/ platelet response, 3 mo renewal w/out platelet response

**Other Criteria**

**Prior Authorization Group**

PROVIGIL

**Drug Names**

PROVIGIL

**Covered Uses**

All FDA approved indications not otherwise excluded from Part D

**Exclusion Criteria**

**Required Medical Information**

If diagnosis is narcolepsy require sleep lab evaluation, if diagnosis of OSAHS require polysomnography and whether the patient is using CPAP.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

**Prior Authorization Group**

REBIF

**Drug Names**

REBIF, REBIF TITRATION PACK

**Covered Uses**

All FDA approved indications not otherwise excluded from Part D

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

**Prior Authorization Group**

RELISTOR

**Drug Names**

RELISTOR

**Covered Uses**

All FDA approved indications not otherwise excluded from Part D

**Exclusion Criteria**

Mechanical gastrointestinal obstruction, known or suspected.

**Required Medical Information**

A. Relistor is being prescribed for treatment of opioid-induced constipation in patients with advanced illness who are receiving palliative care. B. patient must have previous trial/failure of polyethylene glycol.

**Age Restrictions**

<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	4 Months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	REMICADE
<b>Drug Names</b>	REMICADE
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Active infection (including TB, sepsis), concurrent use with other biologics, moderate to severe HF (NYHA Functional Class III/IV) at doses greater than 5mg/kg, murine protein hypersensitivity.
<b>Required Medical Information</b>	LTBI screening, and if results are positive, patient must have completed treatment or must currently be receiving treatment for LTBI. HBV infection ruled out or treatment initiated. If moderate to severe RA, patient has had at least an 8-week maximum tolerated dose trial and failure or has an intolerance or contraindication to at least 1 nonbiologic DMARD (e.g.,methotrexate, cyclosporine, azathioprine, sulfasalazine, leflunomide, hydroxychloroquine) AND patient has had a previous trial and failure to Enbrel or Humira. For moderate to severe RA, patient is receiving MTX concurrently. If moderate to severe psoriatic arthritis with predominantly peripheral symptoms, patient had at least an 8-week maximum tolerated dose trial and failure or has an intolerance or contraindication to at least 1 of the following nonbiologic DMARDs (e.g., methotrexate, cyclosporine, azathioprine, sulfasalazine, leflunomide, hydroxychloroquine) AND patient had a previous trial and failure to Enbrel or Humira. If moderate to severe psoriatic arthritis with predominantly axial symptoms or ankylosing spondylitis, patient has tried and failed to respond to 2 NSAIDs unless patient has a contraindication or intolerance to NSAIDs.
<b>Age Restrictions</b>	For plaque psoriasis, 18 years of age and older.
<b>Prescriber Restrictions</b>	Rheumatologist, Dermatologist and Gastroenterology
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	If moderate to severe plaque psoriasis, affected area is greater than 10% of body surface area OR an area that will affect crucial daily functions (e.g., feet, hands). For moderate to severe plaque psoriasis, patient has tried and failed (or has an intolerance or contraindication to) at least a 60 day trial of 2 conventional therapies including high potency topical steroid therapy, calcipotriene, phototherapy, retinoids, or methotrexate. If ulcerative colitis: patient has tried and failed (or has a contraindication or intolerance to) at least a 60 day trial of 2 conventional therapies such as sulfasalazine, balsalazide, mesalamine, or corticosteroids. If Crohn's disease: patient has tried and failed (or has an intolerance or contraindication to) 1 conventional therapy (eg, corticosteroids) and 1 biologic therapy ((ie, Humira or Cimzia). For continuation of therapy, patient must show an improvement in clinical symptoms or delay in progression of disease.
<b>Prior Authorization Group</b>	REVATIO

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

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

Plan Year

**Prior Authorization Group**

<b>Drug Names</b>	REVLIMID
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diffuse large B-cell lymphoma: relapsed, refractory or progressive disease. Mantle cell lymphoma: as monotherapy for relapsed, refractory or progressive disease. Systemic light chain amyloidosis: use as primary treatment in combination with dexamethasone. Myeloma: FDA approved uses OR palliative treatment OR primary induction in combination with dexamethasone OR maintenance therapy as monotherapy after stem cell transplant or in responders to primary induction therapy. Low or Intermediate-1 Risk MDS: for those with 5q deletion, patients should have transfusion dependent anemia OR clinically significant cytopenias and symptomatic anemia. For those with non-5q deletion and symptomatic anemia, patients should have failed to respond to epoetin alfa or darbepoetin OR have serum erythropoietin levels greater than 500 mU/mL and a low probability of response to immunosuppressive therapy.

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

Plan Year

Male and female patients of child-bearing potential should be instructed on the importance of proper utilization of appropriate contraceptive methods for Revlimid use. Patients should be monitored for signs and symptoms of thromboembolism.

**Prior Authorization Group**

<b>Drug Names</b>	RIBAVIRIN
<b>Covered Uses</b>	REBETOL, RIBAPAK, RIBASPHERE, RIBAVIRIN
<b>Exclusion Criteria</b>	All FDA approved indications not otherwise excluded from Part D
	Hemoglobin less than 8.5 g/dL. Hemoglobinopathy. History of unstable heart disease. Creatinine clearance less than 50 mL/minute unless the patient will receive a modified dose of ribavirin. Pregnancy (self or partner).

<b>Required Medical Information</b>	HCV relapse or nonresponse: patient was initially treated with a less than optimal regimen for HCV or there is a clinical reason that suggests that patient will respond to retreatment AND ribavirin will be used in combination with a pegylated interferon AND this is the first time the patient is being retreated with a pegylated IFN and ribavirin.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 weeks to a total of 72 weeks based on genotype, response, and initial vs. renewal therapy.
<b>Other Criteria</b>	Patient has been instructed to practice effective contraception during therapy and for six months after stopping ribavirin therapy.
<b>Prior Authorization Group</b>	RITUXAN
<b>Drug Names</b>	RITUXAN
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Hypersensitivity to murine proteins or chimeric monoclonal antibodies, or patient is receiving live vaccines.
<b>Required Medical Information</b>	For rheumatoid arthritis (RA), an inadequate response to a nonbiologic DMARD (8-week trial) and an inadequate response to either Enbrel or Humira are required. For continuation of RA therapy, improvement in clinical symptoms that may include improvement in tender and swollen joint count, mobility, or stiffness, or delay in progression of disease is required.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Rheumatologist and Oncologist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	For chronic lymphocytic leukemia and adult acute lymphoblastic leukemia, Rituxan must be used in combination with chemotherapy.
<b>Prior Authorization Group</b>	SANDOSTATIN LAR
<b>Drug Names</b>	SANDOSTATIN LAR DEPOT
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Effective and tolerated prior Sandostatin injection (not depot form) therapy for at least 2 weeks.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	SOMATULINE DEPOT
<b>Drug Names</b>	SOMATULINE DEPOT
<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>	SOMAVERT
<b>Drug Names</b>	SOMAVERT
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	IV administration of Somavert, concomitant use of Sandostatin or Somatuline.
<b>Required Medical Information</b>	An elevated IGF-1 level or elevated GH level with a glucose tolerance test. Patient has tried and failed at least a 3 month trial of Sandostatin or Somatuline.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Endocrinologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For retreatment, reduction in IGF-1 level from baseline.
<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>	Active infection (including tuberculosis), concurrent use with other biologics
<b>Required Medical Information</b>	Screening for latent tuberculosis is required. If results are positive, patient must have completed treatment or must currently be receiving treatment for latent tuberculosis.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For renewal, patient's condition must have improved or stabilized.
<b>Prior Authorization Group</b>	STRATTERA
<b>Drug Names</b>	STRATTERA
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	MAOI concurrent use or within the last 14 days
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	6 years of age and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Monitor for suicidality, clinical worsening, changes in behavior, blood pressure changes, heart rate changes, liver injury.
<b>Prior Authorization Group</b>	SYMLIN
<b>Drug Names</b>	SYMLIN, SYMLINPEN 120, SYMLINPEN 60
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D

**Exclusion Criteria** Severe hypoglycemia that required assistance during the past 6 months, gastroparesis, patient requires drug therapy to stimulate gastrointestinal motility, the presence of hypoglycemia unawareness (i.e., inability to detect and act upon the signs or symptoms of hypoglycemia).

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

Plan Year

The patient must have inadequate glycemic control (HbA1c greater than 7% but less than 9%) at initiation of therapy, patient currently receiving optimal mealtime insulin therapy.

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

TERBINAFINE

TERBINAFINE HCL

All FDA approved indications not otherwise excluded from Part D

LFTs, fungal diagnostic test (e.g., KOH preparation, positive fungal culture, or nail biopsy)

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

2 months for fingernails only, 3 months if toenail involvement, 6 weeks for tinea infections

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

TESTOSTERONES

ANDRODERM

All FDA approved indications not otherwise excluded from Part D

Female, prostate cancer, breast cancer.

Before the start of testosterone therapy patient has (or patient currently has) a confirmed low testosterone level (i.e. total testosterone less than 300 ng/dL, free or bioavailable, testosterone less than 5 ng/dL) or absence of endogenous testosterone.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

Plan Year

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

THALOMID

THALOMID

All FDA approved indications not otherwise excluded from Part D

Pregnancy

<b>Required Medical Information</b>	Mantle cell lymphoma: relapsed, refractory or progressive disease in combination with rituximab. Waldenstrom's macroglobulinemia: third-line, palliative treatment OR as monotherapy for primary treatment in patients with symptomatic hyperviscosity with plasmapheresis. ENL: if moderate to severe neuritis, Thalomid will not be used as monotherapy. Systemic light chain amyloidosis: use with dexamethasone. Myeloma: advanced, refractory disease OR induction therapy with dexamethasone OR induction therapy in transplant ineligible patients used in combination with melphalan and prednisone OR maintenance therapy as monotherapy after stem cell transplant or in those who responded to primary induction therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Patients should be informed to be observant for signs and symptoms of thromboembolism. Male and female patients of child-bearing potential should be instructed on importance of proper utilization of appropriate contraceptive methods for Thalomid use.
<b>Prior Authorization Group</b>	TOPICAL IMMUNOSUPPRESSANT
<b>Drug Names</b>	ELIDEL, PROTOPIC
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A. The diagnosis is documented as atopic dermatitis or eczema. B. AND patients must be at least 2 years of age C. AND patients who have completed a documented trial and failure of at least two medium or higher potency topical steroids or have documented intolerance or unresponsiveness to medium or higher potency topical steroids D. AND patients have been advised that Elidel and Protopic should only be used to treat the immediate problem and then should be stopped when the condition improves.
<b>Age Restrictions</b>	2 years of age and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	TOPICAL-ULCERS
<b>Drug Names</b>	REGRANEX
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Neoplasm(s) at site(s) of application
<b>Required Medical Information</b>	A. Must be used for treatment of lower-extremity diabetic ulcers B. AND the ulcer must extend into subcutaneous tissue C. AND the tissue must have an adequate blood supply D. AND the patient must have concurrent good ulcer treatment practices including ALL of the following: a. Debridement b. Pressure relief c. Infection relief E. AND the ulcer must be less than 10 cm <sup>2</sup> in size.

<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	10 weeks
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	TRACLEER
<b>Drug Names</b>	TRACLEER
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	AST/ALT level greater than 3 times ULN. Pregnancy. Concomitant use of cyclosporine A or glyburide.
<b>Required Medical Information</b>	PAH confirmed by right heart catheterization.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Female patient of childbearing potential must use more than one method of contraception concurrently.
<b>Prior Authorization Group</b>	TYZEKA
<b>Drug Names</b>	TYZEKA
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Hypersensitivity to telbivudine or any component of the product.
<b>Required Medical Information</b>	A. The patient has been diagnosed with chronic hepatitis B. B. AND the patient has evidence of a positive HBsAg (+ or -) serological marker for greater than 6 months OR evidence by a liver biopsy showing chronic hepatitis. C. AND the patient has a Hepatitis B viral load greater than 20,000 IU/mL (100,000 copies/mL). D. AND the patient has elevations in liver aminotransferases (ALT or AST) that are two (2) times greater than normal OR normal liver aminotransferase (ALT or AST) levels with evidence of significant disease found on biopsy. E. AND the patient has been tested for HIV. (Tyzeka therapy can cause HIV resistance in untreated HIV infection). F. AND if the patient has received previous Tyzeka treatment, there is documented clinical improvement shown by a drop in viral load or reduction in the patient's liver aminotransferases. G. AND the patient is not receiving duplicate therapy that includes Baraclade, Epivir and/or Intron A. H. AND evidence of diagnosis, serological markers or liver biopsy, viral load, and liver aminotransferases is documented in patient's chart.
<b>Age Restrictions</b>	16 years of age and older
<b>Prescriber Restrictions</b>	Infectious Disease or Gastroenterologist
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	
<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>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Untreated or inadequately treated depression or actively suicidal, history of hepatic disease or torsade de pointes, use in combination with MAO inhibitors or reserpine (or it has been less than 20 days since reserpine was discontinued).
<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>	XIFAXAN
<b>Drug Names</b>	XIFAXAN
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Hypersensitivity reaction to rifamycin antimicrobial agents. For hepatic encephalopathy, Xifaxan exceeding the recommended dose of two 550mg tablets daily.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Hepatic encephalopathy-6 months
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	XOLAIR
<b>Drug Names</b>	XOLAIR
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Patient is a current smoker, hamster protein hypersensitivity, omalizumab hypersensitivity.

**Required Medical Information** Patient has evidence of reversible disease (demonstrates at least 20 percent improvement in PEF with a short-acting bronchodilator challenge), patient has experienced 2 or more asthma exacerbations per month within the last 3 months, positive skin test to at least 1 perennial aeroallergen, baseline IgE level at or above 30 IU/mL, asthma is inadequately controlled despite adherent use of inhaled corticosteroids for at least 6 months, inadequate response to a 3 month trial of a leukotriene modifier and long-acting beta2-agonist (unless patient demonstrates intolerance to the therapeutic trial).

**Age Restrictions** 12 years of age and older

**Prescriber Restrictions** Pulmonologist, Allergist or Immunologist

**Coverage Duration** Plan Year

**Other Criteria** Patients with prior Xolair therapy must demonstrate an improvement in asthma control with use of Xolair.

**Prior Authorization Group** XYREM

**Drug Names** XYREM

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

**Exclusion Criteria** If the patient is taking/receiving any of the following: anxiolytics, sedatives, hypnotics, barbiturates, benzodiazepines or ethanol.

**Required Medical Information** A. The diagnosis is documented as excessive daytime sleepiness with symptoms that limit their ability to perform normal daily activities. B. AND the diagnosis is documented as cataplexy (a condition characterized by weak or paralyzed muscles) in patients with narcolepsy. C. AND if the patient has received prior treatment with Xyrem, the patient must experience a decrease in daytime sleepiness and/or cataplexy in a narcoleptic patient.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** 3 months

**Other Criteria**

**Prior Authorization Group** ZAVESCA

**Drug Names** ZAVESCA

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

**Exclusion Criteria** Renal failure. Pregnancy. Labor/obstetric delivery.

**Required Medical Information** Diagnosis confirmed by bone marrow histology, DNA testing or measurement of b-glucocerebrosidase enzyme activity less than 30%. Trial and failure of enzyme replacement therapy or is not a therapeutic option. Female patients of childbearing age will be on a form of contraception or have no ability to conceive and been educated on the potential dangers of Zavesca therapy. Must demonstrate a decrease in liver and spleen volume and/or increase in platelet count and/or increase in Hgb concentration in patients who have previously received 24 months of Zavesca therapy.

<b><i>Age Restrictions</i></b>	18 years of age and older
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	