



2010 Formulary - Prior Authorization Updates

PA Criteria

Prior Authorization Group

ACNE

Drug Names

AVITA CREAM, AVITA GEL, RETIN-A MICR GEL, TRETINOIN CREAM, TRETINOIN GEL

Covered Uses

All FDA-approved indications not otherwise excluded from Part D, keratosis follicularis (Darier's disease, Darier-White disease)

Exclusion Criteria

Cosmetic use

Required Medical Information

Age Restrictions

Approve for those 12 years of age and older

Prescriber Restrictions

Coverage Duration

12 months

Other Criteria

Prior Authorization Group

ADCIRCA

Drug Names

ADCIRCA

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Concurrent nitrate therapy. PAH associated with any of the following: left heart disease, chronic thrombotic disease, embolic disease, compression of pulmonary vessels, lung diseases, hypoxemia, sarcoidosis

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

12 months

Other Criteria

Prior Authorization Group AFINITOR
Drug Names AFINITOR

Covered Uses 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 AMPHETAMINES

Drug Names AMPHETAMINE, DEXTROAMPHETAMINE

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 Approve for those 3 years of age and older

Prescriber Restrictions

Coverage Duration 12 months

Other Criteria Monitor for weight loss, decreased growth velocity in children, increased heart rate and blood pressure, appearance or worsening of aggressive behavior or hostility, sleep disturbances and long-term usefulness of the drug

Prior Authorization Group

ARANESP

Drug Names

ARANESP

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

CRF - transferrin saturation less than 20% and patient not receiving iron supplementation where clinically appropriate. CRF and anemia in patients with non-myeloid malignancies - hemoglobin level of the patient (not the result of a recent blood transfusion) greater than 13 g/dL. Lack of initial diagnosis of anemia (hematocrit less than 30% and/or hemoglobin less than 10 g/dL and/or symptomatic with hemoglobin 10-11g/dL).

Required Medical Information

CRF - iron status of the patient has been evaluated (serum transferrin saturation). CRF and anemia of cancer - Hemoglobin level of the patient be monitored prior to each dose when initiating therapy, for dose changes, and at regular intervals when the dose is stabilized. Hemoglobin level of the patient will be monitored prior to each dose when initiating therapy, for dose changes, and at regular intervals when the dose is stabilized. Blood pressure of the patient will be monitored throughout therapy. Patient will be monitored for the occurrence of thrombotic events.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Initiation of therapy and/or dose changes - 6 weeks. Stable on therapy - 12 weeks.

Other Criteria

Once on therapy, compared to pretreatment baseline, the patient must show an objective clinical response (e.g., hemoglobin rise greater than 1 g/dL and/or hematocrit rise greater than 3%) to an appropriate dose/dose increase and duration of therapy.

Prior Authorization Group

Drug Names

B vs D

ACETYLCYSTEINE, ALBUTEROL SULFATE, ALBUTEROL SULFATE/IPRATROPIUM BROMIDE, AMINOSYN, AZASAN, AZATHIOPRINE, CELLCEPT, CHORIONIC GONADOTROPIN, CLIMIMIX , CLINISOL SF 15%, COLISTIMETHATE SODIUM, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, DECAVAC, DIPHTHERIA/TETANUS TOXOID PEDIATRIC, EMEND, ENGERIX-B, FREAMINE , GENGRAF, GRANISETRON HCL, GRANISOL, HEPATAMINE, HEPATASOL, INTRALIPID, IPRATROPIUM BROMIDE, LIPOSYN, MYCOPHENOLATE, MYFORTIC, NEORAL, NEPHRAMINE, NOVAMINE, ONDANSETRON HCL, ONDANSETRON ODT, PREMASOL, PROCALAMINE, PROGRAF, PROSOL, PULMICORT, PULMOZYME, RAPAMUNE, RECOMBIVAX HB, RENAMIN, SANDIMMUNE, TACROLIMUS, TETANUS TOXOID ADSORBED, TETANUS/DIPHTHERIA TOXOIDS-ADSORBED ADULT, TOBI, TRAVASOL, TROPHAMINE, VENTAVIS, XOPENEX

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

Other Criteria

<i>Prior Authorization Group</i>	CELEBREX
<i>Drug Names</i>	CELEBREX
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Post-operative pain following CABG surgery, allergic-type reaction to aspirin, NSAIDs, or sulfonamides
<i>Required Medical Information</i>	Evaluation of cardiovascular disease or risk factors for cardiovascular disease
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	6 months for FAP and JRA, 12 months for dysmenorrhea, OA, RA, AS, 1 month for acute pain
<i>Other Criteria</i>	For all diagnoses, patient must undergo determination of risk versus benefit of treatment with celecoxib for an NSAID-related gastrointestinal (GI) adverse event such as an NSAID-associated gastric ulcer or gastrointestinal bleeding
<i>Prior Authorization Group</i>	CHANTIX
<i>Drug Names</i>	CHANTIX
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Concurrent Zyban use
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 weeks initial, 12 weeks additional upon renewal
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	CIMZIA
<i>Drug Names</i>	CIMZIA
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patients are excluded if they have an active infection or on are on concurrent biologic response modifier. Patient must also be assessed for the risk of hepatitis B and if appropriate, be tested.
<i>Required Medical Information</i>	Patient must demonstrate inadequate response to at least 1 conventional therapy for Crohn's disease (i.e., prednisone, budesonide, sulfasalazine, azathioprine, mesalamine, infliximab or adalimumab)
<i>Age Restrictions</i>	Approve for those 18 years of age or older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	DIFFERIN
<i>Drug Names</i>	DIFFERIN
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Cosmetic use
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	Approve for those 12 years of age and older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	ENBREL
<i>Drug Names</i>	ENBREL
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D, reactive arthritis, inflammatory bowel disease arthritis
<i>Exclusion Criteria</i>	Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patients are excluded if they have an active infection or on are on concurrent biologic response modifier. Patient must also be assessed for the risk of hepatitis B and if appropriate, be tested.
<i>Required Medical Information</i>	Rheumatoid Arthritis/Juvenile Rheumatoid Arthritis - patient must demonstrate inadequate response to at least 1 DMARD or intolerance to 2 DMARDs. Psoriasis - patient must be a candidate for systemic therapy or phototherapy. Ankylosing spondylitis - patient must demonstrate inadequate response or intolerance to at least 2 NSAIDs. Reactive arthritis - patient must demonstrate inadequate response or intolerance to at least 2 of the following, NSAIDs, intra-articular steroid injections, or sulfasalazine, if indicated.
<i>Age Restrictions</i>	Psoriasis - Approve for those 18 years of age or older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	

Prior Authorization Group

EPO

Drug Names

PROCRIT

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

CRF, Hepatitis C, elective surgery, HIV/zidovudine - transferrin saturation less than 20% and patient not receiving iron supplementation where clinically appropriate. CRF, Hepatitis C, elective surgery, HIV/zidovudine, MDS, and anemia in patients with non-myeloid malignancies - hemoglobin level of the patient (not the result of a recent blood transfusion) greater than 13 g/dL. Lack of initial diagnosis of anemia (hematocrit less than 30% and/or hemoglobin less than 10 g/dL and/or symptomatic with hemoglobin 10-11g/dL).

Required Medical Information

CRF, Hepatitis C, elective surgery, HIV/zidovudine - iron status of the patient has been evaluated (serum transferrin saturation). CRF, Hepatitis C, elective surgery, HIV/zidovudine, and anemia of cancer - Hemoglobin level of the patient be monitored prior to each dose when initiating therapy, for dose changes, and at regular intervals when the dose is stabilized. Hemoglobin level of the patient will be monitored prior to each dose when initiating therapy, for dose changes, and at regular intervals when the dose is stabilized. Blood pressure of the patient will be monitored throughout therapy. Patient will be monitored for the occurrence of thrombotic events.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Initiation of therapy and/or dose changes - 6 weeks. Stable on therapy - 12 weeks.

Other Criteria

Once on therapy, compared to pretreatment baseline, the patient must show an objective clinical response (e.g., hemoglobin rise greater than 1 g/dL and/or hematocrit rise greater than 3%) to an appropriate dose/dose increase and duration of therapy.

<i>Prior Authorization Group</i>	GROWTH HORMONE
<i>Drug Names</i>	NORDITROPIN, SAIZEN, TEV-TROPIN
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Severe respiratory impairment or sleep apnea (Prader-Willi syndrome)
<i>Required Medical Information</i>	Growth hormone stimulation tests
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	6 months
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	HUMIRA
<i>Drug Names</i>	HUMIRA
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Patients are excluded if they have an active infection or on are on concurrent biologic response modifier.
<i>Required Medical Information</i>	Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patient must also be assessed for the risk of hepatitis B and if appropriate, be tested.
<i>Age Restrictions</i>	Rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, Crohn's disease, plaque psoriasis - Approve for those 18 years of age or older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	RA/JIA - patient must demonstrate inadequate response to at least 1 DMARD or intolerance to 2 DMARDs. Psoriasis - patient must be a candidate for systemic therapy or phototherapy. Ankylosing spondylitis - patient must demonstrate inadequate response or intolerance to at least 2 NSAIDs. Crohn's disease - patient must demonstrate an inadequate response to 2 conventional therapies such as glucocorticosteroids, sulfasalazine, balsalazide, mesalamine, azathioprine, cyclosporine, methotrexate or 6-mercaptopurine, or to Remicade.

<i>Prior Authorization Group</i>	INCRELEX
<i>Drug Names</i>	INCRELEX
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Closed epiphyses. Other secondary causes of growth failure. Pre-existing thyroid and/or nutritional deficits. Presence of active or suspected neoplasia.
<i>Required Medical Information</i>	Failure of a growth hormone stimulation test. Genetic testing for growth hormone gene deletion. Lab testing for neutralizing antibodies to growth hormone.
<i>Age Restrictions</i>	Approve for those 2 years of age or older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	Height of the patient greater than or equal to 3 standard deviations below the norm for children of the same age and gender prior to beginning Increlex therapy. Basal IGF-1 level greater than or equal to 3 standard deviations below the norm for children of the same age and gender prior to beginning Increlex therapy. Increase in height velocity of 2 cm/year within the first year of Increlex therapy.
<i>Prior Authorization Group</i>	INFERGEN
<i>Drug Names</i>	INFERGEN
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Patient must have compensated liver disease with detectable levels of hepatitis C virus RNA in the serum
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	3 to 9 months depending on genotype and initial vs. renewal therapy
<i>Other Criteria</i>	2-log decrease in viral load for renewals

<i>Prior Authorization Group</i>	ITRACONAZOLE
<i>Drug Names</i>	ITRACONAZOLE CAPS
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Congestive heart failure, history of congestive heart failure, evidence of left ventricular dysfunction.
<i>Required Medical Information</i>	LFTs, fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy)
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Onychomycosis-2 months fingernails, 3 months toenails, all others uses 6 months
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	IVIG
<i>Drug Names</i>	GAMMAGARD, GAMUNEX
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	HSCT - IVIG is to be used in patients that have developed severe hypogammaglobulinemia (IgG less than 400) within the first 100 days post transplant.
<i>Age Restrictions</i>	BMT - patients have to be 20 years of age or older. HIV - patient has to be younger than 13 years of age.
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	4 months- CIDP, BMT, HSCT 6 months - ITP, Kawasaki, Parvovirus B19 12 months - remaining covered uses
<i>Other Criteria</i>	Kawasaki disease - IVIG is to be used in conjunction with high dose aspirin. BMT - IVIG is to be used within the first 100 days after BMT. Dermatomyositis - IVIG is to be used only if corticosteroid is not a therapeutic option. GBS - IVIG is to be used for patients who require aid to walk within 2 or 4 weeks from the onset of neuropathic symptoms. Hyperimmunoglobulinemia E syndrome - diagnosis has to be coincident with eczema and atopic dermatitis. RRMS - IVIG is to be used as 2nd line treatment.

<i>Prior Authorization Group</i>	LIDODERM
<i>Drug Names</i>	LIDODERM
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Sensitivity to local anesthetics of the amide type (e.g., procaine, tetracaine, benzocaine), skin is broken or inflamed where the patch is to be applied.
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	METHYLPHENIDATES
<i>Drug Names</i>	CONCERTA, DEXMETHYLPHENIDATE, METADATE, METADATE CD, METHYLIN, METHYLPHENIDATE, RITALIN LA
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	MAOI concurrent use or within the last 14 days
<i>Required Medical Information</i>	Sleep studies for narcolepsy diagnosis
<i>Age Restrictions</i>	Approved for those 6 years of age or older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	Monitor for weight loss, decreased growth velocity in children, increased heart rate and blood pressure, appearance or worsening of aggressive behavior or hostility, sleep disturbances and long-term usefulness of the drug

<i>Prior Authorization Group</i>	NEULASTA
<i>Drug Names</i>	NEULASTA
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Neulasta treatment within the last 14 days. Treatment of acute afebrile neutropenia.
<i>Required Medical Information</i>	Current and periodic monitoring of WBC count at initiation of and during therapy.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	6 months
<i>Other Criteria</i>	Neulasta administration will be delayed a minimum of 24 hours after the administration of cytotoxic chemotherapy.
<i>Prior Authorization Group</i>	NEUTROPHIL
<i>Drug Names</i>	NEUPOGEN
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D, bone marrow transplantation failure or engraftment delay. Neutropenia AIDS associated with treatment or disease, myelodysplastic syndromes, drug-induced neutropenia.
<i>Exclusion Criteria</i>	Treatment of acute afebrile neutropenia. Patients not at high risk for infection-associated complications or not having prognostic factors that are predictive of poor clinical outcomes.
<i>Required Medical Information</i>	Current and periodic monitoring of WBC count at initiation of and during therapy.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	3 months
<i>Other Criteria</i>	Treatment to be halted in the event of excessive leukocytosis.

Prior Authorization Group OCTREOTIDE
Drug Names OCTREOTIDE

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 ORAL FENTANYL

Drug Names FENTANYL OT LOZENGE

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

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration 1 month for initial or titrating patients, 3 months for all others

Other Criteria

Prior Authorization Group

OSTEOPOROSIS

Drug Names

FORTEO

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Paget's disease, unexplained elevation of alkaline phosphatase, open epiphyses, bone cancer or cancer that has metastasized to the bone, history of breast cancer, prior radiation therapy involving the skeleton, hypercalcemia, treatment with Forteo for greater than or equal to 24 months, concurrent bisphosphonate therapy during treatment with Forteo

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

12 months

Other Criteria

For diagnosis of primary osteoporosis or hypogonadal osteoporosis patient must have at least one of the following: history of osteoporotic fractures, multiple risk factors for fractures, OR has failed or is intolerant to traditional osteoporosis therapy

<i>Prior Authorization Group</i>	PEGASYS
<i>Drug Names</i>	PEGASYS
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	For chronic hepatitis C, patient must have compensated liver disease with detectable levels of HCV RNA in the serum. For chronic hepatitis B, patient must have a positive serum marker for HBV replication, persistently elevated aminotransferase levels greater than 2 times ULN, or signs of chronic hepatitis B on liver biopsy, or cirrhosis of the liver as evidenced by radiological or clinical data, or extrahepatic complications.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Chronic hepatitis C - 3 to 9 months. Chronic hepatitis B - 12 months.
<i>Other Criteria</i>	For chronic hepatitis C, patient must have 2-log decrease in viral load for renewals.
<i>Prior Authorization Group</i>	PEGINTRON
<i>Drug Names</i>	PEGINTRON
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Patient must have compensated liver disease with detectable levels of hepatitis C virus RNA in the serum
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	3 to 9 months depending on genotype and initial vs. renewal therapy
<i>Other Criteria</i>	2-log decrease in viral load for renewals

<i>Prior Authorization Group</i>	PROVIGIL
<i>Drug Names</i>	PROVIGIL
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	If diagnosis is narcolepsy require polysomnography, if diagnosis of OSAHS require polysomnography and whether pt using CPAP
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	REMICADE
<i>Drug Names</i>	REMICADE
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Patients are excluded if they have an active infection or moderate to severe CHF.
<i>Required Medical Information</i>	Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patient must also be assessed for the risk of hepatitis B and if appropriate, be tested.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	RA - patient must demonstrate inadequate response to at least 1 DMARD or intolerance to 2 DMARDs. Remicade is to be used in combination with methotrexate. Crohn's disease - patient must demonstrate an inadequate response to at least 2 first-line agents such as glucocorticosteroids, sulfasalazine, balsalazide, mesalamine, azathioprine, cyclosporine, methotrexate, or 6-mercaptopurine unless the patient has multiple draining enterocutaneous or rectovaginal fistulae, which would make Remicade first-line therapy. Ulcerative colitis - patient must demonstrate an inadequate response to at least 2 first-line agents such as oral or rectal 5-ASA products or glucocorticosteroids. Ankylosing spondylitis - patient must demonstrate inadequate response to at least 2 NSAIDs or intolerance to 2 NSAIDs. Psoriasis - patient must be a candidate for systemic therapy or phototherapy. Reactive arthritis - patient must demonstrate inadequate response to at least 2 first-line agents such as NSAIDs or DMARDs. IBDA - patient must demonstrate an inadequate response to at least 2 first-line agents such as sulfasalazine, azathioprine, 6-mercaptopurine, MTX or oral steroids.

<i>Prior Authorization Group</i>	REVATIO
<i>Drug Names</i>	REVATIO
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Concurrent nitrate therapy. PAH associated with any of the following: left heart disease, chronic thrombotic disease, embolic disease, compression of pulmonary vessels, lung diseases, hypoxemia, sarcoidosis
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	REVLIMID
<i>Drug Names</i>	REVLIMID
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Pregnancy
<i>Required Medical Information</i>	If female of child bearing potential, pregnancy excluded by 2 negative urine or serum pregnancy tests. For MM requirement of combination therapy with dexamethasone and at least one prior MM treatment. For MDS: diagnosis of anemia due to Low- or Intermediate-1-risk MDS associated with a deletion 5q cytogenetic abnormality, transfusion dependent
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	Instruction regarding importance and proper utilization of appropriate contraceptive methods. Monitor CBC on regular basis.

<i>Prior Authorization Group</i>	RIBAVIRIN
<i>Drug Names</i>	REBETOL SOLN, RIBAPAK, RIBASPHERE, RIBAVIRIN
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	History of unstable heart disease, hemoglobin less than 8.5, creatinine clearance less than 50, pregnancy, hemoglobinopathy.
<i>Required Medical Information</i>	Patient must have detectable levels of HCV RNA in the serum and be on an alfa interferon product concurrently.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	4 to 8 months, depending on genotype and initial vs. renewal therapy.
<i>Other Criteria</i>	2-log decrease in viral load for renewals

<i>Prior Authorization Group</i>	RITUXAN
<i>Drug Names</i>	RITUXAN
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D, Chronic lymphocytic leukemia (CLL). Immune thrombocytopenic purpura (ITP). Waldenstrom's macroglobulinemia.
<i>Exclusion Criteria</i>	RA - Rituxan cannot be used concomitantly with another biologic DMARD.
<i>Required Medical Information</i>	Prescriber has to assess the patient for the risk of hepatitis B, and if clinically indicated, test the patient for hepatitis B infection before initiation or continuation of therapy with Rituxan.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	NHL, RA, CLL, Waldenstrom's macroglobulinemia - 12 months. ITP - 1 month.
<i>Other Criteria</i>	For NHL, the diagnosis must fall into one of the following categories of CD20-positive B-cell NHL: - relapsed or refractory, low-grade or follicular - previously untreated follicular, in combination with CVP chemotherapy - low grade in patients with stable disease or who achieve a partial or complete response following first-line treatment with CVP chemotherapy - diffuse large B-cell, treated first line in combination with CHOP or other anthracycline-based chemotherapy - relapsed or refractory diffuse large B-cell lymphoma. For ITP, patient has to be refractory to first line treatment with corticosteroids and/or IVIG.
<i>Prior Authorization Group</i>	SANDOSTATIN LAR
<i>Drug Names</i>	SANDOSTATIN LAR
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Patient had prior therapy with sandostatin injection (not depot form) and treatment was effective and tolerated.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	SOMATULINE DEPOT
<i>Drug Names</i>	SOMATULINE DEPOT
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	Either surgery and/or radiotherapy is not a therapeutic option for the patient or the patient has had inadequate response to surgery and/or radiotherapy
<i>Prior Authorization Group</i>	SOMAVERT
<i>Drug Names</i>	SOMAVERT
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Monitor IGF-1 levels at 6 month intervals after IGF-1 levels stabilize within normal range. Monitor LFTs as recommended during therapy.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	Prior to initiation of therapy IGF-1 levels were above age and gender adjusted normal range. If patient has been on therapy for the past 6 months demonstration of significant decrease in IGF-1 levels required. Patients were considered for/received treatment with surgery, radiation therapy, or medical treatment for acromegaly but rejected as inappropriate or had inadequate response.

<i>Prior Authorization Group</i>	STEROIDS, ANABOLIC
<i>Drug Names</i>	OXANDROLONE
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	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.
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	6 months
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	STRATTERA
<i>Drug Names</i>	STRATTERA
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	MAOI concurrent use or within the last 14 days
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	Approved for those 6 years of age or older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	monitor for suicidality, clinical worsening, changes in behavior, blood pressure changes, heart rate changes, weight loss, decreased growth velocity in children, sleep disturbances, liver injury

<i>Prior Authorization Group</i>	TERBINAFINE
<i>Drug Names</i>	TERBINAFINE
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	LFTs, fungal diagnostic test (e.g., KOH preparation, positive fungal culture, or nail biopsy)
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	2 months for fingernails only, 3 months if toenail involvement
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	TESTOSTERONES
<i>Drug Names</i>	ANDRODERM, ANDROGEL, TESTIM
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Female, prostate cancer, breast cancer
<i>Required Medical Information</i>	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
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	THALOMID
<i>Drug Names</i>	THALOMID
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Pregnancy
<i>Required Medical Information</i>	If female of child bearing potential, pregnancy excluded by 2 negative urine or serum pregnancy tests. For MM requirement of combination therapy with dexamethasone. For ENL if have moderate to severe neuritis Thalomid can not be used as monotherapy.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	Instruction regarding importance and proper utilization of appropriate contraceptive methods.
<i>Prior Authorization Group</i>	TOPICAL-ULCERS
<i>Drug Names</i>	REGGRANEX
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Neoplasm at intended site of application, active wound infection not under control by way of active treatment
<i>Required Medical Information</i>	Ulcer size after 10 weeks of therapy, does ulcer have adequate blood supply, ulcer extending into subcutaneous tissue or beyond
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	3 months, then additional 2 months upon renewal
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	XENAZINE
<i>Drug Names</i>	XENAZINE
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Actively suicidal, untreated or inadequately treated depression, impaired hepatic function, current use of monoamine oxidase inhibitors or reserpine.
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	In patients who are taking reserpine, at least 20 days should elapse after stopping reserpine before initiation of Xenazine therapy.
<i>Prior Authorization Group</i>	XOLAIR
<i>Drug Names</i>	XOLAIR
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Xolair is not to be used as monotherapy.
<i>Required Medical Information</i>	Positive aeroallergen skin or blood test. Pre-treatment IgE level to be between 30 and 700 IU/mL
<i>Age Restrictions</i>	12 years of age and above
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	12 months
<i>Other Criteria</i>	Patient must be inadequately controlled on inhaled corticosteroids.