

PA Criteria

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| Prior Authorization Group | ACTIMMUNE |
| Drug Names | ACTIMMUNE |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | To reduce the frequency and severity of serious infections associated with chronic granulomatous disease, To delay time to disease progression in patients with severe, malignant osteopetrosis |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

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| Prior Authorization Group | ANDRODERM |
| Drug Names | ANDRODERM |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | Not covered for erectile dysfunction |
| Required Medical Information | Covered for classic hypogonadism: the patient has an irreversible condition known to cause pituitary or testicular failure, documented clinically, with verified low testosterone levels, and no contraindications. Covered to maintain bone density during prolonged corticosteroid therapy. Covered to maintain muscle mass and prevent wasting in HIV. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

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| Prior Authorization Group | AVONEX |
| Drug Names | AVONEX |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | Not approved for patients with chronic progressive MS. |
| Required Medical Information | Approved for the treatment of relapsing forms of multiple sclerosis (MS). |
| Age Restrictions | |
| Prescriber Restrictions | Request must come from Neurology or a Multiple Sclerosis (MS) specialist |
| Coverage Duration | 12 months |
| Other Criteria | |

Prior Authorization Group B VS. D
Drug Names ALBUTEROL SULFATE, BROVANA, CALCIJEX, CALCITRIOL, CUBICIN, EPOGEN, FLUDARABINE PHOSPHATE, HECTOROL, HEPARIN SODIUM, HEPARIN SODIUM/D5W, HEPARIN SODIUM/NACL 0.45%, HEPARIN SODIUM/SODIUM CHL, IPRATROPIUM BROMIDE, LEVOCARNITINE, LIDOCAINE/PRILOCAINE, MIACALCIN, PAMIDRONATE DISODIUM, PROCRIT, PULMICORT, SYNAGIS, VANCOMYCIN HCL, ZEMPLAR, ZORTRESS

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Prior Authorization Group BETASERON
Drug Names BETASERON
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria Not approved for patients with chronic progressive MS.
Required Medical Information Approved for the treatment of relapsing forms of multiple sclerosis (MS).
Age Restrictions
Prescriber Restrictions Request must come from Neurology or a Multiple Sclerosis (MS) specialist
Coverage Duration Initial authorization will be 12 months.
Other Criteria

Prior Authorization Group BYETTA
Drug Names BYETTA
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria
Required Medical Information Approved for patients who meet FDA indications: adjunctive treatment of type 2 diabetes not controlled by metformin + sulfonylurea or thiazolidinedione (TZD).
Age Restrictions
Prescriber Restrictions
Coverage Duration 12 months
Other Criteria

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| <i>Prior Authorization Group</i> | CARIMUNE |
| <i>Drug Names</i> | CARIMUNE NANOFILTERED |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | Patient has known hypersensitivity to IGIM, other immunoglobulins, or any component of the formulation. Patient with isolated immunoglobulin A (IgA) deficiency. |
| <i>Required Medical Information</i> | For hepatitis A post-exposure prophylaxis when given soon after exposure to hepatitis A OR To prevent or modify measles in a susceptible person exposed fewer than 6 days previously. |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | 12 months |
| <i>Other Criteria</i> | |
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| <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> | |
| <i>Required Medical Information</i> | COX-2 inhibitors are covered for a patient with indications for NSAID use, who is at risk of serious GI complications: history of ulcer, GI bleed, GERD, elderly, steroid or anticoagulant use, or other risk factor. |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | 12 months |
| <i>Other Criteria</i> | |
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| <i>Prior Authorization Group</i> | CELLCEPT |
| <i>Drug Names</i> | CELLCEPT, CELLCEPT INTRAVENOUS |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | |
| <i>Required Medical Information</i> | Determination of B versus D payment under Medicare rules |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | Lifetime for transplant patients |
| <i>Other Criteria</i> | |

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| Prior Authorization Group | CEREZYME |
| Drug Names | CEREZYME |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Patient must have a diagnosis of Type 1 Gaucher?s disease with at least one of the following: Anemia Thrombocytopenia bone disease Hepatomegaly Splenomegaly |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | Unlimited |
| Other Criteria | |

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| Prior Authorization Group | CLADRIBINE |
| Drug Names | CLADRIBINE |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Chart notes to document diagnosis |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | Unlimited for part B, one year for part D. |
| Other Criteria | |

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| Prior Authorization Group | CLARAVIS |
| Drug Names | CLARAVIS |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | Not approved for ultraviolet induced change in normal skin |
| Required Medical Information | Chart notes documenting diagnosis |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

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| Prior Authorization Group | COPAXONE |
| Drug Names | COPAXONE |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | Not approved for patients with chronic progressive MS. |
| Required Medical Information | Approved for the treatment of relapsing forms of multiple sclerosis (MS). Chart notes and written medical summary |
| Age Restrictions | |
| Prescriber Restrictions | Request must come from Neurology or a Multiple Sclerosis (MS) specialist |
| Coverage Duration | 12 months |
| Other Criteria | |

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| Prior Authorization Group | CYCLOPHOSPHAMIDE |
| Drug Names | CYCLOPHOSPHAMIDE |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Chart notes to document diagnosis |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | lifetime-B, one year part D |
| Other Criteria | |

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|-------------------------------------|---|
| Prior Authorization Group | CYCLOSPORINE |
| Drug Names | CYCLOSPORINE, CYCLOSPORINE MODIFIED |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Chart notes to document diagnosis |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | Lifetime authorization for part B, one year for part D |
| Other Criteria | |

Prior Authorization Group CYMBALTA
Drug Names CYMBALTA
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 CYTARABINE
Drug Names CYTARABINE
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria
Required Medical Information Chart notes to document diagnosis
Age Restrictions
Prescriber Restrictions
Coverage Duration lifetime-B, one year part D
Other Criteria

Prior Authorization Group ELIDEL
Drug Names ELIDEL
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria
Required Medical Information Indicated for the treatment of mild to moderate atopic dermatitis in patients who have failed or have contraindications to topical steroids.
Age Restrictions Older than 2 years
Prescriber Restrictions
Coverage Duration Initial authorization will be 6 months
Other Criteria

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| Prior Authorization Group | ENBREL |
| Drug Names | ENBREL |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Plaque Psoriasis: Dx mod-to-sev chronic (greater than 6 months) plaque psoriasis. Failed phototherapy and systemic therapy with one of the following: MTX, cyclosporine, acitretin, hydroxyurea, sulfasalazine, 6-thioguanine, or mycophenolate. Rheumatoid Arthritis: Dx of mod-to-sev RA. Failed MTX or 2 DMARDs for 3 mo. Juvenile Idiopathic Arthritis: Dx of mod-to-sev polyarticular-course JIA Failed NSAID or steroid and methotrexate for three months. PsA: Dx of active PsA. Failed MTX or 2 DMARDs for 3 mo. Ankylosing Spondylitis: Dx of AS. Failed 2 NSAIDs for 3 mo. Reauthorization: demonstration of clinical response to therapy.? |

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| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

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| Prior Authorization Group | ETHYOL |
| Drug Names | ETHYOL |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Chart notes documenting diagnosis |
| Age Restrictions | |
| Prescriber Restrictions | Must be prescribed by an Oncologist |
| Coverage Duration | 12 months |
| Other Criteria | |

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| Prior Authorization Group | EXJADE |
| Drug Names | EXJADE |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Chart notes documenting The diagnosis of chronic iron overload due to blood transfusions. AND Serum ferritin levels consistently greater than 1000mcg/L (as demonstrated with at least two lab values within the previous two months) AND Evidence of failure/contraindication to deferoxamine injection |
| Age Restrictions | Members age 2 years and older |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

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| Prior Authorization Group | FABRAZYME |
| Drug Names | FABRAZYME |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Chart notes documenting Fabry disease Alpha-galactosidase levels of less than 1.5 nmol/hr/ml on plasma or less than 4nmol/hr/mg in leukocytes. Physician must provide goals of therapy. Physician must provide patient?s baseline disease status and documentation of the patients signs and symptoms of the disease including objective and subjective clinical information (including, but not limited to, labs, progress notes, specialty consult notes) Labs-globotriaosylceramide (GL-3) concentrations in plasma of 5 ng/mcL or greater. Serum creatinine less than 2.5 mg/dL and no history of renal dialysis or transplantation. Decreased fatigue Special considerations: Patient will be referred to high-risk case management. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | initial approval for 3 months, may be renewed for up to one year |
| Other Criteria | |

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| Prior Authorization Group | FENTANYL |
| Drug Names | FENTANYL |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Authorization requirements: all bullet points under either criterion Chart Notes Required 1) Painful terminal illness-Authorization Indefinite Diagnosis of terminal condition Failure of other pain control methods 2. Intractable pain-Initial Authorization One Year Cause has been fully evaluated and diagnosed. There is no generally accepted relief or cure. The diagnosis is one that usually causes severe pain. A consultant specializing in the body area, system or organ perceived as the source of pain has confirmed the diagnosis and treatment. Documentation of failure or contraindications to other standard treatments, such as surgery, physical therapy, NSAIDS, antidepressants, activity modifications, exercise, local injections, etc. Lack of contraindications No active substance abuse, and willing to submit to urine screening Psychological problems controlled Informed consent Consent signed consistent with Oregon Intractable Pain law Narcotics contract for single provider, single pharmacy, and written plan for dosage and follow-up visits. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

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| <i>Prior Authorization Group</i> | FORTEO |
| <i>Drug Names</i> | FORTEO |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | |
| <i>Required Medical Information</i> | Osteoporosis: BMD T score of -3.0 or less and a previous fracture resulting from minimal trauma, or both of the following: failure to a formulary bisphosphonate and patient has a history of fracture resulting from minimal trauma or BMD T score of -2.5 or less.? |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | Treatment with teriparatide is limited to 24 months. |
| <i>Other Criteria</i> | |
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| <i>Prior Authorization Group</i> | GAMASTAN |
| <i>Drug Names</i> | GAMASTAN S/D |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | NOT covered for members who have the following contraindications: IgA deficiency; hypersensitivity to IgG; severe thrombocytopenia or any coagulation disorder which would contraindicate intramuscular injections? |
| <i>Required Medical Information</i> | For hepatitis A post-exposure prophylaxis when given soon after exposure to hepatitis A OR To prevent or modify measles in a susceptible person exposed fewer than 6 days previously. Patient meets one or more of the following criteria: Patient is susceptible with negative history of measles and no prior vaccination Exposure is likely to result in infection Patient is at higher risk for measles-related complications than the general population OR To provide passive immunity against varicella in immunocompromised patients only when Varicella-Zoster Immune Globulin (VZIG) is not available. OR For prophylaxis of rubella in early pregnancy for susceptible pregnant women who will not consider a therapeutic abortion. OR In patients with immunoglobulin deficiencies to prevent serious infection. Patient meets one or more of the following criteria: Prophylactic therapy against encapsulated bacteria Diagnosis of Bruton-type, sex-linked congenital agammaglobulinemia, agammaglobulinemia associated with thymoma, and acquired agammaglobulinemia. |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | 12 months |
| <i>Other Criteria</i> | |

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| Prior Authorization Group | GAMMAGARD |
| Drug Names | GAMMAGARD LIQUID |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | Patient has known hypersensitivity to IGIM, other immunoglobulins, or any component of the formulation. Patient with isolated immunoglobulin A (IgA) deficiency. |
| Required Medical Information | Chart notes with diagnosis |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

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| Prior Authorization Group | GENGRAF |
| Drug Names | GENGRAF |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Chart notes to document diagnosis |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | Lifetime authorization for part B, one year for part D |
| Other Criteria | |

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| Prior Authorization Group | GENOTROPIN |
| Drug Names | GENOTROPIN |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | For children: Growth hormone deficiency in individuals less than 16 years of age or radiographic evidence of non-closure of epiphyseal plates. Appropriate medical work up: Assessment and evaluation must indicate absolute growth less than 4.5 cm per year without growth hormone. Subnormal growth, greater than or equal to 2 standard deviations below the mean for age. Serum growth hormone concentration of less than 10ng/ml in two of any of the following stimulation tests. Insulin L-arginine Clonidine L-dopa Glucagon For adults: Diagnosis of Pituitary insufficiency confirmed by growth stimulation test (less than 5 ng/ml serum concentration). Patients treated for pediatric deficiency must be retested. Panhypopituitary patients with surgical or radiological eradication of pituitary confirmed by MRI or CT scan OR Patients with organic panhypopituitarism (e.g. septo-optic dysplasia) Turner's Syndrome in females is an approved indication |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

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| Prior Authorization Group | HEPSERA |
| Drug Names | HEPSERA |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Approved for treatment of chronic Hepatitis B in adults with evidence of active viral replication and either evidence of persistent elevations in LFTs or histologically active disease: failure of Epivir HBV. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

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| Prior Authorization Group | HERCEPTIN |
| Drug Names | HERCEPTIN |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Chart notes to document diagnosis |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | Lifetime for Part B, one year part D. |
| Other Criteria | |

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| Prior Authorization Group | HUMATROPE |
| Drug Names | HUMATROPE, HUMATROPE COMBO PACK |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | For children: Growth hormone deficiency in individuals less than 16 years of age or radiographic evidence of non-closure of epiphyseal plates. Appropriate medical work up: Assessment and evaluation must indicate absolute growth less than 4.5 cm per year without growth hormone. Subnormal growth, greater than or equal to 2 standard deviations below the mean for age. Serum growth hormone concentration of less than 10ng/ml in two of any of the following stimulation tests. Insulin L-arginine Clonidine L-dopa Glucagon For adults: Diagnosis of Pituitary insufficiency confirmed by growth stimulation test (less than 5 ng/ml serum concentration). Patients treated for pediatric deficiency must be retested. Panhypopituitary patients with surgical or radiological eradication of pituitary confirmed by MRI or CT scan OR Patients with organic panhypopituitarism (e.g. septo-optic dysplasia) Turner's Syndrome in females is an approved indication |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

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| Prior Authorization Group | HUMIRA |
| Drug Names | HUMIRA, HUMIRA PEN-CROHNS DISEASE |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | <p>Crohn's disease: Dx of mod-to-sev CD. Failed one FDA-approved conventional therapy such as anti-inflammatory, corticosteroids, or immunosuppressive agents.</p> <p>Plaque Psoriasis: Clinically diagnosed plaque psoriasis. Failed/ intolerant to corticosteroids. Failed/ intolerant to Methotrexate.</p> <p>Rheumatoid Arthritis: Clinically diagnosed rheumatoid arthritis. Failed/ intolerant to at least one DMARD. Failed/ intolerant to Methotrexate.</p> |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

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| Prior Authorization Group | INCRELEX |
| Drug Names | INCRELEX |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | <p>Growth hormone deficiency in pediatric patients. Appropriate medical work up: Assessment and evaluation must indicate absolute growth less than 4.5 cm per year without growth hormone. Subnormal growth, greater than or equal to 2 standard deviations below the mean for age. Serum growth hormone concentration of less than 10ng/ml in two of any of the following stimulation tests. Insulin, L-arginine, Clonidine, L-dopa, Glucagon</p> |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

Prior Authorization Group INTRON-A
Drug Names INTRON-A, INTRON-A W/DILUENT
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria
Required Medical Information Chart notes to document diagnosis
Age Restrictions
Prescriber Restrictions
Coverage Duration 12 months
Other Criteria

Prior Authorization Group KEPPRA
Drug Names KEPPRA
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria
Required Medical Information Determination of B versus D payment under Medicare rules
Age Restrictions
Prescriber Restrictions
Coverage Duration Lifetime for Part B, one year part D.
Other Criteria

Prior Authorization Group LETAIRIS
Drug Names LETAIRIS
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria
Required Medical Information available only through the Letairis Education Access Program (LEAP) by calling 1-866-664-LEAP (5327) or by logging on to www.letairis.com
Age Restrictions
Prescriber Restrictions
Coverage Duration 12 months
Other Criteria

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| <i>Prior Authorization Group</i> | LEUKINE |
| <i>Drug Names</i> | LEUKINE |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | |
| <i>Required Medical Information</i> | Chart notes to document diagnosis |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | Lifetime for Part B, one year part D. |
| <i>Other Criteria</i> | |

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| <i>Prior Authorization Group</i> | LEUSTATIN |
| <i>Drug Names</i> | LEUSTATIN |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | |
| <i>Required Medical Information</i> | Chart notes to document diagnosis |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | Lifetime for Part B, one year part D. |
| <i>Other Criteria</i> | |

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| <i>Prior Authorization Group</i> | LIPITOR |
| <i>Drug Names</i> | LIPITOR |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | |
| <i>Required Medical Information</i> | Tried, failed or where generic Statins are not medically indicated |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | Initial authorization will be two years |
| <i>Other Criteria</i> | |

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| Prior Authorization Group | MARINOL |
| Drug Names | DRONABINOL |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Marinol® is NOT covered for members w/ the following criteria: A.If the member has any of the following contraindications: breast-feeding or sesame oil hypersensitivity. B. If the patient is taking/receiving any of the following: Nabilone. |
| Required Medical Information | REQUIRED MEDICAL INFORMATION The following copies of chart notes/laboratory reports are required: If the diagnosis is anorexia associated with weight loss in a patient with AIDS, documentation that: A. patient has had an involuntary weight loss of greater than 10% of pre-illness baseline body weight or body mass index (BMI) B. patient has completed a 30 day trial and failure of megestrol (Megace). C. if the patient has received Marinol therapy, he/she has shown a positive response to treatment. If the diagnosis is nausea and vomiting associated with cancer chemotherapy in a cancer patient: A. patient is receiving chemotherapy or radiation therapy B. patient has completed a trial and failure through at least one cycle of chemotherapy with IV Zofran and at least one of the following oral anti-emetic agents: i. metoclopramide. ii. promethazine. iii. prochlorperazine. iv. dimenhydrinate. v. meclizine. vi. trimethobenzamide. vii. Oral 5-HT3 receptor Antagonist (e.g., Anzemet, Zofran, Kytril, Zomig). C if the patient has received previous Marinol therapy, he/she has shown a positive response and a reduced incidence of emesis and/or nausea. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 6 months |
| Other Criteria | COVERAGE POLICY Marinol is covered for pts who meet the following criteria: A. The diagnosis is documented as anorexia associated w/ wt loss in a pt w/ AIDS. AND the pt has had an involuntary wt loss of Greater than 10% of pre-illness baseline body wt or body mass index (BMI) Less than 20 kg/m2 in the absence of a concurrent illness or medical condition other than HIV infxn that may cause wt loss. AND the pt has failed to respond to a 30-day drug regimen of megestrol (Megace) AND if the pt has received previous Marinol tx, he/she must show a positive response to tx by maintaining or increasing their initial wt and/or muscle mass before initiating Marinol tx. B. The diagnosis is documented as nausea and vomiting associated w/ CA chemotx in a CA pt. AND the pt is receiving a chemotx or radiation regimen. (Please verify in the pts chart notes). AND if Marinol tx is NOT being used as a full therapeutic replacement for an intravenous anti-emetic drug (e.g., Aloxi, Zofran). If Marinol is used as a full replacement of IV antiemetic administration and the tx is or will be w/in 48 hours of CA tx, Medicare Part B will pay for the tx. Please verify w/ the provider). AND if Marinol tx is being used as a full therapeutic replacement for an intravenous anti- emetic drug (e.g., Aloxi, Zofran BUT Marinol tx will NOT be w/in 48 hours of CA tx. (If Marinol is used as a full replacement of IV antiemetic administration and the tx is or will be w/in 48 hours of CA tx, Medicare Part B will pay for the tx. Please verify w/ the provider). AND |

the pt has had a full trial and failure through at least one cycle of chemotx w/ IV Zofran AND at least one of the following oral anti-emetic agents: 1. metoclopramide. 2. promethazine. 3. prochlorperazine. 4. dimenhydrinate. 5. meclizine. 6. trimethobenzamide. 7. Oral 5-HT3 receptor Antagonist (e.g., Anzemet, Zofran, Kytril, Zomig). AND if the pt has received previous Marinol tx, he/she must show a positive response by showing a reduced incidence of emesis and/or nausea.

Prior Authorization Group MYFORTIC
Drug Names MYFORTIC
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria
Required Medical Information Chart notes to document diagnosis
Age Restrictions
Prescriber Restrictions
Coverage Duration Lifetime for Part B, one year part D.
Other Criteria

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

Prior Authorization Group NEXAVAR
Drug Names NEXAVAR
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria
Required Medical Information Chart notes to document diagnosis
Age Restrictions
Prescriber Restrictions
Coverage Duration Lifetime for Part B, one year part D.
Other Criteria

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| Prior Authorization Group | NICOTROL |
| Drug Names | NICOTROL INHALER, NICOTROL NS |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Patient must be part of a comprehensive behavioral smoking cessation program. Must have tried/failed bupropion SR? |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 3 months |
| Other Criteria | |

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| Prior Authorization Group | NUTROPIN |
| Drug Names | NUTROPIN AQ PEN |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | For children: Growth hormone deficiency in individuals less than 16 years of age or radiographic evidence of non-closure of epiphyseal plates. Appropriate medical work up: Assessment and evaluation must indicate absolute growth less than 4.5 cm per year without growth hormone. Subnormal growth, greater than or equal to 2 standard deviations below the mean for age. Serum growth hormone concentration of less than 10ng/ml in two of any of the following stimulation tests. Insulin L-arginine Clonidine L-dopa Glucagon For adults: Diagnosis of Pituitary insufficiency confirmed by growth stimulation test (less than 5 ng/ml serum concentration). Patients treated for pediatric deficiency must be retested. Panhypopituitary patients with surgical or radiological eradication of pituitary confirmed by MRI or CT scan OR Patients with organic panhypopituitarism (e.g. septo-optic dysplasia) Turner?s Syndrome in females is an approved indication |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

Prior Authorization Group OCTREOTIDE
Drug Names OCTREOTIDE ACETATE
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria
Required Medical Information Chart notes with diagnosis
Age Restrictions
Prescriber Restrictions
Coverage Duration 12 months with 24 month additional renewal
Other Criteria

Prior Authorization Group OCTREOTIDE ACETATE
Drug Names OCTREOTIDE ACETATE
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria
Required Medical Information Chart notes with diagnosis
Age Restrictions
Prescriber Restrictions
Coverage Duration 12 months with 24 month additional renewal
Other Criteria

Prior Authorization Group OXYCONTIN
Drug Names OXYCONTIN
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria
Required Medical Information Authorization requirements: All bullet points under either criterion Chart Notes Required
 1) Painful terminal illness- Diagnosis of terminal condition Failure of other pain control methods
 2. Intractable pain- Cause has been fully evaluated and diagnosed. There is no generally accepted relief or cure. The diagnosis is one that usually causes severe pain. Documentation of failure or contraindications to other standard treatments, such as surgery, physical therapy, NSAIDS, antidepressants, activity modifications, exercise, local injections, etc. Lack of contraindications No active substance abuse, and willing to submit to urine screening Psychological problems controlled Informed consent Consent signed consistent with Oregon Intractable Pain law Narcotics contract for single provider, single pharmacy, and written plan for dosage and follow-up visits.
Age Restrictions
Prescriber Restrictions
Coverage Duration 12 months
Other Criteria

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| <i>Prior Authorization Group</i> | PEG-INTRON |
| <i>Drug Names</i> | PEG-INTRON, PEG-INTRON REDIPEN |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | For patients who fail to achieve a 2 log reduction, treatment should be discontinued after 16 weeks |
| <i>Required Medical Information</i> | Chart notes / written medical summary documenting diagnosis of Chronic HCV are required. Recent lab reports documenting elevated HCV RNA are required, along with genotype. |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | GI or infectious disease specialist |
| <i>Coverage Duration</i> | Initial auth-16 wks: greater than 2 log reduction in viral load, therapy continued up to 48 wks |
| <i>Other Criteria</i> | |
| <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> | For patients who fail to achieve a 2 log reduction, treatment should be discontinued after 16 weeks |
| <i>Required Medical Information</i> | Chart notes to document diagnosis |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | GI or infectious disease specialist |
| <i>Coverage Duration</i> | Initial auth-16 wks: greater than 2 log reduction in viral load, therapy continued up to 48 wks |
| <i>Other Criteria</i> | |
| <i>Prior Authorization Group</i> | PROGRAF |
| <i>Drug Names</i> | PROGRAF, TACROLIMUS |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | |
| <i>Required Medical Information</i> | Chart notes to document diagnosis |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | Lifetime for Part B, one year part D. |
| <i>Other Criteria</i> | |

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| <i>Prior Authorization Group</i> | PROVIGIL |
| <i>Drug Names</i> | NUVIGIL, PROVIGIL |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | |
| <i>Required Medical Information</i> | Covered for narcolepsy, obstructive sleep apnea as an adjunct to standard treatment (s) for the underlying obstruction, shift work sleep disorder and for adverse reaction to drug-somnolence. |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | 12 months |
| <i>Other Criteria</i> | |
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| <i>Prior Authorization Group</i> | PULMOZYME |
| <i>Drug Names</i> | PULMOZYME |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | |
| <i>Required Medical Information</i> | Chart notes documenting diagnosis |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | Prescribed by Pulmonologist |
| <i>Coverage Duration</i> | 12 months |
| <i>Other Criteria</i> | |
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| <i>Prior Authorization Group</i> | RAPAMUNE |
| <i>Drug Names</i> | RAPAMUNE |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | |
| <i>Required Medical Information</i> | Chart notes to document diagnosis |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | Lifetime for Part B, one year part D. |
| <i>Other Criteria</i> | |

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|--|---|
| <i>Prior Authorization Group</i> | REBETOL |
| <i>Drug Names</i> | REBETOL |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | For patients who fail to achieve a 2 log reduction, treatment should be discontinued after 16 weeks |
| <i>Required Medical Information</i> | Chart notes / written medical summary documenting diagnosis of Chronic HCV are required. Recent lab reports documenting elevated HCV RNA are required, along with genotype. |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | GI or infectious disease specialist |
| <i>Coverage Duration</i> | Initial auth-16 wks: greater than 2 log reduction in viral load, therapy continued up to 48 wks |
| <i>Other Criteria</i> | |

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|--|---|
| <i>Prior Authorization Group</i> | REBIF |
| <i>Drug Names</i> | REBIF, REBIF TITRATION PACK |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | Not approved for patients with chronic progressive MS. |
| <i>Required Medical Information</i> | Approved for the treatment of relapsing forms of multiple sclerosis (MS). |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | Request must come from Neurology or a Multiple Sclerosis(MS) specialist. |
| <i>Coverage Duration</i> | 12 months |
| <i>Other Criteria</i> | |

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| <i>Prior Authorization Group</i> | REGRANEX |
| <i>Drug Names</i> | REGRANEX |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | |
| <i>Required Medical Information</i> | Clinically diagnosed lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond. Classification of diabetic wound severity WOCN and NPUAP: Stage III or IV lower extremity diabetic ulcer (extending through the dermis into the subcutaneous tissue or beyond) U Texas: Diabetic ulcer classified as a grade 2 or 3, stage A (clean, nonischemic, noninfected wounds penetrating to the tendon or capsule or into bone or joint) Wagner Grade 1 or 2 (partial/full thickness ulcer or probing to tendon or capsule) Lower extremity wound must possess an adequate blood supply. Must be used as adjunct treatment to, not a replacement for, good ulcer care including sharp debridement, pressure relief, standard of care moist dressing changes, and prevention and treatment of infection. Nutritional status must be addressed for any protein and / or calorie malnutrition. The wound must be free of infection |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | Initial auth: 15 gram/month for 5 months |
| <i>Other Criteria</i> | Must have failed standard therapy for at least 2 months , Failed treatment with Granulex. |

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| <i>Prior Authorization Group</i> | RESTASIS |
| <i>Drug Names</i> | RESTASIS |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | |
| <i>Required Medical Information</i> | Clinically diagnosed tear deficiency due to ocular inflammation in patients with keratoconjunctivitis sicca Patient must have a functioning lacrimal gland. |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | Must be prescribed by an ophthalmologist or optometrist |
| <i>Coverage Duration</i> | 12 months |
| <i>Other Criteria</i> | |

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| <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> | |
| <i>Required Medical Information</i> | Clinical diagnosis of pulmonary hypertension WHO group I. Patients with NYHA class II-IV. |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | two years |
| <i>Other Criteria</i> | |
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| <i>Prior Authorization Group</i> | RHEUMATREX |
| <i>Drug Names</i> | RHEUMATREX |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | |
| <i>Required Medical Information</i> | Must have tried and failed generic or generic contraindicated |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | one year |
| <i>Other Criteria</i> | |
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| <i>Prior Authorization Group</i> | RIBASPHERE |
| <i>Drug Names</i> | RIBASPHERE |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | For patients who fail to achieve a 2 log reduction, treatment should be discontinued. Retreatment not approvable |
| <i>Required Medical Information</i> | Chart notes / written medical summary documenting diagnosis of Chronic HCV are required. Recent lab reports documenting elevated HCV RNA are required, along with genotype. |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | GI or infectious disease specialist |
| <i>Coverage Duration</i> | Initial auth-12 wks: greater than 2 log reduction in viral load, therapy continued up to 48 wks |
| <i>Other Criteria</i> | |

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|--|--|
| <i>Prior Authorization Group</i> | RIBAVIRIN |
| <i>Drug Names</i> | RIBAVIRIN |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | For patients who fail to achieve a 2 log reduction, treatment should be discontinued. Retreatment not approvable |
| <i>Required Medical Information</i> | Chart notes / written medical summary documenting diagnosis of Chronic HCV are required. Recent lab reports documenting elevated HCV RNA are required, along with genotype. |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | GI or infectious disease specialist |
| <i>Coverage Duration</i> | Initial auth-12 wks: greater than 2 log reduction in viral load, therapy continued up to 48 wks |
| <i>Other Criteria</i> | |
| <i>Prior Authorization Group</i> | SAIZEN |
| <i>Drug Names</i> | SAIZEN, SAIZEN CLICK.EASY |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | |
| <i>Required Medical Information</i> | For children: Growth hormone deficiency in individuals less than 16 years of age or radiographic evidence of non-closure of epiphyseal plates. Appropriate medical work up: Assessment and evaluation must indicate absolute growth less than 4.5 cm per year without growth hormone. Subnormal growth, greater than or equal to 2 standard deviations below the mean for age. Serum growth hormone concentration of less than 10ng/ml in two of any of the following stimulation tests. Insulin L-arginine Clonidine L-dopa Glucagon For adults: Diagnosis of Pituitary insufficiency confirmed by growth stimulation test (less than 5 ng/ml serum concentration). Patients treated for pediatric deficiency must be retested. Panhypopituitary patients with surgical or radiological eradication of pituitary confirmed by MRI or CT scan OR Patients with organic panhypopituitarism (e.g. septo-optic dysplasia) Initial authorization will be 12 months |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | 12 months |
| <i>Other Criteria</i> | |

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|-------------------------------------|---|
| Prior Authorization Group | SANDIMMUNE |
| Drug Names | SANDIMMUNE |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Determination of B versus D payment under Medicare rules |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | Lifetime for Part D patient |
| Other Criteria | |

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|-------------------------------------|---|
| Prior Authorization Group | SANDOSTATIN |
| Drug Names | SANDOSTATIN LAR DEPOT |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Diagnosis of therapeutically unresponsive severe diarrhea due to vasoactive intestinal polypeptide tumor (VIPoma). Diagnosis of Carcinoid Syndrome, Metastatic. Reduction of blood levels of growth hormone and IGF-I in acromegaly patients who have inadequate response or cannot be treated by surgical resection, pituitary irradiation, or bromocriptine mesylate at maximum tolerated doses |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

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|-------------------------------------|---|
| Prior Authorization Group | SEROSTIM |
| Drug Names | SEROSTIM |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Chart notes to document diagnosis |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

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|-------------------------------------|---|
| Prior Authorization Group | SIMULECT |
| Drug Names | SIMULECT |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Chart notes to document diagnosis |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | Lifetime auth for part B, one year part D |
| Other Criteria | |

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|-------------------------------------|--|
| Prior Authorization Group | SOMAVERT |
| Drug Names | SOMAVERT |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Indicated for the treatment of acromegaly in patients who have had an inadequate response to surgery, radiation therapy, or other medical therapies, or for whom these therapies are inappropriate: the goal of treatment is to normalize serum IGF-I levels (Prod Info SOMAVERT(R) injection, 2006) |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | Plan year |
| Other Criteria | |

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|-------------------------------------|---|
| Prior Authorization Group | SOTRET |
| Drug Names | SOTRET |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | Not approved for ultraviolet induced change in normal skin |
| Required Medical Information | Chart notes to document diagnosis |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

| | |
|-------------------------------------|---|
| Prior Authorization Group | SPORANOX |
| Drug Names | SPORANOX |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | Not covered for cosmetic purposes |
| Required Medical Information | Chart notes with diagnosis |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | Initial authorization will be 3 months in duration |
| Other Criteria | |

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|-------------------------------------|---|
| Prior Authorization Group | STRIANT |
| Drug Names | STRIANT |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | Not covered for erectile dysfunction |
| Required Medical Information | Covered for classic hypogonadism: the patient has an irreversible condition known to cause pituitary or testicular failure, documented clinically, with verified low testosterone levels, and no contraindications. Covered to maintain bone density during prolonged corticosteroid therapy. Covered to maintain muscle mass and prevent wasting in HIV. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | Initial authorization will be 12 months |
| Other Criteria | |

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|-------------------------------------|---|
| Prior Authorization Group | SUTENT |
| Drug Names | SUTENT |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Determination of coverage as a Part B drug or Part D Drug |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | lifetime for part D patient |
| Other Criteria | |

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|-------------------------------------|---|
| Prior Authorization Group | TARCEVA |
| Drug Names | TARCEVA |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Chart notes to document diagnosis |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | Lifetime for Part B, one year part D. |
| Other Criteria | |

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|-------------------------------------|---|
| Prior Authorization Group | TARGRETIN |
| Drug Names | TARGRETIN |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Covered for approved indications-chart notes required |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

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|-------------------------------------|---|
| Prior Authorization Group | TERBINAFFINE HCL |
| Drug Names | TERBINAFFINE HCL |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | Not covered for cosmetic purposes |
| Required Medical Information | Chart notes with diagnosis |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | Initial authorization will be 3 months in duration |
| Other Criteria | |

| | |
|-------------------------------------|--|
| Prior Authorization Group | TEV-TROPIN |
| Drug Names | TEV-TROPIN |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | For children: Growth hormone deficiency in individuals less than 16 years of age or radiographic evidence of non-closure of epiphyseal plates. Appropriate medical work up: Assessment and evaluation must indicate absolute growth less than 4.5 cm per year without growth hormone. Subnormal growth, greater than or equal to 2 standard deviations below the mean for age. Serum growth hormone concentration of less than 10ng/ml in two of any of the following stimulation tests. Insulin L-arginine Clonidine L-dopa Glucagon For adults: Diagnosis of Pituitary insufficiency confirmed by growth stimulation test (less than 5 ng/ml serum concentration). Patients treated for pediatric deficiency must be retested. Panhypopituitary patients with surgical or radiological eradication of pituitary confirmed by MRI or CT scan OR Patients with organic panhypopituitarism (e.g. septo-optic dysplasia) Turner?s Syndrome in females is an approved indication |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

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|-------------------------------------|---|
| Prior Authorization Group | TORISEL |
| Drug Names | TORISEL |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Chart notes documenting diagnosis |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | Lifetime for Part B, one year part D. |
| Other Criteria | |

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|-------------------------------------|--|
| Prior Authorization Group | TRACLEER |
| Drug Names | TRACLEER |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | Currently on epoprostenol (Flolan) Currently on treprostinil (Remodulin) Female and pregnant |
| Required Medical Information | Primary or secondary arterial hypertension WHO Class II through IV |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

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|-------------------------------------|---|
| Prior Authorization Group | TRETINOIN |
| Drug Names | TRETINOIN |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | Not approved for cosmetic purposes |
| Required Medical Information | Diagnosis: Acne vulgaris |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

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|-------------------------------------|---|
| Prior Authorization Group | TYZEKA |
| Drug Names | TYZEKA |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | Clinically diagnosed chronic hepatitis B with evidence of viral replication and either evidence of persistent elevations in serum aminotransferases or histologically active disease. |
| Age Restrictions | Must be 16 years of age or older |
| Prescriber Restrictions | |
| Coverage Duration | Initial Authorization: Indefinite |
| Other Criteria | |

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| <i>Prior Authorization Group</i> | VFEND |
| <i>Drug Names</i> | VFEND, VFEND IV |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | |
| <i>Required Medical Information</i> | A. The patient is diagnosed with invasive aspergillosis B. OR the patient is diagnosed with candidiasis and/or candidemia C. AND the patient has previous trial and failure or contraindication to BOTH fluconazole and itraconazole D. OR the patient is diagnosed with furariosis or Scedosporium sp. E. AND Vfend is being used as salvage therapy due to failure, intolerance or contraindication of other therapies.? |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | 3 months |
| <i>Other Criteria</i> | |
| | |
| <i>Prior Authorization Group</i> | ZORBTIVE |
| <i>Drug Names</i> | ZORBTIVE |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | |
| <i>Required Medical Information</i> | Chart notes documenting diagnosis |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | 12 months |
| <i>Other Criteria</i> | |

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|-------------------------------------|---|
| <i>Prior Authorization Group</i> | ZYVOX |
| <i>Drug Names</i> | ZYVOX |
| <i>Covered Uses</i> | All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | If the patient is receiving any of the following: MAO inhibitors (e.g., phenelzine, isocarboxazid) concomitantly with Zyvox.?? |
| <i>Required Medical Information</i> | Infectious disease consult Clinically documented infection that is susceptible to linezolid if the patient has a severe allergy to beta lactamase inhibitors or any antibiotic that the organism is susceptible -OR Clinically documented infection that is susceptible to linezolid if the patient has failed treatment with antibiotics that the organism is susceptible-OR Clinically documented Vancomycin-Resistant Enterococcus faecium infection -OR Clinically documented MRSA and has failed or is intolerant to Vancomycin if the organism is susceptible to Vancomycin |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | 28 days |
| <i>Other Criteria</i> | |