

Prior Authorization Group Description	Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
5HT3 ANTI-NAUSEA AGENT BVD DETERMINATION	GRANISETRON HCL GRANISOL ONDANSETRON HCL ONDANSETRON ODT	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.						
ABATACEPT	ORENCIA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	INITIAL: FOR ALL DIAGNOSIS: NO TRIAL OF AT LEAST ONE OF THE FOLLOWING: ENBREL, HUMIRA, REMICADE, CIMZIA, OR SIMPONI. INITIAL: FOR RHEUMATOID ARTHRITIS OR JUVENILE ARTHRITIS: NO TRIAL/FAILURE OR EXPERIENCE WITH INTOLERABLE SIDE EFFECTS TO AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, OR AURANOFIN). RENEWAL: LESS THAN 20% IMPROVEMENT IN TENDER AND SWOLLEN JOINT COUNT.			PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST.	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS	APPLIES TO NEW STARTS ONLY. RHEUMATOID ARTHRITIS/JUVENILE IDOPATHIC ARTHRITIS: TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, OR AURANOFIN).
ABIRATERONE	ZYTIGA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
ADALIMUMAB	HUMIRA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	INITIAL: FOR ACTIVE RHEUMATOID ARTHRITIS/JUVENILE IDIOPATHIC ARTHRITIS: NO TRIAL/FAILURE/INTOLERABLE SIDE EFFECTS TO A LEAST ONE DMARD THERAPY(METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, OR AURANOFIN), FOR MODERATE TO SEVERE PLAQUE PSORIASIS COVERING GREATER THAN OR EQUAL TO 10% BSA OR LESIONS COVERING HANDS, FEET, OR GENITAL AREA: NO TRIAL/FAILURE OF PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE. CROHN'S DISEASE: NO TRIAL/FAILURE OF CORTICOSTEROID, AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE. RENEWAL: ACTIVE RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS/JUVENILE ARTHRITIS: LESS THAN 20%IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT. ANKYLOSING SPONDYLITIS: LESS THAN 50%IMPROVEMENT OR LESS THAN 2 UNIT INCREASE FROM BASELINE IN BASDAI. PLAQUE PSORIASIS: PATIENT HAS NOT ACHIEVED CLEAR OR MINIMAL DISEASE OR A DECREASE IN PASI OF AT LEAST 50%.			PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST, DERMATOLOGIST, GASTROENTEROLOGIST	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.	APPLIES TO NEW STARTS ONLY. RENEWAL: RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS/ANKYLOSING SPONDYLITIS: FOR HUMIRA 40 MG EVERY WEEK. TRY/FAIL AT LEAST A 3 MONTH TRIAL OF HUMIRA 40MG EVERY OTHER WEEK.
ADHD ORAL STIMULANT AGENTS	AMPHETAMINE SALT COMBO CONCERTA DEXMETHYLPHENIDATE HCL DEXTROAMPHETAMINE SULFATE METHYLIN METHYLIN ER METHYLPHENIDATE HCL METHYLPHENIDATE SR	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL OFF LABEL COVERAGE FOR NARCOLEPSY.					12 MONTHS	
ALEFACEPT	AMEVIVE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	INITIAL: FOR MODERATE TO SEVERE PLAQUE PSORIASIS COVERING 10% BSA: NO TRIAL/FAILURE/INTOLERABLE SIDE AFFECTS TO AT LEAST ONE PREFERRED THERAPY (PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE). RENEWAL: TWO PRIOR 3 MONTH COURSES OF ALEFACEPT.			PRESCRIBED BY OR SUPERVISED BY A DERMATOLOGIST.	3 MONTHS	APPLIES TO NEW STARTS ONLY. INITIAL: PLAQUE PSORIASIS: TRIAL OF PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE. RENEWAL: 3 MONTH INTERVAL SINCE PREVIOUS COURSE OF TREATMENT AND A DECREASE IN PASI OF 50% OR MORE OR SIGNIFICANT IMPROVEMENT IN QUALITY OF LIFE OBSERVED BY PHYSICIAN AND PATIENT.
APREPITANT BVD DETERMINATION	EMEND	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.						
AROMATASE INHIBITORS	ANASTROZOLE EXEMESTANE LETROZOLE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
BECAPLERMIN	REGRANEX	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NON-DIABETIC. KNOWN NEOPLASM AT APPLICATION SITE. PRESSURE OR VENOUS STASIS ULCERS. ULCER DOES NOT EXTEND THROUGH DERMIS.			VASCULAR SURGEON, PODIATRIST, ENDOCRINOLOGIST OR PHYSICIAN PRACTICING IN A SPECIALTY WOUND CLINIC ONLY	3 MONTHS	

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BOTULINUM NEUROTOXIN	BOTOX	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	COSMETIC DIAGNOSIS: WRINKLES, MIGRAINE HEADACHE; NO TRIAL OF TWO OF THE FOLLOWING BETA BLOCKERS, TRICYCLIC ANTIDEPRESSANTS, OR VALPROIC ACID. BLEPHAROSPASM: NO TRIAL OF BOTOX.				12 MONTHS	
CALCINEURIN INHIBITORS	ELIDEL PROTOPIC	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NOT TRIED/FAILED OR INTOLERABLE ADVERSE EFFECTS TO TOPICAL CORTICOSTEROIDS		ELIDEL 1% AND PROTOPIC 0.03%: 2 YEARS OR OLDER. PROTOPIC 0.1%: OVER 14 YEARS.		12 MONTHS	
CERTOLIZUMAB PEGOL	CIMZIA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	FOR ALL DIAGNOSIS: TRIAL OF HUMIRA, OR SIMPONI. FOR MODERATE TO SEVERE CROHN'S DISEASE: NO TRIAL/FAILURE OF ONE OR MORE CONVENTIONAL THERAPIES FOR CROHN'S DISEASE SUCH AS CORTICOSTEROIDS, AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE. FOR MODERATE TO SEVERE RHEUMATOID ARTHRITIS: NO TRIAL/FAILURE OF AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, OR AURANOFIN).			PRESCRIBED BY OR SUPERVISED BY A GASTROENTEROLOGIST OR RHEUMATOLOGIST.	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS	APPLIES TO NEW STARTS ONLY.
CHOLINESTERASE INHIBITORS	ARICEPT EXELON	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	MINI MENTAL STATE EXAM (MMSE) SCORE GREATER THAN 26	MINI MENTAL STATE EXAM (MMSE) SCORE OF 26 OR LESS			12 MONTHS	
CORTICOSTEROID BVD DETERMINATION	A-HYDROCORT A-METHAPRED CORTISONE DEPO-MEDROL DEXAMETHASONE DEXAMETHASONE SODIUM PHOSPHATE HYDROCORTISONE METHYLPREDNISOLONE METHYLPREDNISOLONE ACETATE METHYLPREDNISOLONE SOD SUCC PREDNISOLONE SODIUM PHOSPHATE PREDNISONE PREDNISONE INTENSOL SOLU-MEDROL VERIPRED 20	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.						
CYCLOPHOSPHAMIDE BVD DETERMINATION	CYCLOPHOSPHAMIDE	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.						
CYCLOSPORINE OPHTHALMIC	RESTASIS	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		KERATOCONJUNCTIVITIS SICCA (KCS) OR DRY EYE DISEASE.		PRESCRIBED BY OR SUPERVISED BY A OPHTHALMOLOGIST, OPTOMETRIST, OR RHEUMATOLOGIST.	12 MONTHS	
DALFAMPRIDINE	AMPYRA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	PATIENT HAS NOT EXPERIENCED OR MAINTAINED AT LEAST 15% IMPROVEMENT IN WALKING ABILITY.	WALKING DISABILITY SUCH AS MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS OR UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA.		NEUROLOGIST	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS	
DENOSUMAB	PROLIA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		A PATIENT WITH EITHER A HISTORY OF OSTEOPORITIC FRACTURE(S) OR GREATER THAN OR EQUAL TO TWO FACTORS FOR FRACTURE (E.G. HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS), OR FAILED AN ADEQUATE TRIAL OF BISPHOSPHONATES, IS INTOLERANT, OR HAS A CONTRAINDICATION TO BISPHOSPHONATES.			12 MONTHS	
DENOSUMAB-XGEVA	XGEVA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	DIAGNOSIS OF MULTIPLE MYELOMA				12 MONTHS	
ELTROMBOPAG	PROMACTA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	INITIAL: ADEQUATE RESPONSE TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR SUFFICIENT RESPONSE TO SPLENECTOMY, RENEWAL: NO CLINICAL RESPONSE AS DEFINED BY AN INCREASE IN PLATELET COUNT OF GREATER THAN OR EQUAL TO 50 X10 ⁹ /L AT THE MAX DOSE OF 75MG PER DAY FOR 4 WEEKS				INITIAL:1 MONTH RENEWAL: NO RESPONSE AFTER INITIAL:1 MONTH AT MAX DOSE, IF RESPONSE: 12 MONTHS.	
ENDOTHELIN RECEPTOR ANTAGONISTS	LETAIRIS TRACLEER	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIAGNOSIS OF PULMONARY ARTIERAL HYPERTENTION GREATER OR EQUAL TO NYHA/WHO FUNCTIONAL CLASS II.		CARDIOLOGIST OR PULMONOLOGIST.	12 MONTHS	

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EPIDERMAL GROWTH FACTOR RECEPTOR INHIBITORS	IRESSA TARCEVA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		NON SMALL CELL LUNG CANCER: EPIDERMAL GROWTH FACTOR RECEPTOR ACTIVATING MUTATIONS.			12 MONTHS	FOR NON SMALL CELL LUNG CANCER: IF NO EPIDERMAL GROWTH FACTOR RECEPTOR ACTIVATING MUTATIONS PATIENT WILL NEED TRIAL OF OR CONTRAINDICATION TO IV CHEMOTHERAPY. CURRENT OR PREVIOUS TREATMENT/BENEFIT FROM IRESSA CAN CONTINUE TREATMENT WITH DRUG. IF NOT WILL NEED TRIAL OF TARCEVA. FOR PANCREATIC CANCER: TARCEVA USED IN COMBINATION WITH GEMCITABINE.
ERIBULIN	HALAVEN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	PREVIOUS TREATMENT WITH AN ANTHRACYCLINE (DAUNORUBICIN, DOXORUBICIN, IDARUBICIN, EPIRUBICIN, OR MITOXANTRONE) AND A TAXANE (DOCETAXEL OR PACLITAXEL).
ERYTHROPOIESIS STIMULATING AGENTS ARANESP	ARANESP	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		CHRONIC RENAL FAILURE: HEMAGLOBIN LEVELS BETWEEN 9.5 AND 11.5 G/DL OR PRE-TREATMENT HEMOGLOBIN LESS THAN 10 G/DL. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CHEMOTHERAPY: HEMOGLOBIN LEVELS BETWEEN 10 AND 12 G/DL OR HEMOGLOBIN LEVEL LESS THAN 11 G/DL OR HEMOGLOBIN LEVEL DECREASED AT LEAST 2 G/DL BELOW THEIR BASELINE.			RENAL FAILURE/CANCER CHEMOTHERAPY THERAPY: 12 MONTHS.	ALL INDICATIONS: TRIAL OF PROCRIT. PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.
ERYTHROPOIESIS STIMULATING AGENTS EPOETIN ALFA	EPOGEN PROCRIT	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL OFF LABEL COVERAGE FOR REDUCTION OF ALLOGENIC BLOOD TRANSFUSION IN SURGERY PATIENTS, ANEMIA IN HEPATITIS C BEING TREATED IN COMBINATION WITH RIBAVIRIN AND AN INERFERON ALFA OR PEGINTERFERON ALFA.		CHRONIC RENAL FAILURE HEMAGLOBIN LEVELS BETWEEN 9.5 AND 11.5 G/DL OR PRE-TREATMENT HEMOGLOBIN LESS THAN 10 G/DL. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CHEMOTHERAPY: HEMOGLOBIN LEVELS BETWEEN 10 AND 12 G/DL OR HEMOGLOBIN LEVEL LESS THAN 11 G/DL OR HEMOGLOBIN LEVEL DECREASED AT LEAST 2 G/DL BELOW THEIR BASELINE. ZIDOVUDINE THERAPY: HEMOGLOBIN LEVEL BETWEEN 10 AND 12 G/DL OR HEMOGLOBIN LESS THAN 10 G/DL. ELECTIVE, NONCARDIAC, NONVASCULAR SURGERY: HEMOGLOBIN LESS THAN 13 G/DL. CONCURRENT HEPATITIS C TREATMENT: HEMOGLOBIN LESS BETWEEN 10 AND 12 G/DL OR CONTRAINDICATION TO RIBAVIRIN AND HEMOGLOBIN LESS THAN 10 G/DL.			RENAL FAILURE/CANCER CHEMOTHERAPY/ZIDOVUDINE THERAPY: 12 MONTHS. SURGERY: 1 MONTH. HEP C: 6 MONTHS.	ALL INDICATIONS: TRIAL OF PROCRIT. PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.
ESRD BVD DETERMINATION	BONIVA CALCITRIOL CUBICIN HECTOROL HEPARIN SODIUM LEVOCARNITINE MIACALCIN PAMIDRONATE DISODIUM VANCOMYCIN HCL	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.						
ETANERCEPT	ENBREL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	INITIAL: FOR RHEUMATOID ARTHRITIS OR JUVENILE ARTHRITIS: NO TRIAL/FAILURE TO AT LEAST ONE DMARD AGENT. FOR MODERATE TO SEVERE PLAQUE PSORIASIS COVERING 10% BSA OF LESIONS COVERING HANDS, FEET, OR GENITAL AREA: NO TRIAL/FAILURE/INTOLERABLE SIDE AFFECTS TO AT LEAST ONE PREFERRED THERAPY (PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE). RENEWAL: ACTIVE RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS/JUVENILE ARTHRITIS: NO LESS THAN 20% OR GREATER IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT. ANKYLOSING SPONDYLITIS: NO LESS THAN 50% IMPROVEMENT OR INCREASE IN 2 UNITS FROM BASELINE IN BASDAI. PLAQUE PSORIASIS: PATIENT HAS NOT ACHIEVED CLEAR OR MINIMAL DISEASE OR A DECREASE IN PASI OF 50% OR MORE.			PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST OR DERMATOLOGIST.	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS	APPLIES TO NEW STARTS ONLY. INITIAL:FOR ALL DIAGNOSIS: TRIAL OF HUMIRA OR SIMPONI
FENTANYL TRANSDERMAL PATCH	FENTANYL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	PATIENT ABLE TO TAKE OR HAS NOT FAILED A SUSTAINED-RELEASE MORPHINE PRODUCT. PRESCRIBED FOR AS NEEDED DOSAGE FREQUENCY.				12 MONTHS	EVERY 48 HOUR DOSING CONSIDERED FOR PATIENTS WHO FAIL EVERY 72 HOUR DOSING.
FENTANYL TRANSMUCOSAL AGENTS	FENTANYL CITRATE	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		CANCER: ON A MAINTENANCE DOSE OF CONTROLLED- RELEASE PAIN MEDICATION, AND EITHER A TRIAL AND FAILURE OF 1 IMMEDIATE-RELEASE ORAL PAIN AGENT OR DIFFICULTY SWALLOWING TABLETS/CAPSULES			6 MONTHS	

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FINGOLIMOD	GILENYA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	CONTRAINDICATION OR HAS NOT TRIED INTERFERON THERAPY (AVONEX, BETASERON, EXTAVIA, OR REBIF) AND COPAXONE.
FONDAPARINUX	ARIXTRA	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ACUTE DVT/PE TREATMENT: IS STABILIZED ON WARFARIN AND HAS ESTABLISHED AN ORAL ANTICOAGULANT EFFECT WITH A THERAPEUTIC INR BETWEEN 2 TO 3.				HIP REPLACEMENT/FRACTURE SURGERY UP TO 33 DAYS KNEE/ABDOMINAL SURGERY/DVT/PE TREATMENT UP TO 14 DAYS	
GLP-1 ANALOGS	BYETTA VICTOZA 3-PAK	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	DIAGNOSIS: NON TYPE 2 DIABETES. NO FAILURE TO REACH TREATMENT GOAL WITH METFORMIN, SULFONYLUREA, OR THIAZOLIDINEDIONE.	DIAGNOSIS: TYPE 2 DIABETES			12 MONTHS	
GOLIMUMAB	SIMPONI	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		RENEWAL: ACTIVE RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS: GREATER THAN 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT. ANKYLOSING SPONDYLITIS: GREATER THAN 20% IMPROVEMENT IN ANKYLOSING SPONDYLITIS (ASAS20) CRITERIA.	18 YEARS OR OLDER	PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST OR DERMATOLOGIST.	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS	APPLIES TO NEW STARTS ONLY. ACUTE RHEUMATOID ARTHRITIS: CURRENTLY ON METHOTREXATE. PSORIATIC ARTHRITIS: TRIAL/FAILURE OR EXPERIENCE WITH INTOLERABLE SIDE EFFECTS TO AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, OR AURANOFIN).
HEPATITIS A VACCINE (INACTIVATED) BVD DETERMINATION	HAVRIX VAQTA	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.						
HEPATITIS B VACCINE BVD DETERMINATION	ENGERIX-B RECOMBIVAX HB	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.						
IMIQUIMOD - ALDARA	IMIQUIMOD	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL OFF LABEL COVERAGE FOR ACTINIC KERATOSIS NOT LIMITED TO THE FACE AND SCALP IN NON-IMMUNOCOMPETENT PATIENTS, MOLLUSCUM CONTAGIOSUM, AND LETIGO MALIGNA.	EXTERNAL GENITAL OR PERIANAL WARTS: NO TRIAL OR CONTRAINDICATION TO PODOFILOX. ACTINIC KERATOSIS: NO TRIAL OF OR NO CONTRAINDICATION TO TOPICAL 5-FLUOROURACIL.		EXTERNAL GENITAL OR PERIANAL WARTS: GREATER THAN OR EQUAL TO 12 YEARS OF AGE. ACTINIC KERATOSIS: GREATER THAN OR EQUAL TO 18 YEARS OF AGE.	ACTINIC KERATOSIS: DERMATOLOGIST ONLY. SUPERFICIAL BASAL CELL CARCINOMA/LETIGO MALIGNA: DERMATOLOGIST OR ONCOLOGIST ONLY.	4 MONTHS	CRITERIA APPLIES TO NEW STARTS ONLY. SUPERFICIAL BASAL CELL CARCINOMA: LESS THAN 2CM IN SIZE AND NOT ON THE FACE. MOLLUSCUM CONTAGIOSUM LIMITED TO THE FACE.
IMIQUIMOD - ZYCLARA	ZYCLARA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	EXTERNAL GENITAL OR PERIANAL WARTS: NO TRIAL OR CONTRAINDICATION TO TOPICAL 5-FLUOROURACIL OR GENERIC IMIQUIMOID 5%. ACTINIC KERATOSIS: NO TRIAL OF OR NO CONTRAINDICATION TO TOPICAL 5-FLUOROURACIL AND GENERIC IMIQUIMOID 5%.		EXTERNAL GENITAL OR PERIANAL WARTS: GREATER THAN OR EQUAL TO 12 YEARS OF AGE. ACTINIC KERATOSIS: GREATER THAN 18 YEARS OF AGE.	DERMATOLOGIST SUPERVISION.	4 MONTHS	CRITERIA APPLIES TO NEW STARTS ONLY.
IMMUNE GLOBULIN BVD DETERMINATION	CARIMUNE NF NANOFILTERED GAMASTAN S-D GAMMAGARD LIQUID GAMMAPLEX GAMUNEX HIZENTRA PRIVIGEN VIVAGLOBIN	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.						
IMMUNOSUPPRESSANT BVD DETERMINATION	AZATHIOPRINE AZATHIOPRINE SODIUM CELLCEPT CYCLOSPORINE CYCLOSPORINE MODIFIED GENGRAF MYCOPHENOLATE MOFETIL MYFORTIC ORTHOCLONE OKT-3 PROGRAF RAPAMUNE SIMULECT TACROLIMUS ZORTRESS	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.						

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INFLIXIMAB	REMICADE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		RENEWAL: RHEUMATOID/PSORIASIC ARTHRITIS: GREATER THAN 20% IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT. FOR PLAQUE PSORIASIS: PASI OF GREATER THAN 50% OR SIGNIFICANT IMPROVEMENT IN QUALITY OF LIFE OBSERVED BY PHYSICIAN AND PATIENT. FOR ANKYLOSING SPONDYLITIS: IMPROVEMENT OF AT LEAST 50%, OR 2 UNITS (SCALE OF 1-10), IN THE BATH ANKYLOSING SPONDYLITIS DISEASE ACTIVITY INDEX (BASDAI) OR IMPROVEMENT OF AT LEAST 20% IN THE ASSESSMENT IN ANKYLOSING SPONDYLITIS (ASAS20) CRITERIA.		PRESCRIBED BY OR SUPERVISED BY A GASTROENTEROLOGIST, RHEUMATOLOGIST OR DERMATOLOGIST.	CROHN'S/UC/ACUTE ENTEROCUTANEOUS FISTULA: 12 MO. OTHER INDICATIONS INITIAL: 3 MO RENEWAL: 12 MO	APPLIES TO NEW STARTS ONLY. PART B VERSUS PART D COVERAGE DETERMINATION. INITIAL: FOR MODERATE TO SEVERE CROHN'S DISEASE/ULCERATIVE COLITIS/ACUTE ENTEROCUTANEOUS FISTULA: TRIAL/FAILURE OF ONE OR MORE CONVENTIONAL THERAPIES FOR CROHN'S DISEASE SUCH AS SULFASALAZINE, CORTICOSTEROIDS, AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OLSALAZINE CYCLOSPORINE, OR MESALAMINE. FOR PSORIASIC ARTHRITIS/JUVENILE ARTHRITIS: TRIAL/FAILURE TO AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THOMALATE, OR AURANOFIN). FOR RHEUMATOID ARTHRITIS: ON METHOTREXATE. FOR SEVERE PLAQUE PSORIASIS COVERING 10% BSA: TRIAL/FAILURE/INTOLERABLE SIDE AFFECTS TO AT LEAST ONE PREFERRED THERAPY (PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE).
INFUSIBLE DRUG BVD DETERMINATION	ABELCET ACYCLOVIR SODIUM ADRIAMYCIN AMBISOME AMPHOTEC AMPHOTERICIN B BLEOMYCIN SULFATE CLADRIBINE CYTARABINE DOXIL FLUOROURACIL FOSCARNET SODIUM GANCICLOVIR SODIUM HERCEPTIN IFOSFAMIDE IFOSFAMIDE-MESNA METHOTREXATE MITOMYCIN REMODULIN TORISEL VINBLASTIN SULFATE VINCRISTINE SULFATE	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.						
INTERFERON AGENTS - INTERFERON ALFA-2B	INTRON A	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	DIAGNOSIS: HEPATITIS C: NOT IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED. PRETREATMENT HCV RNA LEVEL UNDER 50 IU/ML.				HEP C: GENOTYPE 2 OR 3: 6-MONTHS. ALL OTHER INDICATIONS: 4 MONTHS. RENEWAL: 6 MONTHS.	
INTERFERON AGENTS - PEG-INTERFERON ALFA-2A	PEGASYS	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	DIAGNOSIS: HEPATITIS C: NO TRIAL OF PEGINTRON. NOT IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED. PRETREATMENT HCV RNA LEVEL UNDER 50 IU/ML. RENEWAL: HEPATITIS C: GENOTYPE 2 OR 3: NO RENEWAL. GENOTYPE 1, 4, 5, 6: UNABLE TO ACHIEVE A 2-LOG REDUCTION IN QUANTITATIVE HCV RNA LEVEL BY 12 WEEKS OR HAS A HCV RNA LEVEL GREATER THAN 50 IU/ML AT 24 WEEKS.			GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST).	HEP B AND HEP C GENOTYPE 2, 3: 6 MONTHS. GENOTYPE 1, 4, 5, 6: 4-MONTHS.	RENEWAL: HEP B: 6-MONTHS. HEP C: GENOTYPE 1, 4, 5, 6: HCV RNA LESS THAN 50 IU/ML AT 24 WKS: 12 MONTHS. HCV RNA ABOVE 50 IU/ML AT 12 WKS: 2 MONTHS THEN RE-TEST AT 24 WKS.
INTERFERON AGENTS - PEG-INTERFERON ALFA-2B	PEGINTRON PEGINTRON REDIPEN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	DIAGNOSIS: HEPATITIS C: NOT IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED. PRETREATMENT HCV RNA LEVEL UNDER 50 IU/ML. RENEWAL: HEPATITIS C: GENOTYPE 2 OR 3: NO RENEWAL. GENOTYPE 1, 4, 5, 6: UNABLE TO ACHIEVE A 2-LOG REDUCTION IN QUANTITATIVE HCV RNA LEVEL BY 12 WEEKS OR HAS A HCV RNA LEVEL GREATER THAN 50 IU/ML AT 24 WEEKS.		OVER 2 YEARS.	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST).	HEP C: GENOTYPE 2 OR 3: 6-MONTHS. GENOTYPE 1, 4, 5, 6: 4-MONTHS.	RENEWAL: HEP C: GENOTYPE 1, 4, 5, 6: HCV RNA LESS THAN 50 IU/ML AT 24 WKS: 12 MONTHS. HCV RNA ABOVE 50 IU/ML AT 12 WKS: 2 MONTHS THEN RE-TEST AT 24 WKS.
LOW MOLECULAR WEIGHT HEPARIN AGENTS	FRAGMIN	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	CURRENTLY ON WARFARIN AND SCHEDULED FOR MINOR SURGERY OR MAJOR SURGERY AND HAS A THERAPEUTIC INR (GREATER THAN 2 FOR AT LEAST 2 DAYS).	PREGNANCY TEST, INR.			CANCER: LIFETIME. HIP REPLACEMENT/FRACTURE SURGERY UP TO 30 DAYS. OTHER INDICATIONS UP TO 17 DAYS.	
MEMANTINE	NAMENDA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	MINI MENTAL STATE EXAM (MMSE) SCORE GREATER THAN 19				12 MONTHS	
METHOTREXATE BVD DETERMINATION	METHOTREXATE TREXALL	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.						
METHYLNALTREXONE	RELISTOR	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NOT ON PALLIATIVE CARE.	CONSTIPATION DUE TO OPIOIDS			UP TO 6 MONTHS	

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MODAFINIL AND ARMODAFINIL	PROVIGIL	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	NARCOLEPSY: TRIAL/FAILURE OR CONTRAINDICATION TO AMPHETAMINE, DEXTROAMPHETAMINE AND/OR METHYLPHENIDATE.
NATALIZUMAB	TYSABRI	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	MULTIPLE SCLEROSIS: NO TRIAL OF AN INTERFERON OR COPAXONE. CROHN'S DISEASE: NO TRIAL OF A TNF-ALPHA INHIBITOR. RENEWAL: CROHN'S: CONTINUED CONCOMITANT CORTICOSTEROID TREATMENT AFTER 6 MONTHS ON NATALIZUMAB, OR REQUIRED MORE THAN 3 MONTHS OF CORTICOSTEROID				MULTIPLE SCLEROSIS: 12 MONTHS. CROHN'S DISEASE: 6 MONTHS. RENEWAL: CROHN'S: 12 MONTHS.	
NEBULIZER BVD DETERMINATION	ALBUTEROL SULFATE CROMOLYN SODIUM PULMOZYME TOBI	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.						
OFATUMUMAB	ARZERRA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	CHRONIC LYMPHOCYTIC LEUKEMIA: NO FAILED TREATMENT WITH FLUDARABINE AND ALEMTUZUMAB				6 MONTHS	
OMALIZUMAB	XOLAIR	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		INITIAL: PATIENT MEETS THE CRITERIA OF MODERATE TO SEVERE ASTHMA, POSITIVE SKIN PRICK OR RAST TEST, FEV1 LESS THAN 80%, DEMONSTRATED INADEQUATELY CONTROLLED SYMPTOMS ON INHALED CORTICOSTEROIDS AND SECOND ASTHMA CONTROLLER, BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30 IU/ML. RENEWAL: PATIENT REDUCED EXACERBATIONS BY AT LEAST 25% FROM BASELINE, REDUCTION IN ORAL OR INHALED CORTICOSTEROID USE FROM BASELINE.	PATIENT 12 YEARS OF AGE OR OLDER	SPECIALIST IN ALLERGY OR PULMONARY MEDICINE ONLY	12 MONTHS	
PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION	ADCIRCA REVATIO	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		PULMONARY ARTERIAL HYPERTENSION: WHO CLASS I-IV SYMPTOMS		CARDIOLOGIST OR PULMONOLOGIST	12 MONTHS	
PLERIXAFOR	MOZOBIL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		USE IN COMBINATION WITH GRANULOCYTE-COLONY STIMULATING FACTOR (G-CSF) TO MOBILIZE HEMATOPOIETIC STEM CELLS TO THE PERIPHERAL BLOOD FOR COLLECTION AND SUBSEQUENT AUTOLOGOUS TRANSPLANTATION IN PATIENTS WITH NON-HODGKIN'S LYMPHOMA AND MULTIPLE MYELOMA		HEMATOLOGIST OR ONCOLOGIST	4 DOSES (UP TO 8 VIALS) FOR ONE FILL PER DAY.	
PRAMLINTIDE	SYMLIN SYMLINPEN 120 SYMLINPEN 60	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		TYPE I OR TYPE II DIABETES: REQUIRING INSULIN OR CONTINUOUS INSULIN INFUSION (INSULIN PUMP) FOR GLYCEMIC CONTROL.			12 MONTHS	
QUININE SULFATE	QUALAQUIN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
RABIES VACCINE BVD DETERMINATION	IMOVAX RABIES VACCINE RABAVERT	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.						
RIFAXIMIN	XIFAXAN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL OFF LABEL COVERAGE FOR SMALL INTESTINAL BACTERIAL OVERGROWTH (SIBO).	TRAVELERS' DIARRHEA: NO PREVIOUS TRIAL OF CIPROFLOXACIN OR AZITHROMYCIN. HEPATIC ENCEPHALOPATHY: NO TRIAL OF LACTULOSE MONOTHERAPY. SMALL INTESTINAL BACTERIAL OVERGROWTH: NO TRIAL OF AT LEAST 2 OF THE FOLLOWING: AMOXICILLIN-CLAVULANIC ACID, CIPROFLOXACIN, DOXYCYCLINE, METRONIDAZOLE, NEOMYCIN, TETRACYCLINE, OR TRIMETHOPRIM-SULFAMETHOXAZOLE.		TRAVELERS' DIARRHEA: 12 YEARS OR OLDER. HEPATIC ENCEPHALOPATHY: 18 YEARS OR OLDER.		TRAVELERS' DIARRHEA: 1 FILL IN 1 MONTH. HEPATIC ENCEPHALOPATHY: 12 MONTHS. SIBO: 10 DAYS.	
RITUXIMAB	RITUXAN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	INITIAL: FOR RHEUMATOID ARTHRITIS: NOT ON METHOTREXATE AND NO TRAIL OF ENBREL, HUMIRA, REMICADE, SIMPONI OR CIMZIA. RENEWAL: FOR RHEUMATOID ARTHRITIS: LESS THAN 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT.	FOR NON-HODGKIN'S LYMPHOMA OR CHRONIC LYMPHOCYTIC LEUKEMIA: USED IN COMBINATION WITH CHEMOTHERAPY.		PRESCRIBED BY OR SUPERVISED BY: FOR RHEUMATOID ARTHRITIS A RHEUMATOLOGIST. FOR NHL OR CLL AN ONCOLOGIST.	RA: INITIAL 3 MO. RENEW 6 MO. HNL: 1 YEAR. CLL: 6 MO. WG, MPA: 1 MO.	APPLIES TO NEW STARTS ONLY.

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ROMIDEPSIN	ISTODAX	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ABLE TO TOLERATE ORAL MEDICATIONS AND NOT TRIED VORINOSTAT, OR NOT ABLE TO TOLERATE ORAL MEDICATIONS AND NOT TRIED AT LEAST ONE SYSTEMIC THERAPY (RETINOID, INTERFERON, EXTRACORPOREAL PHOTOPHERESIS, DENILEUKIN DIFTITOX, METHOTREXATE, LIPOSOMAL DOXORUBICIN, GEMCITABINE, CHLORAMBUCIL, PENTOSTATIN, ETOPOSIDE, CYCLOPHOSPHAMIDE, TEMOZOLOMIDE, BORTEZOMIB).				12 MONTHS	
SOMATROPIN	GENOTROPIN HUMATROPE NORDITROPIN NORDIFLEX NUTROPIN NUTROPIN AQ NUTROPIN AQ NUSPIN OMNITROPE SAIZEN SEROSTIM TEV-TROPIN ZORBTIVE	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ATHLETIC ENHANCEMENT OR ANTI-AGING PURPOSE. GROWTH FAILURE DUE TO CHRONIC RENAL INSUFFICIENCY(CRI) IF PATIENT HAS HAD A RENAL TRANSPLANT	FOR GROWTH FAILURE DUE TO (CRI): PATIENT HAS NOT UNDERGONE A RENAL TRANSPLANT, PATIENT'S HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER, LACK OF RESPONSE FROM PREVIOUS YEAR, PATIENT HAS REACHED 50TH PERCENTILE FOR TARGET HEIGHT FOLLOWING GROWTH HORMONE THERAPY. FOR HIV/WASTING: THE PATIENT ON ANTIRETROVIRAL THERAPY, MEETS CRITERIA OF WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, 7.5% OVER 6 MONTHS, 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN) OR 23% (WOMEN) OF TOTAL BODY WT. AND A BODY MASS INDEX (BMI) LESS THAN 27KG/M2, OR BMI LESS THAN 20KG/M2. IF CURRENTLY ON GROWTH HORMONE, PATIENT HAS SHOWN CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT OR IF NOT ON GROWTH HORMONE, PATIENT HAS HAD INADEQUATE RESPONSE TO PREVIOUS THERAPY. (I.E. EXERCISE TRAINING, NUTRITIONAL SUPPLEMENTS, APPETITE STIMULANTS OR ANABOLIC STEROIDS). FOR SHORT-BOWEL SYNDROME: CURRENTLY ON SPECIALIZED NUTRITIONAL SUPPORT.			HIV/AIDS: 3 MONTHS. SHORT BOWEL: 4 WEEK ONCE. ALL OTHER DIAGNOSES: 12 MONTHS.	
TERIPARATIDE	FORTEO	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		A PATIENT WITH EITHER A DIAGNOSIS OF SEVERE OSTEOPOROSIS (T-SCORE LESS THAN -2.5 WITH FRAGILITY FRACTURE) OR A T SCORE EQUAL TO OR LESS THAN -2.5 AND MULTIPLE RISK FACTORS FOR FRACTURE (E.G. HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS), OR FAILED AN ADEQUATE TRIAL OF BISPHOSPHONATES, IS INTOLERANT, OR HAS A CONTRAINDICATION TO BISPHOSPHONATES.			12 MONTHS	
TESTOSTERONE	ANDROGEL TESTOSTERONE CYPIONATE TESTOSTERONE ENANTHATE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		CURRENTLY RECEIVING TESTOSTERONE REPLACEMENT. MALE HYPOGONADISM CONFIRMED BY EITHER: 1) LABORATORY CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL OF LESS THAN 250NG/DL (8.7NMOL/L) OR A LOW TOTAL SERUM TESTOSTERONE LEVEL AS INDICATED BY A LAB RESULT WITH A REFERENCE RANGE OBTAINED WITHIN 90 DAYS, OR 2) LABORATORY CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL BETWEEN 250NG/DL AND 350NG/DL (12NMOL/L) TOGETHER WITH A FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 50NG/L (174 PMOL/L) OR A LOW, LOW/NORMAL TOTAL SERUM TESTOSTERONE LEVEL WITH A CONFIRMED LOW FREE SERUM TESTOSTERONE LEVEL AS INDICATED BY A LAB REFERENCE RANGE OR 3) MALE DELAYED PUBERTY NOT SECONDARY TO PATHOLOGY.			12 MONTHS	
TETANUS TOXOID VACCINE BVD DETERMINATION	TETANUS TOXOID ADSORBED	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.						
TETRABENAZINE	XENAZINE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.				NEUROLOGIST	12 MONTHS	
TOCILIZUMAB	ACTEMRA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NO FAILURE OF AT LEAST ONE OF THE FOLLOWING: ENBREL, HUMIRA, REMICADE, SIMPONI OR CIMZIA	DIAGNOSIS: ACTIVE RHEUMATOID ARTHRITIS. RENEWAL: AT LEAST 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT.		RHEUMATOLOGIST	INITIAL: 6 MONTHS. RENEWAL: 6 MONTHS	

Prior Authorization Group Description	Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TOPICAL TRETINOIN	AVITA TRETINOIN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	WRINKLES, PHOTOAGING, MELASMA.				12 MONTHS	BRAND TRETINON WILL REQUIRE TRIAL OF GENERIC TOPICAL TRETINOIN.
TOTAL PARENTERAL NUTRITION AGENT BVD DETERMINATION	AMINOSYN AMINOSYN II AMINOSYN II 3.5% M-DEXTROSE 5% AMINOSYN II 3.5%-DEXTRROSE 25% AMINOSYN II 3.5%-DEXTRROSE 5% AMINOSYN II 4.25% M-DEXT 10% AMINOSYN II 4.25%-DEXTRROSE 25% AMINOSYN II 5% IN 25% DEXTROSE AMINOSYN II IN DEXTROSE AMINOSYN II WITH LYLES-CA-DW AMINOSYN M AMINOSYN-HBC AMINOSYN-HF AMINOSYN-PF CLINIMIX CLINIMIX E CLINISOL DEXTROSE IN WATER FREAMINE III FREAMINE III WITH ELECTROLYTES HEPATAMINE HEPATASOL INTRALIPID LIPOSYN II LIPOSYN III NEPHRAMINE PREMASOL PROCALAMINE PROSOL TRAVASOL TROPHAMINE	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.						
USTEKINUMAB	STELARA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	INITIAL: PLAQUE PSORIASIS: LESS THAN 10% BODY SURFACE AREA OR PASI SCORE LESS THAN 12. NO TRIAL/FAILURE OF AT LEAST ONE OF THE FOLLOWING: PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORIN. RENEWAL: PHYSICIAN'S GLOBAL ASSESSMENT GREATER THAN 1 OR LESS THAN 50% DECREASE IN PASI SCORE.			DERMATOLOGIST OR RHEUMATOLOGIST	INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS	
VALGANCICLOVIR	VALCYTE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ABLE TO TOLERATE ORAL SOLID MEDICATIONS.				6 MONTHS	
VANDETANIB	VANDETANIB	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	CRITERIA APPLIES TO NEW STARTS ONLY.
VARENICLINE	CHANTIX	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	INITIAL: NOT ENROLLED IN A SMOKING CESSATION PROGRAM. RENEWAL: NOT ABSTAINING FROM CIGARETTE USE DURING THE INITIAL 12 WEEKS OF TREATMENT				INITIAL: 12 WEEKS. RENEWAL: 12 WEEKS.	
VILAZODONE	VIIBRYD	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	CONTRAINDICATION OR HAS TRIED AN SSRI (PAROXETINE, SERTARLINE, CITALOPRAM, FLUOXETINE, OR ESCITALOPRAM) AND A SECOND AGENT (BUPROPION HCL (IR, SR, OR XL), MIRTAZAPINE, OR VENLAFAXINE (IR OR XR)).				12 MONTHS	