

PRIOR AUTHORIZATION CRITERIA – Formulary F

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Actemra	All FDA-approved indications not otherwise excluded from Part D.		<p>Initial Therapy for Rheumatoid Arthritis (RA):</p> <ol style="list-style-type: none"> 1. Diagnosis of moderate-to-severe RA; AND 2. Failed methotrexate or 1 DMARD (azathioprine, cyclosporine, gold, hydroxychloroquine, leflunomide, penicillamine, sulfasalazine); AND 3. Failed 1 TNF antagonist <p>Reauthorization: Demonstration of clinical response to therapy.</p>	RA: 18 years and older.	RA (Initial): Prescribed or recommended by a rheumatologist.	Initial Therapy: 6 months Reauthorization: 12 months	RA: Verification that the patient has been evaluated for tuberculosis and treated accordingly.
Adcirca	All FDA-approved indications not otherwise excluded from Part D.	Patients using organic nitrates.	<p>Pulmonary Arterial Hypertension (PAH): Patients with a confirmed diagnosis of pulmonary arterial hypertension which is symptomatic.</p>			12 months	
Afinitor	All FDA-approved indications not otherwise excluded from Part D.		<p>Renal Cell Cancer (RCC)</p> <ol style="list-style-type: none"> 1. Diagnosis of advanced renal cell cancer. 		Prescribed by an oncologist	1 year	<p>Failure of treatment with sunitinib or sorafenib.</p> <p>Afinitor will be approved for continuation of prior therapy.</p>
Alimta	All FDA-approved indications not otherwise excluded from Part D.		<p>Non-Small Cell Lung Cancer:</p> <ol style="list-style-type: none"> 1. Confirmed diagnosis of locally advanced or metastatic NSCLC; AND 2. One of the following: <ol style="list-style-type: none"> a. Prior history of first-line chemotherapy treatment for NSCLC (Avastin [bevacizumab] in combination with chemotherapy, or platinum-based 			1 year	Alimta will be approved for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>combination chemotherapy).</p> <p>b. Used in combination with cisplatin or carboplatin.</p> <p>c. Tumor response or stable disease after 4 cycles of first-line platinum-based chemotherapy.</p> <p>d. Used as first-line monotherapy in patients 70 years of age or greater.</p> <p>e. Used as first-line monotherapy in patients less than 70 and not eligible for platinum-based chemotherapy (eg, poor performance status or comorbidities).</p>				
Alpha-1 Proteinase Inhibitors: Aralast NP, Glassia, Prolastin, Prolastin-C Zemaira	All FDA-approved indications not otherwise excluded from Part D.		<p>Alpha-1 Antitrypsin (ATT) Deficiency:</p> <ol style="list-style-type: none"> 1. Diagnosis of congenital ATT deficiency 2. Serum ATT level $\leq 11 \mu\text{M} / \text{L}$, or $\leq 80 \text{ mg/dL}$ 3. Clinical demonstration of emphysema 	18 years and older		1 year	
Amevive	All FDA approved indications not otherwise excluded from Part D	CD4+ T-lymphocyte cell count ≤ 250 cells per microliter.	<p>Initial Therapy for Plaque Psoriasis:</p> <ol style="list-style-type: none"> 1. Diagnosis of moderate-to-severe plaque psoriasis; AND 2. Failure to systemic therapy with one of the following: methotrexate, cyclosporine, acitretin, hydroxyurea, sulfasalazine, 6-thioguanine, or mycophenolate. <p>Reauthorization for Plaque Psoriasis: Confirmation of positive clinical response to therapy</p>		Prescribed by a dermatologist	<p>Initial Therapy: 12 weeks</p> <p>Re-authorization: 12 week courses</p>	Amevive will be reauthorized only if it has been at least 12 weeks since patient's last treatment
Ampyra	All FDA approved indications not otherwise excluded from Part D		<p>Initial Therapy for Multiple Sclerosis:</p> <ol style="list-style-type: none"> 1. Diagnosis of multiple sclerosis. 2. Physician confirmation that patient has difficulty walking. <p>Reauthorization for Multiple Sclerosis: Physician confirmation that the patient's walking improved with Ampyra therapy.</p>			<p>Initial Therapy: 3 months.</p> <p>Re-authorization: 1 year.</p>	
Anadrol-50	All FDA approved indications		<p>Acquired Aplastic Anemia:</p> <ol style="list-style-type: none"> 1. History of failure; OR 2. Used in combination with, antilymphocyte 			12 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	not otherwise excluded from Part D		<p>globulin or both antilymphocyte globulin and corticosteroid treatment.</p> <p>Hypoplastic Anemia:</p> <ol style="list-style-type: none"> 1. Diagnosis of hypoplastic anemia due to myelotoxic drugs; AND 2. Failure to an erythropoietic stimulating agent. <p>Chronic Renal Failure:</p> <ol style="list-style-type: none"> 1. Diagnosis of chronic renal failure. 2. Failure to an erythropoietic stimulating agent. <p>Pure Red Cell Aplasia:</p> <ol style="list-style-type: none"> 1. Diagnosis of pure red cell aplasia. 2. Failure to immunosuppressive therapy. 				
Aranesp	<p>All FDA approved indications not otherwise excluded from Part D.</p> <p>Refractory anemia in Myelodysplastic Syndrome</p>	<p>Anemia Due to Chronic Renal Failure: Patient is on dialysis (covered under Part B).</p> <p>Anemia in cancer patients on chemotherapy: Patient is not receiving cancer chemotherapy or patient has malignancy for which therapy with Aranesp is contraindicated.</p>	<p>Initial Therapy for Anemia Chronic Renal Failure:</p> <ol style="list-style-type: none"> 1. Chronic Renal Failure not on dialysis; AND 2. Hct < 33% OR Hgb < 11 gm/dl (Hgb/Hct levels must be collected within prior 30 days of request); AND 3. Verification of iron evaluation for adequate iron stores. <p>Reauthorization for Chronic Renal Failure:</p> <ol style="list-style-type: none"> 1. Chronic Renal Failure not on dialysis; AND 2. Verification that average Hct was below 36% over a 3-month period; AND 3. Verification of iron evaluation for adequate iron stores; AND 4. One of the following: <ol style="list-style-type: none"> a. Hgb/Hct reached target range (Hgb 10 to 12 g/dL or Hct 30% to 36%); OR b. Decrease in blood transfusion; OR c. Hgb is ≥ 1 g/dL from pre-treatment level. <p>Initial Therapy for Chemotherapy:</p> <ol style="list-style-type: none"> 1. Verification that other causes of anemia have been ruled out; AND 2. Verification of anemia with one of the following (Hgb/Hct levels collected within prior two weeks of request): 			<p>Initial Therapy: Three months for chemotherapy and MDS. Six months for CRF.</p> <p>Reauthorization: 12 months for CRF and MDS</p>	Aranesp is subject to Part B vs. Part D review.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
		<p>Other off-label requests: Hgb greater than 10 gm/dL or Hct greater than 30%</p>	<p>a. Hct < 30%; OR b. Hgb < 10 gm/dl; 3. Verification of iron evaluation for adequate iron stores 4. Verification that the cancer is a non-myeloid malignancy. 5. AND one of the following: a. Verification that the patient is concurrently on chemotherapy; OR b. Will be on concomitant chemotherapy for 2 months; OR c. The anemia is caused by cancer chemotherapy.</p> <p>Reauthorization for Chemotherapy: 1. Hct < 30% OR Hgb < 10 gm/dl; AND 2. Hgb/Hct reached target range (Hgb 10 to 12 g/dL or Hct 30% to 36%); AND 3. One of the following: a. Decrease in blood transfusion; OR b. Hgb is 1 g/dL; OR c. greater from pre-treatment level. 4. One of the following: a. Verification that the patient is concurrently on chemotherapy; OR b. Will be on concomitant chemotherapy for 2 months; OR c. The anemia is caused by cancer chemotherapy.</p> <p>Initial Therapy for Myelodysplastic Syndrome: 1. Hct < 33%; OR Hgb < 11 g/dL (Hgb/Hct levels must be collected within prior 30 days of request); AND 2. One of the following: a. Serum erythropoietin of ≤ 500 mU/mL; OR b. Diagnosis of transfusion-dependent MDS. 3. Verification of adequate iron stores.</p> <p>Reauthorization of Myelodysplastic Syndrome:</p>				

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<ol style="list-style-type: none"> 1. Verification that average Hct was below 36% over a 3 month period; AND 2. One of the following: <ol style="list-style-type: none"> a. Hgb/Hct reached target range (Hgb 10 to 12 g/dL or Hct 30% to 36%); OR b. Decrease in blood transfusion; OR c. Hgb increase \geq 1 g/dL from pre-treatment level. 				
Arcalyst	All FDA approved indications not otherwise excluded from Part D			12 years and older		1 year	
Arzerra	All FDA approved indications not otherwise excluded from Part D		Chronic lymphocytic leukemia (CLL): <ol style="list-style-type: none"> 1. Confirmed diagnosis of chronic lymphocytic leukemia (CLL). 2. Relapsed or refractory to two prior CLL regimens containing one or more of the following agents: Campath, Treanda, Leukeran, Cytosan, Fludara, Nipent, or Rituxan. 			24 weeks	Prior authorization applies to new starts only
Avastin	All FDA approved indications not otherwise excluded from Part D. Macular Edema.	NSCLC: <ol style="list-style-type: none"> 1. Squamous cell histology. 2. History of hemoptysis. 3. Performance status is not 0 to 1. 	Colorectal Cancer: <ol style="list-style-type: none"> 1. Diagnosis of metastatic colorectal cancer; AND 2. Used in combination with: <ol style="list-style-type: none"> a. 5-FU; OR b. oxaliplatin plus capecitabine; OR c. capecitabine. Non-Small Cell Lung Cancer: <ol style="list-style-type: none"> 1. Diagnosis of unresectable locally advanced recurrent or metastatic NSCLC; AND 2. Used in combination with paclitaxel and carboplatin. Renal Cell Cancer: <ol style="list-style-type: none"> 1. Diagnosis of metastatic renal cell cancer; AND 2. Used in combination with interferon-alpha Breast Cancer: <ol style="list-style-type: none"> 1. Diagnosis of metastatic breast cancer; AND 		ARMD, Macular Edema: Prescribed or recommended by ophthalmologist	Colorectal Cancer, RCC, Breast Cancer, ARMD, Macular Edema, Glioblastoma: a: 12 months NSCLC: 6 months	Avastin will be approved for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>2. Used in combination with paclitaxel.</p> <p>Age-Related Macular Degeneration::</p> <p>1. Diagnosis of age-related macular degeneration</p> <p>Macular Edema:</p> <p>1. Diagnosis of macular edema following retinal vein occlusion.</p> <p>Glioblastoma:</p> <p>1. Relapsed, refractory, or disease progression on one of the following: radiation therapy, temozolomide, nitrosurea, combination PCV, or platinum-based regimen.</p>				
Avonex	All FDA approved indications not otherwise excluded from Part D		<p>Relapsing Multiple Sclerosis (MS):</p> <p>1. Relapsing forms of MS (eg, relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses); OR</p> <p>2. High risk of developing clinically definite MS defined by both of the following:</p> <p>a. Recent history of a first clinical demyelinating event; AND</p> <p>b. MRI-detected brain lesions consistent with MS</p>			1 year	
Berinert	All FDA approved indications not otherwise excluded from Part D		<p>Hereditary Angioedema</p> <p>For the treatment of acute abdominal or facial Hereditary Angioedema attacks</p>		Prescribed by an immunologist, allergist, or rheumatologist	12 months	
Betaseron	All FDA approved indications not otherwise excluded from Part D		<p>Relapsing Multiple Sclerosis:</p> <p>1. Relapsing forms of MS (eg, relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses); OR</p> <p>2. High risk of developing clinically definite MS defined by both of the following:</p> <p>a. Recent history of a first clinical demyelinating event; AND</p> <p>b. MRI-detected brain lesions consistent with</p>			1 year	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
Botox	<p>All FDA approved indications not otherwise excluded from Part D.</p> <p>Migraine.</p> <p>Achalasia.</p> <p>Anal Fissure.</p> <p>Urinary Incontinence.</p>		<p>MS</p> <p>Initial Therapy for Primary Axillary Hyperhidrosis:</p> <ol style="list-style-type: none"> History of failure to topical prescription strength drying agents; AND One of the following: <ol style="list-style-type: none"> Score of 3 or 4 on the Hyperhidrosis Disease Severity Scale (HDSS); OR Skin maceration with secondary infection. <p>Reauthorization for Hyperhidrosis: At least a 2-point improvement in HDSS.</p> <p>Initial Therapy for Migraine:</p> <ol style="list-style-type: none"> At least two prophylactic therapies for migraine (eg, beta blocker, TCA, CCB, cyproheptadine, divalproex sodium, topiramate) ; AND Submission of chart documentation documenting complete evaluation of the patient. <p>Reauthorization for Migraine:</p> <ol style="list-style-type: none"> Reduction in headache frequency; AND Submission of chart notes documenting decreased utilization of pain medications or triptans, or a reduction in the number of emergency room visits. <p>Initial Therapy for Achalasia:</p> <ol style="list-style-type: none"> High risk of complication from pneumatic dilation or surgical myotomy; OR Failure to prior pneumatic dilation or surgical myotomy; OR Prior dilation caused esophageal perforation; OR Patient has an epiphrenic diverticulum or hiatal hernia. <p>Reauthorization for Achalasia:</p> <ol style="list-style-type: none"> Documentation of improvement or reduction in symptoms of achalasia. 	<p>VII cranial nerve disorders: 12 years and older.</p> <p>Chronic back pain: 18 years or older.</p>	<p>Initial therapy for Migraine : Prescribed by a neurologist or pain specialist.</p> <p>Initial Therapy for Chronic Back Pain: Prescribed by a neurologist, neurosurgeon, orthopedist, or pain specialist.</p> <p>Initial therapy for Urinary Incontinence : Prescribed by a neurologist, neurosurgeon , or urologist.</p>	<p>Hyperhidrosis: One prescription</p> <p>Back Pain: One treatment (may be reauthorized for a maximum of two treatments per year).</p> <p>Urinary Incontinence: 1 dose per 6 months</p> <p>Other uses: 6 months</p>	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>Initial Therapy for Anal Fissure: 1. Failure of two conventional therapies (eg, bulk forming laxatives, sitz baths, emollient suppositories, topical analgesics, topical nitrates, oral or topical CCB).</p> <p>Reauthorization for Anal Fissure: 1. Incomplete healing of fissure or recurrence of fissure; AND 2. Improved symptoms with prior treatment with Botox.</p> <p>Initial Therapy for Chronic Back Pain: 1. Confirmed history of persistent low back pain ≥ 6 months duration; AND 2. Failure to at least one oral NSAID and at least one oral opioid.</p> <p>Reauthorization for Back Pain: Confirmed improvement in symptoms with initial Botox treatment.</p> <p>Initial Therapy for Urinary incontinence: 1. Detrusor sphincter dyssynergia or neurogenic detrusor overactivity; AND 2. Failure to two oral anticholinergic agents.</p> <p>Reauthorization for Urinary Incontinence: 1. Confirmed improvement in symptoms with initial Botox treatment; AND 2. At least 6 months elapsed since last Botox treatment.</p>				
Buprenorphine	All FDA approved indications not otherwise excluded from Part D		Opioid dependence: Documented participation in addiction counseling.		Pain management : Prescribed by pain management or palliative care specialist.	12 months	
Campath	All FDA approved indications not otherwise				Prescribed by an oncologist and/or hematologist.	12 months	Approve for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D						
Cellcept Intravenous (IV)	All FDA approved indications not otherwise excluded from Part D		<p>Transplant</p> <ol style="list-style-type: none"> 1. Patient received a renal (kidney), cardiac (heart), or hepatic (liver) transplant; AND 2. Patient is unable to take oral formulations of mycophenolate. <p>Lupus Nephritis:</p> <ol style="list-style-type: none"> 1. Diagnosis of lupus nephritis; AND 2. Failure to combination therapy with corticosteroids and cyclophosphamide. 3. Patient is unable to take oral formulations of mycophenolate. 			12 months	<p>Cellcept is subject to Part B vs. Part D review (not limited to new starts only).</p> <p>Cellcept will be approved for continuation of prior therapy if Part D.</p>
Cellcept oral	<p>All FDA approved indications not otherwise excluded from Part D</p> <p>Bone marrow/stem cell transplant.</p> <p>Lupus nephritis.</p> <p>Obliterative bronchiolitis.</p>		<p>Transplant:</p> <ol style="list-style-type: none"> 1. Patient received a renal (kidney), cardiac (heart), or hepatic (liver) transplant. 2. Patient received a bone marrow/stem cell transplant. <p>Lupus Nephritis:</p> <ol style="list-style-type: none"> 1. Diagnosis of lupus nephritis; AND 2. Failure to combination therapy with corticosteroids and cyclophosphamide. <p>Obliterative Bronchiolitis:</p> <p>Diagnosis of obliterative bronchiolitis following lung transplantation.</p>			12 months	<p>Cellcept is subject to Part B vs. Part D review (not limited to new starts only).</p> <p>Cellcept will be approved for continuation of prior therapy if Part D.</p>
Ceredase	All FDA approved indications not otherwise excluded from Part D		<p>Gaucher's disease:</p> <ol style="list-style-type: none"> 1. Diagnosis of Type 1 Gaucher's disease. 2. Symptomatic disease defined by one of the following: moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly. 			12 months	
Cerezyme	All FDA approved indications not otherwise excluded from Part D		<p>Gaucher's disease:</p> <ol style="list-style-type: none"> 1. Diagnosis of Type 1 Gaucher's disease. 2. Symptomatic disease defined by one of the following: moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly. 			12 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Cesamet	All FDA approved indications not otherwise excluded from Part D		<p>Nausea and Vomiting Associated with Cancer Chemotherapy:</p> <ol style="list-style-type: none"> 1. Patient is receiving cancer chemotherapy 2. Failure to 5HT-3 receptor antagonist 3. Failure to one of the following agents: <ol style="list-style-type: none"> a. Antihistamine; OR b. Corticosteroid; OR c. Prokinetic agent; OR d. Antipsychotic 			Authorization will be issued for 6 months	<p>Cesamet is subject to Part B vs. Part D review.</p> <p>Cesamet will be approved for therapy continuation covered under Part B and when patient is receiving cancer chemotherapy</p>
Chantix	All FDA approved indications not otherwise excluded from Part D		<p>Smoking cessation:</p> <p>Trial on nicotine replacement therapy or bupropion SR.</p>	18 years or older		12 weeks	
Chorionic Gonadotropin: Novarel, Pregnyl	All FDA approved indications not otherwise excluded from Part D	Used to promote fertility.	<p>Prepubertal Cryptorchidism:</p> <p>Diagnosis of prepubertal cryptorchidism not due to anatomical obstruction.</p> <p>Male Hypogonadotropic Hypogonadism:</p> <p>For the treatment of selected cases of hypogonadotropic hypogonadism secondary to pituitary deficiency, verified by low testosterone and low LH or FH, in males.</p>			6 months	
Cimzia	All FDA approved indications not otherwise excluded from Part D		<p>Initial Therapy for Moderate to severe Crohn's disease:</p> <ol style="list-style-type: none"> 1. Failure to one of the following therapies supported by the American College of Gastroenterology Crohn's disease practice guideline: aminosalicylates, azathioprine, corticosteroids, methotrexate, or 6-mercaptopurine.; AND 2. Verification that patient has been evaluated for tuberculosis and treated accordingly. <p>Reauthorization:</p> <p>Demonstrated remission or significant clinical response to Cimzia therapy.</p> <p>RA (initial therapy):</p> <ol style="list-style-type: none"> 1. Diagnosis of moderately to severely active 	18 years and older	<p>CD:</p> <p>Prescribed or recommended by gastroenterologist</p> <p>RA:</p> <p>Prescribed or recommended by a rheumatologist.</p>	<p>CD Initial Therapy:</p> <p>2 months</p> <p>CD Reauthorization:</p> <p>12 months</p> <p>RA:</p> <p>12 months</p>	<p>CD:</p> <p>400 mg initially and at weeks 2 and 4, followed by 400 mg every 4 weeks.</p> <p>RA:</p> <p>400 mg initially and at weeks 2 and 4, followed by 200 mg every other week or 400 mg every 4 weeks.</p>

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			RA. 2. Failed MTX or 2 DMARDs 3. Verification that the patient has been evaluated for tuberculosis and treated accordingly. Reauthorization: Submission of chart documentation demonstrating a positive clinical response.				
Cinryze	All FDA approved indications not otherwise excluded from Part D		Hereditary Angioedema 1. For the long term prevention of Hereditary Angioedema (HAE) attacks; AND 2. One of the following: a. Failure to danazol; OR b. Failure to one alkylated androgen	Prescribed by an immunologist, allergist, or rheumatologist		1 year	
Copaxone	All FDA approved indications not otherwise excluded from Part D		Relapsing Multiple Sclerosis: 1. Relapsing forms of MS (eg, relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses); OR 2. High risk of developing clinically definite MS defined by both of the following: a. Recent history of a first clinical demyelinating event; AND b. MRI-detected brain lesions consistent with MS			1 year	
Degarelix	All FDA-approved indications not otherwise excluded from Part D.		Prostate Cancer: 1. For palliative treatment of advanced prostate cancer, AND 2. Failure to one formulary GnRH agonist product.			12 months	Approve for continuation of prior therapy.
Drugs to Avoid in the Elderly	All FDA-approved indications not otherwise excluded from Part D.			No PA required if less than 65 years old.		12 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Dysport	All FDA-approved indications not otherwise excluded from Part D.		<p>Initial Therapy for Cervical Dystonia: Diagnosis of cervical dystonia (also known as spasmodic torticollis)</p> <p>Reauthorization for Cervical Dystonia: 1. Confirmed improvement in symptoms with initial Dysport treatment; AND 2. At least 3 months has elapsed since the last treatment with Dysport</p>			<p>Initial Therapy: 3 months for a single dose (up to 500 units)</p> <p>Reauthorization: 3 months for a single dose (up to 1000 units)</p>	
Egrifta	All FDA-approved indications not otherwise excluded from Part D.		<p>Initial Therapy for HIV-associated Lipodystrophy: 1. Waist-circumference \geq 95 cm (37.4 inches) in men or \geq 94 cm (37 inches) for women; AND 2. Waist-to-hip ratio \geq 0.94 for men or \geq 0.88 for women; AND 3. Body mass index (BMI) $>$ 20 kg/m²; AND 4. Fasting blood glucose (FBG) levels \leq 150 mg/dL (8.33 mmol/L); AND 5. Patient has been on a stable regimen of antiretrovirals (eg, NRTIs, NNRTI, Protease Inhibitors, Integrase Inhibitors) for at least 8 weeks.</p> <p>Reauthorization for HIV-associated Lipodystrophy: Documentation of clinical improvement (eg, improvement in VAT, decrease in waist circumference, belly appearance).</p>			6 months	
Emcyt					Prescribed by an oncologist.	12 months	Approve for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Emend	All FDA-approved indications not otherwise excluded from Part D.		<p>Acute Chemotherapy-Induced Nausea and Vomiting:</p> <ol style="list-style-type: none"> 1. Patient is currently receiving moderately or highly emetogenic chemotherapy; AND 2. Patient is concurrently on both a corticosteroid and a 5-HT3 receptor antagonist. <p>Delayed Chemotherapy-Induced Nausea and Vomiting:</p> <ol style="list-style-type: none"> 1. Patient is currently receiving highly emetogenic chemotherapy and a steroid; OR 2. Patient is on an anthracycline and cyclophosphamide. <p>Prevention of Postoperative Nausea and Vomiting:</p> <p>For the prevention of postoperative nausea and vomiting when administered prior to the induction of anesthesia.</p>			Acute CINV, Delayed CINV, PONV: 6 months	Emend is subject to Part B vs. Part D review.
Epoetin alpha: Epogen, Procrit	All FDA-approved indications not otherwise excluded from Part D.	<p>Anemia in cancer patients on chemotherapy: Patient is not receiving cancer chemotherapy; OR Patient has malignancy for which therapy with epoetin is contraindicated.</p> <p>Chronic Renal</p>	<p>Anemia due to Chronic Renal Failure:</p> <ol style="list-style-type: none"> 1. Chronic Renal Failure not on dialysis; AND 2. Hematocrit (Hct) less than 33% or hemoglobin (Hgb) less than 11 gm/dl (Hgb/Hct levels must be collected within prior 30 days of request). <p>Reauthorization of CRF:</p> <ol style="list-style-type: none"> 1. Chronic Renal Failure not on dialysis; AND 2. Average Hct was below 36% over 3-months: AND 3. One of the following: <ol style="list-style-type: none"> a. Hgb/Hct reached target (Hgb 10-12 g/dL, Hct 30% to 36%); OR b. Decrease in blood transfusion; OR c. Hgb is 1 g/dL or greater from pre-treatment level. <p>Anemia in HIV-infected patients:</p> <ol style="list-style-type: none"> 1. Anemia is due to zidovudine treatment or 			<p>Initial Therapy Pre-Op: 1 month</p> <p>Chemo, HCV, and MDS: 3 months.</p> <p>CRF, HIV: 6 months</p> <p>Reauthorization CRF, HIV: 6 months</p> <p>HCV: 3 months.</p>	Epoetin will be subject to Part B vs. Part D review.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		<p>Failure: Patient is on dialysis (covered under Part B).</p> <p>Other off-label requests: Hgb greater than 10 gm/dL or Hct greater than 30%</p>	<p>due to HIV infection; AND</p> <p>2. Hgb less than 12 g/dL or Hct less than 36% (Hgb/Hct levels must be collected within prior 30 days of request).</p> <p>Reauthorization in HIV:</p> <p>1, Hct was below 36% over 3 months; AND</p> <p>2. One of the following:</p> <p>a. Hgb/Hct reached target (Hgb 10-12 g/dL, Hct 30% to 36%); OR</p> <p>b. Decrease in blood transfusion; OR</p> <p>c. Hgb is 1 g/dL or greater from pre-treatment level.</p> <p>Anemia in cancer patients on Chemotherapy:</p> <p>1. Verify other causes of anemia have been ruled out; AND</p> <p>2. Hct less than 30% or Hgb less than 10 gm/dl (Hgb/Hct levels must be collected within prior two weeks of request); AND.</p> <p>3. Cancer is a non-myeloid malignancy; AND</p> <p>4. Concurrently on chemo, will be on concomitant chemo for 2 months OR anemia is caused by cancer chemotherapy.</p> <p>Reauthorization in Chemo:</p> <p>1. Hct less than 30% or Hgb less than 10 gm/dl; AND</p> <p>2. One of the following; AND:</p> <p>a. Hgb/Hct reached target (Hgb 10-12 g/dL, Hct 30% to 36%); OR</p> <p>b. Decrease in blood transfusion</p> <p>c. Hgb is 1 g/dL or greater from pre-treatment level.</p> <p>3. Concurrently on chemotherapy for 2 months or anemia is caused by cancer chemo.</p> <p>Preoperative use in patients undergoing surgery for reduction of allogeneic blood transfusion (Pre-op):</p> <p>1. Hgb greater than 10 to less than 13 g/dL scheduled to undergo elective, non-cardiac/vascular surgery to reduce blood</p>			<p>Other uses: 12 months</p>	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>transfusions; OR</p> <p>2. Patient at high risk for perioperative transfusions with expected blood loss of 2 units or greater.</p> <p>Refractory anemia in Myelodysplastic Syndrome:</p> <p>1. Hct less than 33% or Hgb less than 11 g/dL (Hgb/Hct levels must be collected within prior 30 days of request); AND</p> <p>2. One of the following:</p> <p>a. Serum erythropoietin of 500 mU/mL or less</p> <p>b. Diagnosis of transfusion-dependent MDS.</p> <p>Reauthorization for MDS:</p> <p>1. Average Hct was below 36% or Hgb below 12 g/dL over 3 months; AND</p> <p>2. One of the following:</p> <p>a. Hgb/Hct reached target (Hgb 10-12 g/dL, Hct 30% to 36%)</p> <p>b. Decrease in blood transfusion</p> <p>c. Hgb increase of 1 g/dL or more from pre-treatment level.</p> <p>Treatment of anemia in HCV-infected patients due to ribavirin in combination with interferon or peg-interferon:</p> <p>1. Hgb less than 11 g/dL or Hct less than 33% (Hgb/Hct levels must be collected within prior 30 days of request.); AND</p> <p>2. Is concurrently on ribavirin and interferon or peg-interferon alfa for the treatment of HCV and the anemia is due to treatment.</p> <p>Reauthorization of HCV:</p> <p>1. Average Hct was below 36% over a 3 months; And</p> <p>2. One of the following:</p> <p>a. Hgb/Hct reached target (Hgb 10-12 g/dL, Hct 30% to 36%)</p> <p>b. Decrease in blood transfusion</p> <p>c. Hgb is 1 g/dL or greater from pre-</p>				

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>treatment level.</p> <p>All uses: Verify iron evaluation for adequate Fe stores.</p>				
Erbitux	<p>All FDA-approved indications not otherwise excluded from Part D.</p> <p>NSCLC.</p>		<p>Head and Neck Cancer:</p> <ol style="list-style-type: none"> 1. One of the following: <ol style="list-style-type: none"> a. Confirmed diagnosis of locally or regionally advanced squamous cell carcinoma of the head and neck; OR b. Recurrent or metastatic squamous cell head and neck cancer; AND 2. One of the following: <ol style="list-style-type: none"> a. Used in combination with radiation therapy; OR b. After failure of platinum-based chemotherapy. <p>Colorectal Cancer:</p> <ol style="list-style-type: none"> 1. Confirmed diagnosis of metastatic carcinoma of the colon or rectum; AND 2. One of the following: <ol style="list-style-type: none"> a. Used in combination with irinotecan-based chemotherapy b. Intolerance to irinotecan-based chemotherapy c. Failure of irinotecan or oxaliplatin-based chemotherapy regimens; AND 3. Tumor expresses wild-type KRAS gene. <p>NSCLC:</p> <ol style="list-style-type: none"> 1. Confirmed diagnosis of recurrent or metastatic NSCLC stage IIIB or IV 2. Used in combination with vinorelbine and cisplatin 3. ECOG performance status 0 to 2. 4. EGFR expression by immunohistochemistry (greater than or equal to 1 tumor cell) 5. No known brain metastases 6. No prior chemotherapy or anti-EGFR therapy 	<p>NSCLC: 18 years and older</p>		6 months	Erbitux will be approved for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
Fentanyl	All FDA-approved indications not otherwise excluded from Part D.		1. Confirmed diagnosis of malignant pain; AND 2. Demonstrated tolerance to opioids.		Prescribed by an oncologist or pain specialist.	12 months	
Fentanyl (Brand)	All FDA-approved indications not otherwise excluded from Part D.		Cancer Pain: 1. Confirmed diagnosis of malignant pain; AND 2. Demonstrated tolerance to opioids.		Prescribed by an oncologist or pain specialist.	12 months	Chronic Pain: Failure to generic fentanyl.
Folotyn	All FDA-approved indications not otherwise excluded from Part D.		Peripheral T-cell lymphoma 1. Diagnosis of relapsed or refractory peripheral T-cell lymphoma 2. Verification that patient is receiving folic acid and vitamin B12 supplementation.			12 months	Folotyn will be approved for continuation of prior therapy.
Forteo	All FDA-approved indications not otherwise excluded from Part D.		Postmenopausal Osteoporosis: BMD T score of -3.0 or less and a previous fracture resulting from minimal trauma, or both of the following: 1. Patient has a history of fracture resulting from minimal trauma or BMD T score of -2.5 or less; AND 2. One of the following: a. Failure to one oral bisphosphonate b. Failure, contraindication, intolerance to one injectable bisphosphonate c. Contraindication or intolerance to one oral bisphosphonate and failure to one injectable bisphosphonate. Hypogonadal Osteoporosis: BMD T score of -3.0 or less and a previous fracture resulting from minimal trauma, or both of the following: 1. Patient has a history of fracture resulting from minimal trauma or BMD T score of -2.5 or less; AND 2. Failure to a formulary bisphosphonate. Glucocorticoid-Induced Osteoporosis:			12 months with maximum 2 years of therapy	Forteo is subject to Part B vs. Part D review.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			BMD T score of -3.0 or less and a previous fracture resulting from minimal trauma, or both of the following: <ol style="list-style-type: none"> 1. Patient has a history of fracture resulting from minimal trauma or BMD T score of -1.5 or less; AND 2. Failure to a formulary bisphosphonate. 				
Gamastan	All FDA approved indications not otherwise excluded from Part D		<p>Hepatitis A: For use before or soon after exposure.</p> <p>Measles: For use in susceptible individuals exposed fewer than 6 days previously.</p> <p>Varicella: For use in immunocompromised patients.</p> <p>Rubella: For pregnant women who will not consider a therapeutic abortion.</p>			12 months	
Gilenya	All FDA approved indications not otherwise excluded from Part D		<p>Multiple Sclerosis: Patients with relapsing forms of multiple sclerosis.</p>			12 months	
Gleevec	All FDA approved indications not otherwise excluded from Part D		<p>Chronic Myeloid Leukemia (Adults): Diagnosis of Philadelphia chromosome positive CML.</p> <p>Chronic Myeloid Leukemia (Children): 1. Diagnosis of Philadelphia chromosome positive (Ph+) chronic phase CML</p> <p>Acute Lymphoblastic Leukemia: Adult patients with Philadelphia chromosome positive ALL.</p> <p>Myelodysplastic/Myeloproliferative disease: Adults diagnosed with MDS/MPD diseases associated with platelet-derived growth factor receptor gene rearrangements.</p>		Prescribed by an oncologist.	12 months	Gleevec will be approved for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>Aggressive systemic mastocytosis: 1. Adults diagnosed with aggressive systemic mastocytosis; AND 2. One of the following: a. Patient is without the D816V c-Kit mutation b. c-Kit mutation status unknown.</p> <p>Hypereosinophilic syndrome and chronic eosinophilic leukemia : Adults diagnosed with HES or CEL.</p> <p>Dermatofibrosarcoma protuberans: Adults with unresectable, recurrent and/or metastatic DFSP.</p> <p>Gastrointestinal Stromal Tumors: Patients with a confirmed diagnosis of unresectable and/or metastatic GIST, or diagnosis of primary GIST and history of complete gross resection of Kit (CD 117) positive GIST.</p> <p>Desmoid Tumors: Diagnosis of unresectable, metastatic, or recurrent desmoid tumor.</p>				
<p>Growth Hormones: Genotropin, Genotropin Miniquick, Humatrope, Humatrope Combo Pack, Norditropin Cartridge, Norditropin Nordiflex Pen, Nutropin, Nutropin Aq, Nutropin Aq Pen, Omnitrope,</p>	<p>All FDA approved indications not otherwise excluded from Part D:</p> <p>Growth Hormone Deficiency (GHD) in Children</p> <p>Prader-Willi Syndrome (PWS)</p> <p>Small for</p>	<p>Childhood Onset Growth Hormone Deficiency in Adults: 1. Males with bone age greater than 17 yrs or females with bone age greater than 15 years 2. Closed</p>	<p>GHD Children: 1. Diagnosis of GH deficiency based on 2 GH stimulation tests or low Insulin-like growth factor 1 (IGF-1) levels; AND 2. Demonstrate growth failure based on growth velocity or height shorter than 2 standard deviations (SD) below the mean height for age.</p> <p>Prader-Willi Syndrome or Small for Gestational Age: 1. Diagnosis of PWS confirmed by genetic testing; OR 2. Diagnosis of SGA confirmed by birth wt of less than 2500g at gestation of more than 37 wks or at birth weight or length below the 3rd percentile for gestational age who failed to catch up by 2 years of age.</p>		<p>GHD (Child), AOGH, COGHDA, IGHDA, Initial Therapy for TS or NS, and ISS: Prescribed by an endocrinologist.</p> <p>GRCRF: Prescribed by an endocrinologist or nephrologist.</p>	<p>12 months</p>	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Saizen, Saizen Click Easy, Tev-Tropin	Gestational Age (SGA) Turner Syndrome (TS) Noonan Syndrome (NS) Growth Retardation associated with Chronic Renal Insufficiency (GRCRF) Idiopathic Short Stature (ISS) Adult Onset Growth Hormone Deficiency (AOGHD), Childhood Onset GH Deficiency in Adults (COGHDA) Isolated GH Deficiency in Adults (IGHDA)	bone epiphyses on radiograph 3. Growth velocity less than 2 cm/year during previous year of treatment unless COGHD criteria are met.	<p>Turner Syndrome, Noonan Syndrome:</p> <ol style="list-style-type: none"> 1. Treatment of short stature in females w/bone age less than 15 years associated w/TS or NS; OR 2. Treatment of short stature in males w/bone age less than 17 years associated w/NS. <p>Growth Retardation associated with Chronic Renal Insufficiency:</p> <ol style="list-style-type: none"> 1. Diagnosis of chronic renal insufficiency; AND 2. Height shorter than or equal to 2 SD below the median age for children or where growth velocity falls to below 4.5 cm/year. <p>Reauthorization for GHD in Children, PWS, SGA, TS, NS, GRCRF:</p> <ol style="list-style-type: none"> 1. Increase in growth velocity of at least 2 cm/year during previous year of treatment; AND 2. Males with bone age less than 17 yrs or females with bone age less than 15 years. <p>Idiopathic Short Stature:</p> <ol style="list-style-type: none"> 1. Height less than or equal to 2.25 SD below the mean height for age. Growth velocity less than the 25th percentile for bone age; AND 2. Verify open epiphyses on last bone age radiograph; AND 3. Absence of comorbid conditions that should be observed or treated by other means. <p>Reauthorization of ISS:</p> <ol style="list-style-type: none"> 1. Increase in growth velocity of at least 4.5 cm/year during previous year of treatment; AND 2. Males w/bone age less than 17 years or females w/bone age less than 15 years. <p>Adult Onset Growth Hormone Deficiency:</p> <ol style="list-style-type: none"> 1. Pts who have GHD associated with multiple hormone deficiencies because of pituitary 				

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>disease/insult, hypothalamic disease, surgery, or radiation treatment; AND</p> <p>2. IGF-1 level less than 77 mcg/L or 2 SD below the mean value, matched by age and gender.</p> <p>Childhood Onset GH Deficiency in Adults:</p> <p>1. Childhood onset in patients who were GH deficient during childhood who have GH deficiency confirmed as an adult before replacement treatment with GH is started; AND</p> <p>2. Persistent deficiency of GH documented by GH stimulation tests.</p> <p>Isolated GH Deficiency in Adults:</p> <p>Documented deficiency of GH documented by 2 GH stimulation tests.</p>				
Halaven	All FDA approved indications not otherwise excluded from Part D.		<p>Breast Cancer:</p> <p>1. Diagnosis of recurrent or metastatic breast cancer; AND</p> <p>2. Previous treatment with both of the following:</p> <p>a. an anthracycline; AND</p> <p>b. a taxane.</p>		Prescribed by an oncologist.	12 months	Halaven will be approved for continuation of prior therapy.
Hexalen	All FDA approved indications not otherwise excluded from Part D.		<p>1. Diagnosis of ovarian cancer</p> <p>2. Cancer has progressed or recurred following first-line treatment with a cisplatin or alkylating agent-based combination</p>		Prescribed by an oncologist	12 months	Hexalen will be approved for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
Humira, Humira Pen-Crohns Disease	All FDA approved indications not otherwise excluded from Part D.		<p>Moderate to severe Rheumatoid Arthritis (RA): 1. Diagnosis of moderate-to-severe RA; AND 2. Failed methotrexate or 2 DMARDs for 3 months.</p> <p>Juvenile Idiopathic Arthritis (JIA): 1. Diagnosis of moderate-to-severe poly-articular course JIA 2. Failed NSAID or steroid and methotrexate for three months.</p> <p>Psoriatic Arthritis (PsA): 1. Diagnosis of active PsA. 2. Failed methotrexate or 2 DMARDs for 3 months.</p> <p>Ankylosing Spondylitis (AS): 1. Diagnosis of AS. 2. Failed 2 NSAIDs for 3 months.</p> <p>Plaque Psoriasis (PPs): 1. Diagnosis moderate-to-severe plaque psoriasis. 2. Failed systemic therapy</p> <p>Crohn's disease (CD): 1. Diagnosis of moderate to severe CD; AND 2. Failed one conventional therapy.</p> <p>Reauthorization: Demonstration of clinical response to therapy.</p>	<p>RA, PsA, CD, AS, Plaque Psoriasis: 18 years and older.</p> <p>JIA: 4 years and older.</p>	<p>RA, AS, JIA: Prescribed or recommended by a rheumatologist.</p> <p>PsA: Prescribed or recommended by a rheumatologist or dermatologist .</p> <p>Plaque Psoriasis: Prescribed or recommended by a dermatologist .</p> <p>CD: Prescribed or recommended by gastro- enterologist.</p>	<p>Initial Authorization: 4 months for Plaque Psoriasis; 12 months for other uses.</p> <p>Reauthorization 12 months</p>	<p>RA: Authorization is for 40 mg every other week unless documented treatment failure to Humira every other week dosing. Then Humira may be approved for every week dosing if other criteria met.</p> <p>Plaque Psoriasis: Humira dosage is 80 mg followed by 40 mg every other week.</p> <p>CD: 160 mg followed by one dose of 80 mg, followed by 40 mg every week</p> <p>All diagnoses: Verification that the patient has been evaluated for TB and treated accordingly.</p>
<p>Immune Globulin: Carimune Nanofiltered, Gammagard, Liquid, Gammaplex, Gamunex, Octagam, Polygam S/D, Vivaglobin,</p>	<p>All FDA approved indications not otherwise excluded from Part D</p> <p>Bone Marrow Transplant (BMT).</p>		<p>Idiopathic Thrombocytopenic Purpura (ITP): For patients with ITP who require a rapid temporary increase in platelet count or to control excessive bleeding</p> <p>B-cell Chronic Lymphocytic Leukemia (CLL): 1. Documented hypogammaglobulinemia (IgG less than 600mg/dL); OR 2. History of bacterial infections associated</p>		<p>MG: Prescribed by a neurologist.</p>	<p>BMT: 100 days after transplant</p> <p>KD: 1 month</p> <p>MG, GBS: 1 treatment course</p>	<p>Immune Globulin is subject to Part B vs. Part D review.</p> <p>For Part D: For patients in which immune globulin is administered in the patient's home.</p>

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Hizentra	Dermatomyositis. Multifocal Motor Neuropathy. HIV. Guillain-Barre Syndrome (GBS). Lambert-Eaton Myasthenic Syndrome (LEMS). Myasthenia Gravis (MG). Relapsing Remitting Multiple Sclerosis (MS). Stiff-Person Syndrome.		with B-cell CLL. Bone Marrow Transplantation (BMT): 1. Confirmed allogeneic BMT within the last 100 days; AND 2. Documented severe hypogammaglobulinemia (IgG less than 400 mg/dL) Dermatomyositis: Failure or intolerance to one of the following: corticosteroid therapy, methotrexate, azathioprine, or cyclophosphamide. HIV: Documented hypogammaglobulinemia (IgG less than 400 mg/dL). Guillane-Barre Syndrome (GBS): 1. Confirmed diagnosis of severe GBS; AND 2. Patients with severe disease requiring aid to walk; AND 3. Onset of muscle weakness within the last 4 weeks. Acute Myasthenia Gravis (MG) Exacerbation : 1. Confirmed diagnosis of myasthenia gravis with myasthenic exacerbation, defined by one of the following: a. Difficulty swallowing b. Acute respiratory failure c. Major functional disability responsible for the discontinuation of physical activity. Relapsing-Remitting Multiple Sclerosis (MS) : 1. Confirmed diagnosis of relapsing remitting form of MS AND 2. Failure to two of the following: Betaseron, Avonex, Rebif, Copaxone, Tysabri. Stiff Person Syndrome : Chart documentation confirming a diagnosis of			ITP, LEMS: 6 months Other Uses: 1year	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			stiff-person syndrome.				
Infergen	All FDA approved indications not otherwise excluded from Part D		<p>Hepatitis C - Treatment Naive Patients:</p> <ol style="list-style-type: none"> 1. For patients with Chronic Hepatitis C with compensated liver disease 2. Positive HCV antibody 3. HCV RNA level measurement 4. Genotype test result 5. No prior interferon therapy 6. Use in combination with or failure to ribavirin. <p>Hepatitis C - Continuation of Therapy: For genotypes 2, 3, or 5: Evidence of delayed virological response</p> <p>Hepatitis C – Retreatment:</p> <ol style="list-style-type: none"> 1. Patient is a partial responder to prior therapy with a peginterferon product. 2. Used in combination with ribavirin. 	Hepatitis C in Treatment Naive patients: 18 years and older.		<p>Treatment-Naive: genotypes 2, 3, 5: 6 months</p> <p>Genotypes 1, 4, 6. or HIV/HCV: 12 months</p> <p>Continuation of treatment in genotypes 2, 3, 5: 6 months</p>	
Insulin-like Growth Factor: Increlex	All FDA approved indications not otherwise excluded from Part D		<p>IGF-1 deficiency</p> <ol style="list-style-type: none"> 1. All of the following: <ol style="list-style-type: none"> a. Diagnosis of severe primary IGF-1 deficiency. b. Height standard deviation score of -3.0 or less. c. Basal IGF-1 standard deviation score of -3.0 or less. d. Normal or elevated growth hormone. e. Open finger epiphyses on last bone radiograph <p>GH gene deletion:</p> <ol style="list-style-type: none"> a. Diagnosis of growth hormone gene deletion who have developed neutralizing antibodies to GH; AND b. Have open finger epiphyses on last bone radiograph. 			12 months	
Intron-A, Intron-A W/Diluent	All FDA approved indications not otherwise excluded from Part D		<p>Hepatitis B - HBeAg positive:</p> <ol style="list-style-type: none"> 1. HBsAg positive for at least 6 months; AND 2. HBV DNA level greater than 20,000 IU/mL or 100,000 copies/mL; AND. 3. Without decompensated liver disease; AND 4. One of the following: persistent ALT 2 times ULN or moderate to severe hepatitis or 	Hep B - HBeAg positive, Hep B - HBeAg negative: 1 year of age	RCC: Prescribed by an oncologist.	<p>HepB+: 16 weeks</p> <p>HepB-: 1 year</p> <p>HepC:</p>	Intron A will be approved for continuation of prior therapy for neoplastic diseases.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
	<p>Multiple Myeloma.</p> <p>Acute Hepatitis C.</p> <p>Metastatic Renal Cell Carcinoma (RCC).</p>		<p>fibrosis on biopsy, or evidence of icteric ALT flare ups.</p> <p>Hepatitis B - HBeAg negative:</p> <ol style="list-style-type: none"> 1. HBsAg positive for at least 6 months; AND 2. HBV DNA level of 2000 IU/mL or more or 11,200 copies/mL; AND 3. Without decompensated liver disease; AND 4. One of the following: persistent ALT 2 times ULN or moderate to severe hepatitis or fibrosis on biopsy, or evidence of icteric ALT flare ups. <p>Hepatitis C - Treatment Naive Patients:</p> <ol style="list-style-type: none"> 1. For patients with Chronic Hepatitis C without decompensated liver disease 2. Positive HCV antibody 3. HCV RNA level measurement 4. Genotype test result 5. No prior interferon therapy 6. Use in combination with or failure to ribavirin. <p>Hepatitis C - Continuation of Therapy: For genotypes 2, 3, or 5: evidence of delayed virological response</p> <p>Non-Hepatitis Diagnoses Diagnosis of one of the following:</p> <ol style="list-style-type: none"> 1. Malignant Melanoma 2. Hairy cell leukemia (HCL) 3. Stage III or IV follicular Non-Hodgkin's Lymphoma 4. Condylomata acuminata 5. AIDS-related Kaposi's sarcoma 6. Multiple Myeloma. <p>Acute Hepatitis C: Patients with acute hepatitis C.</p> <p>Metastatic Renal Cell Carcinoma (RCC):</p> <ol style="list-style-type: none"> 1. Diagnosis of metastatic RCC; AND 2. Used in combination with Avastin 	<p>or older.</p> <p>Hep C - Treatment Naive Patients, Non-Hepatitis Diagno-ses, Acute Hep C, malignant melanoma, HCL, NHL, Warts, Kaposi, multiple myeloma: 18 years old and older.</p> <p>Hep C - Treatment Naive Patients (in combi-nation with ribavirin): 3 years of age and older.</p>		<p>genotypes 2, 3, 5: 6 months</p> <p>HepC: genotypes 1, 4, 6, HIV/HCV: 12 months</p> <p>Acute HepC: 3 months</p> <p>HCL, Kaposi, RCC: 6 months.</p> <p>Warts: 3 weeks.</p> <p>Other uses: 1year</p>	
Istodax	All FDA		Cutaneous T-Cell Lymphoma (CTCL):			12 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	approved indications not otherwise excluded from Part D		Confirmed diagnosis of CTCL. Failure to one systemic therapy.				
Jevtana	All FDA approved indications not otherwise excluded from Part D		Prostate Cancer: 1. Diagnosis of metastatic hormone-refractory prostate cancer, AND 2. Used in combination with prednisone. 3. Previous treatment with a docetaxel-containing chemotherapy regimen. 4. Documented disease progression during or after completion of docetaxel therapy.			12 months	Approve for continuation of prior therapy.
Kalbitor	All FDA approved indications not otherwise excluded from Part D		Hereditary Angioedema For the treatment of acute Hereditary Angioedema attack.		Prescribed by an immunologist, allergist, or rheumatologist	12 months	
Ketek	All FDA approved indications not otherwise excluded from Part D		Community-Acquired Pneumonia: 1. Diagnosis of CAP in an adult outpatient; AND 2. Failure, intolerance, or resistance to one of the following: azithromycin or clarithromycin.			30 days	
Kineret	All FDA approved indications not otherwise excluded from Part D		Initial Therapy for Rheumatoid Arthritis (RA): 1. Moderate to severe active RA; AND 2. Failure with a TNF-alpha-blocker; AND 3. Failure on either methotrexate or at least 1 DMARD Reauthorization for RA: Submission of chart documentation demonstrating positive clinical response.	RA: 18 years and older	RA: Prescribed or recommended by a rheumatologist.	12 months	
Leukine	All FDA approved indications not otherwise excluded from Part D		Bone Marrow/Stem Cell Transplant (BMSCT): 1. Patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous/allogeneic BMT; OR 2. Mobilization of hematopoietic progenitor cells into the peripheral blood for collection	AML: Greater than or equal to 55 years old.	Prescribed by oncologist and/or hematologist	BMSCT, AML, NDDC, CFN, FN (prophylaxis): 3 months or duration of	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	<p>Treatment of febrile neutropenia (FN).</p> <p>HIV-Related neutropenia (HIVN).</p>		<p>by leukapheresis; OR</p> <p>3. Peripheral stem cell transplant patients who have received myeloablative chemotherapy.</p> <p>Acute Myeloid Leukemia (AML) Induction or Consolidation Therapy: For patients with AML following induction or consolidation chemotherapy.</p> <p>Neutropenia associated with dose dense chemotherapy (NDDC):</p> <ol style="list-style-type: none"> 1. Patient is receiving the National Comprehensive Cancer Network's (NCCN's) Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer; OR 2. A dose-dense regimen for which the incidence of febrile neutropenia is unknown. <p>Chemotherapy with risk of febrile neutropenia (CFN):</p> <ol style="list-style-type: none"> 1. Patient is receiving a chemotherapy regimen associated with more than 20% incidence of febrile neutropenia; OR 2. Patient is receiving chemotherapy regimen associated with 10-20% incidence of febrile neutropenia and has one or more risk factors associated with chemotherapy-induced infection, febrile neutropenia or neutropenia. <p>Febrile Neutropenia (FN):</p> <ol style="list-style-type: none"> 1. For patients receiving myelosuppressive anticancer drugs associated with neutropenia; AND 2. Patient either has febrile neutropenia or has a history of febrile neutropenia during a previous course of chemotherapy. <p>HIV-related neutropenia (HIVN): HIV-infected patients with an Absolute Neutrophil Count (ANC) less than or equal to</p>			<p>treatment</p> <p>FN (treatment): 1 month</p> <p>HIVN: 6 months</p>	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			1,000 cells/mm ³ with or without one or more risk factors for developing chronic neutropenia.				
Lotronex	All FDA approved indications not otherwise excluded from Part D	Initial therapy for Irritable Bowel Syndrome (IBS) in the male gender.	<p>Initial Therapy for Irritable Bowel Syndrome (IBS):</p> <ol style="list-style-type: none"> Confirmed diagnosis of IBS with diarrhea predominant symptoms for at least 6 months; AND Failure to an antispasmodic and an anti-diarrhea agent. <p>Reauthorization for Irritable Bowel Syndrome (IBS):</p> <ol style="list-style-type: none"> Recurrence of diarrhea-predominant IBS; AND Documentation of positive clinical response while on Lotronex. 	Initial Therapy: 18 years and older.		<p>Initial Therapy: 12 weeks</p> <p>Reauthorization: 6 months</p>	
Miacalcin injectable	All FDA approved indications not otherwise excluded from Part D		<p>Postmenopausal Osteoporosis:</p> <ol style="list-style-type: none"> Failure to a bisphosphonate or selective estrogen-receptor modulator (SERM); AND Failure to Miacalcin Nasal Spray; AND History of vertebral compression fractures, or fractures of the hip or distal radius resulting from minimal trauma, or T score of -2.5 or less. <p>Initial Therapy for Paget's Disease: History of failure or intolerance to oral bisphosphonates.</p> <p>Reauthorization for Paget's Disease: Serum alkaline phosphatase concentration fails to normalize after the previous 6 months of therapy.</p> <p>Hypercalcemia:</p> <ol style="list-style-type: none"> Corrected total serum calcium of 12 mg/dl; OR Greater or corrected total serum calcium of 6 mEq/L or greater. 			<p>Post-menopausal Osteoporosis: 12 months</p> <p>Hypercalcemia: 1 month</p> <p>Paget's Disease: 6 months</p>	Miacalcin is subject to Part B vs. Part D review.
Mozobil	All FDA-approved		Used in combination with granulocyte-colony stimulating factor (G-CSF).		Prescribed by a	One course of therapy up	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded from Part D.				hematologist/ oncologist	to 4 days	
Neulasta	All FDA approved indications not otherwise excluded from Part D		<p>Chemotherapy with risk of febrile neutropenia (CFN):</p> <ol style="list-style-type: none"> 1. Patient is receiving a chemotherapy regimen associated with more than 20% incidence of febrile neutropenia; OR 2. a. Patients is receiving chemotherapy regimen associated with 10-20% incidence of febrile neutropenia; AND <ol style="list-style-type: none"> b. Has risk factors associated with chemotherapy-induced infection, febrile neutropenia or neutropenia. <p>Neutropenia associated with dose dense chemotherapy (NDDC):</p> <ol style="list-style-type: none"> 1. Patients is receiving NCCN's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer; OR 2. A dose-dense regimen for which the incidence of febrile neutropenia is unknown. <p>Febrile Neutropenia (FN):</p> <ol style="list-style-type: none"> 1. For patients receiving myelosuppressive anticancer drugs associated with neutropenia; AND 2. Patient either has febrile neutropenia or has a history of febrile neutropenia during a previous course of chemotherapy. 		Prescribed by oncologist/he matologist.	<p>CFN, NDDC, FN (prophylaxis): 3 months or duration of treatment.</p> <p>FN (treatment): 1 month.</p>	
Neumega	All FDA approved indications not otherwise excluded from Part D	Patients with myeloablative chemotherapy.	<p>Thrombocytopenia following chemotherapy</p> <ol style="list-style-type: none"> 1. Verification that the cancer is a non-myeloid malignancy; AND 2. Platelet count is less than 50,000 cells/microliter; AND 3. Patients with one or more of the following risk factors: <ol style="list-style-type: none"> a. Extensive prior cytotoxic chemotherapy b. Prior severe chemotherapy-induced 		Prescribed by oncologist/he matologist.	Thrombocyto penia following chemotherapy: 3 week intervals for up to 6 cycles post-chemotherapy.	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			thrombocytopenia c. Receiving chemotherapy regimens associated with high risk for thrombocytopenia.				
Nexavar	All FDA approved indications not otherwise excluded from Part D		One of the following: 1. Diagnosis of renal cell carcinoma with relapse following surgical excision 2. Diagnosis of renal cell carcinoma with medically or surgically unresectable tumor 3. Diagnosis of Stage IV renal cell carcinoma 4. Diagnosis of unresectable hepatocellular carcinoma.		Hepato-cellular carcinoma: Prescribed by an oncologist, hepatologist, or gastroenterologist. All other indications: Prescribed by an oncologist.	6 months	Nexavar will be approved for continuation of prior therapy.
Ontak	All FDA approved indications not otherwise excluded from Part D				Prescribed by an oncologist or hematologist	12 months	Approve for continuation of prior therapy,
Opium tincture	All FDA approved indications not otherwise excluded from Part D		Initial Therapy for Diarrhea: 1. Treatment of diarrhea; AND 2. Failed, contraindication, or intolerance to Imodium (loperamide) and Lomotil (diphenoxylate/atropine).	18 years and older.	Prescribed by a gastroenterologist or in consultation with a gastroenterologist.	1 year	
Orencia	All FDA approved indications not otherwise excluded from Part D		Rheumatoid Arthritis (RA): 1. Diagnosis of moderate-to-severe RA; AND 2. Failed methotrexate or 2 DMARDs. Juvenile Idiopathic Arthritis (JIA): Failed NSAID or steroid and methotrexate. All uses: Verification that the patient has been evaluated for tuberculosis and treated accordingly.	RA: 18 years and older. JIA: 6 years and older.	Prescribed or recommended by a rheumatologist.	12 months.	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Reauthorization for all uses: Documentation of clinical improvement from ongoing therapy.				
oxandrolone	All FDA approved indications not otherwise excluded from Part D	Weight gain not related to AIDS wasting/cachexia.	Bone Pain: Diagnosis of bone pain due to osteoporosis. Initial Therapy for AIDS Wasting: Diagnosis of AIDS wasting/cachexia Reauthorization for AIDS Wasting: Verification that the patient's weight has increased a minimum of 2% while taking Oxandrin			AIDS wasting (Initial): 3 months AIDS wasting (Reauthorization), Bone Pain: 12 months	
Oxandrin	All FDA approved indications not otherwise excluded from Part D	Weight gain not related to AIDS wasting/cachexia.	Bone Pain: 1. Diagnosis of bone pain due to osteoporosis. 2. Failure to generic oxandrolone Initial Therapy for AIDS Wasting: 1. Diagnosis of AIDS wasting/cachexia 2. Failure to generic oxandrolone. Reauthorization for AIDS Wasting: Verification that the patient's weight has increased a minimum of 2% while taking Oxandrin			AIDS wasting (Initial): 3 months AIDS wasting (Reauthorization), Bone Pain: 12 months	
Oxsoralen	All FDA approved indications not otherwise excluded from Part D		Failure to two medium to high potency corticosteroid topical treatments.		Prescribed by a dermatologist	12 months	
Pegasys	All FDA approved indications not otherwise excluded from Part D Acute Hep C.		Hepatitis B - HBeAg positive patients: 1. HBsAg positive for at least 6 months; AND 2. HBV DNA level greater than 20,000 IU/mL or 100,000 copies/mL; AND 3. Compensated liver disease; AND 4. One of the following: a. ALT (liver enzyme) 2 times upper limits of normal (ULN) b. Moderate-to-severe hepatitis or fibrosis on biopsy. c. Evidence of icteric ALT flare ups	For all covered uses: 18 years and older		Hepatitis B (+): 48 weeks Hepatitis B (-): 1 year Hepatitis C Genotypes 2,3, 5: 24 weeks;	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>Hepatitis - HBeAg negative patients:</p> <ol style="list-style-type: none"> 1. HBsAg positive for at least 6 months; AND 2. HBV DNA level of 2000 IU/mL or more or 11,200 copies/mL; AND 3. Compensated liver disease; AND 4. One of the following: <ol style="list-style-type: none"> a. ALT 2 times ULN b. Moderate-to-severe hepatitis or fibrosis on biopsy. c. Evidence of icteric ALT flare ups <p>Hepatitis C - Treatment Naive Patients:</p> <ol style="list-style-type: none"> 1. Chronic Hepatitis C with compensated liver disease; AND 2. Positive HCV antibody HCV RNA; AND 3. HCV RNA level measurement; AND 4. Genotype test result; AND 5. For patients who have not previously been treated with interferon. 6. Used in combination with or failure to ribavirin. <p>Continuation of Therapy:</p> <p>A. For genotypes 1 or 5:</p> <ol style="list-style-type: none"> 1. Evidence of delayed virological response <p>B. For genotype 3:</p> <ol style="list-style-type: none"> 1. Baseline HCV RNA more than 600,000 IU/mL; AND 2. Steatosis or advanced fibrosis on liver biopsy. <p>Hepatitis C Retreatment:</p> <ol style="list-style-type: none"> 1. One of the following <ol style="list-style-type: none"> a. Retreatment in patients who have failed or relapsed following standard or pegylated interferon monotherapy; OR b. For non-responders or relapsers who have significant fibrosis or cirrhosis who have undergone previous regimens of treatment using non-pegylated interferon; OR c. Retreatment in patients with genotype 2 or 3 who have relapsed following 6 			<p>Genotypes 1, 4, 6, HIV/HCV: 48wk.</p> <p>Hepatitis C Continuation therapy: Genotypes 1,3, 5: 24 weeks,</p> <p>Hepatitis C Retreatment: 1year</p> <p>Acute Hepatitis C: 12 weeks</p>	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>month treatment of pegylated interferon plus ribavirin combination therapy.</p> <p>2. Used in combination with ribavirin.</p> <p>Acute Hepatitis C: Patients with acute hepatitis C</p>				
PEG-Intron, PEG-Intron Redipen	<p>All FDA approved indications not otherwise excluded from Part D</p> <p>Acute Hep C.</p>		<p>Hepatitis C - Treatment Naive Patients:</p> <ol style="list-style-type: none"> 1. Chronic Hepatitis C with compensated liver disease; AND 2. Positive HCV antibody HCV RNA; AND 3. HCV RNA level measurement; AND 4. Genotype test result; AND 5. For patients who have not previously been treated with interferon. 6. Used in combination with or failure to ribavirin. <p>Hepatitis C (Continuation):</p> <p>A. For genotypes 1 or 5:</p> <ol style="list-style-type: none"> 1. Evidence of delayed virological response <p>B. For genotype 3:</p> <ol style="list-style-type: none"> 1. Baseline HCV RNA more than 600,000 IU/mL; AND 2. Steatosis or advanced fibrosis on liver biopsy. <p>Hepatitis C (Retreatment):</p> <ol style="list-style-type: none"> 1. One of the following: <ol style="list-style-type: none"> a. Retreatment in patients who have failed or relapsed following standard or pegylated interferon monotherapy; OR b. For non-responders or relapsers who have significant fibrosis or cirrhosis who have undergone previous regimens of treatment using non-pegylated interferon; OR c. Retreatment in patients with genotype 2 or 3 who have relapsed following 6 month treatment of pegylated interferon plus ribavirin combination therapy. 2. Used in combination with ribavirin. <p>Acute Hepatitis C:</p>	<p>Treatment Naive Patients: 3 years and older</p> <p>Acute Hepatitis C: 18 years and older</p>		<p>Genotypes 2, 3, 5: 24 weeks</p> <p>Genotypes 1, 4, 6, HIV/HCV: 48 weeks.</p> <p>Hepatitis C Continuation : Genotypes 1, 3, 5: 24 weeks</p> <p>Hepatitis C Retreatment: 1 year</p> <p>Acute Hepatitis C: 12 weeks</p>	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Patients with acute hepatitis C				
Pradaxa	All FDA-approved indications not otherwise excluded from Part D. Treatment of acute venous thromboembolism (VTE). Prophylaxis of VTE after orthopedic surgery.		Stroke prevention in patients with non-valvular atrial fibrillation (AF): Diagnosis of AF in patients without rheumatic mitral valve disease, a prosthetic heart valve, or mitral valve repair. Acute VTE: 1. Diagnosis of acute VTE; AND 2. Failure, contraindication, or intolerance to warfarin. Prophylaxis of VTE: Completion of total knee or total hip replacement surgery.	Acute VTE, Prophylaxis of VTE: Age greater than or equal to 18 years.		Stroke prevention: 12 months. Acute VTE: 6 months. Prophylaxis of VTE: 35 days.	
Pristiq	All FDA approved indications not otherwise excluded from Part D		Failure to generic antidepressant.			1 year	
Prograf (intravenous)	All FDA approved indications not otherwise excluded from Part D Lung, pancreas, small bowel, or bone marrow transplant. Severe Uveitis		Severe Uveitis: Failure to one corticosteroid. Transplant: 1. One of the following: a. Patient received a renal (kidney), cardiac (heart), lung, pancreas, small bowel, or hepatic (liver) transplant. b. Patient received a bone marrow/stem cell transplant. AND 2. Patient is unable to take oral tacrolimus.			12 months	Prograf is subject to Part B vs. Part D review (not limited to new starts only). Prograf will be approved for continuation of prior therapy if Part D.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Prograf (oral)	All FDA approved indications not otherwise excluded from Part D Lung, pancreas, small bowel, or bone marrow/stem cell transplant. Severe uveitis.		Severe Uveitis: Failure to one corticosteroid. Transplant: Patient received a renal (kidney), cardiac (heart), lung, pancreas, small bowel, hepatic (liver) transplant, bone marrow/stem cell transplant			12 months	Prograf is subject to Part B vs. Part D review (not limited to new starts only) Prograf will be approved for continuation of prior therapy if Part D.
Proleukin	All FDA approved indications not otherwise excluded from Part D		Metastatic Renal Cell Carcinoma or Metastatic Melanoma: 1. Good neurologic or ambulatory performance status; AND 2. Adequate organ function determined by all of the following: a. Normal cardiac stress test results b. FEV1 greater than 2 L on pulmonary function tests c. Creatinine concentration 1.5 mg/dL or less or calculated creatinine clearance > 60 ml/min	18 years and older	Prescribed by an oncologist and/or hematologist	3 months	Proleukin will be approved for continuation of prior therapy.
Prolia	All FDA-approved indications not otherwise excluded from Part D.		Postmenopausal osteoporosis: 1. Diagnosis of postmenopausal osteoporosis; AND 2. History of vertebral compression fractures or fractures of the hip or distal radius resulting from minimal trauma, or T-score less than or equal to -.2.5; AND 3. One of the following: a. Failure to one oral bisphosphonate b. Failure, contraindication, or intolerance to one injectable bisphosphonate c. Contraindication or intolerance to one oral bisphosphonate and failure to one injectable bisphosphonate.			12 months	
Promacta	All FDA		Chronic ITP			6 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
	approved indications not otherwise excluded from Part D		<ol style="list-style-type: none"> 1. Diagnosis of ITP. 2. Failure to corticosteroids, immunoglobulins, or splenectomy. 				
Provigil	<p>All FDA approved indications not otherwise excluded from Part D</p> <p>Idiopathic Hypersomnia.</p>	<p>Initial Therapy for Shift Work Sleep Disorder (SWSD): Symptoms do not meet criteria for any other sleep disorder producing insomnia or excessive sleepiness.</p>	<p>Narcolepsy: Submission of sleep study confirming the diagnosis of narcolepsy.</p> <p>Initial Therapy for Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS):</p> <ol style="list-style-type: none"> 1. Fully compliant and concurrently using continuous positive airway pressure (CPAP); AND 2. One of the following: <ol style="list-style-type: none"> a. 15 or more obstructive respiratory events; OR b. More than 5 obstructive apneas, each greater than 10 seconds in duration, per hour of sleep confirmed by a sleep study, and one of the following: <ol style="list-style-type: none"> i. Frequent arousals from sleep associated with apneas ii. Bradycardia iii. Arterial oxygen desaturation in association with apneas. iv. Unintentional sleep episodes v. Daytime sleepiness vi. Unrefreshing sleep vii. Fatigue viii. Insomnia ix. Waking up gasping x. Loud snoring xi. Breathing interruptions during sleep <p>Reauthorization for Obstructive Sleep Apnea/Hypopnea Syndrome: Patient continues to be fully compliant on concurrent CPAP and is experiencing relief of symptomatic hypersomnolence with Provigil use.</p> <p>Shift Work Sleep Disorder:</p> <ol style="list-style-type: none"> 1. One of the following: 			<p>OSAHS (Initial), SWSD (Initial and Reauthorizat ion): 3 months</p> <p>Other uses 12 months</p>	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>a. Symptoms of excessive sleepiness or insomnia, for at least 3 months, which is temporally associated with a work period that occurs during the habitual sleep phase</p> <p>b. Sleep study demonstrating loss of a normal sleep-wake pattern. AND</p> <p>2. Sleep disturbance causes significant distress or significant impairment; AND</p> <p>3. No other disorder accounts for the symptoms.</p> <p>Reauthorization for Shift Work Sleep Disorder:</p> <p>1. Patient is experiencing relief with use of Provigil for excessive sleepiness; AND</p> <p>2. Sleep disturbance continues to cause clinically significant distress or significant impairment in occupational functioning.</p> <p>Idiopathic Hypersomnia:</p> <p>Submission of sleep study confirming the diagnosis of Idiopathic Hypersomnia as defined by the International Classification of Sleep Disorders.</p>				
Quaalun	All FDA approved indications not otherwise excluded from Part D	<p>Chloroquine sensitive and resistant malaria:</p> <p>Severe or complicated P. falciparum malaria.</p> <p>Prevention of Malaria.</p> <p>For treatment or prevention of nocturnal</p>	<p>Chloroquine-sensitive malaria:</p> <p>1. Diagnosis of Malaria; AND</p> <p>2. History of failure, contraindication or intolerance to chloroquine.</p> <p>Chloroquine-resistant malaria:</p> <p>Diagnosis of malaria.</p>			7 days	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		leg cramps.					
Rebif, Rebif Titration Pack	All FDA approved indications not otherwise excluded from Part D		<p>Relapsing Multiple Sclerosis:</p> <ol style="list-style-type: none"> Relapsing forms of MS (eg, relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses); OR High risk of developing clinically definite MS defined by both of the following: <ol style="list-style-type: none"> Recent history of a first clinical demyelinating event MRI-detected brain lesions consistent with MS 			1 year	
Reclast	<p>All FDA approved indications not otherwise excluded from Part D.</p> <p>Hypercalcemia of malignancy.</p> <p>Osteolytic bone metastases of breast cancer.</p> <p>Metastatic bone lesions from solid tumors.</p> <p>Osteolytic lesions of multiple myeloma (MM).</p>		<p>Initial Therapy for Hypercalcemia of malignancy:</p> <ol style="list-style-type: none"> Corrected total serum calcium \geq 12 mg/dL <p>Reauthorization for Hypercalcemia of malignancy:</p> <ol style="list-style-type: none"> Corrected total serum calcium fails to normalize or remain normal after initial dose. <p>Initial Therapy for Paget's disease:</p> <ol style="list-style-type: none"> One of the following: <ol style="list-style-type: none"> Serum alkaline phosphatase of \geq 2 times the upper limit of normal reference range Symptoms caused by Paget's disease At risk for complications <p>Reauthorization for Paget's disease:</p> <ol style="list-style-type: none"> Serum alkaline phosphatase fails to normalize after previous therapy or patient is experiencing symptoms associated with Paget's disease. <p>Osteolytic bones metastases of breast cancer</p> <ol style="list-style-type: none"> Diagnosis of stage IV breast cancer At least one lytic, metastatic bone lesion Serum creatinine level below 3.0 mg/dL <p>Metastatic bone lesions from solid tumors</p> <ol style="list-style-type: none"> Diagnosis of prostate cancer or other solid tumor At least one lytic, metastatic bone lesion 			<p>Hypercalcemia, Paget's disease:</p> <p>One treatment</p> <p>Osteolytic bone metastases, metastatic bone lesions, osteolytic lesions, osteoporosis:</p> <p>12 months</p>	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>3. Serum creatinine level below 3.0 mg/dL</p> <p>Osteolytic lesions of multiple myeloma</p> <ol style="list-style-type: none"> 1. Diagnosis of stage III multiple myeloma 2. At least one lytic, metastatic bone lesion 3. Serum creatinine level below 3.0 mg/dL <p>Prevention and treatment of osteoporosis</p> <ol style="list-style-type: none"> 1. One of the following <ol style="list-style-type: none"> a. Treatment of postmenopausal osteoporosis or osteoporosis in men, and one of the following: <ol style="list-style-type: none"> i. compression fracture in spine or peripheral fractures ii. Bone Mineral Density (BMD) T-Score ≤ -2.5 b. Prevention of postmenopausal osteoporosis in women and one of the following: <ol style="list-style-type: none"> i. BMD T-Score -1.0 to -2.5 ii. 10-year probability of a hip fracture $\geq 3\%$ or a 10-year probability of a major osteoporosis-related fracture $\geq 20\%$ based on the WHO Fracture Risk Algorithm (FRAX) c. Treatment of glucocorticoid-induced osteoporosis or prevention of glucocorticoid-induced osteoporosis in patients initiating or continuing on ≥ 7.5 mg/day oral prednisone for at least 12 months 				
Regranex	All FDA approved indications not otherwise excluded from Part D		<p>Diabetic Neuropathic Ulcers</p> <ol style="list-style-type: none"> 1. Diabetic patient with ulcer wound. 2. Debridement being performed as needed; AND 2. At least two of the following are present: <ol style="list-style-type: none"> a. Stage III or IV wound b. Wound at least 1 cm x 1 cm c. Long-standing wound that does not heal with standard care d. Patients at high risk for amputation (peripheral neuropathy, peripheral vascular disease, skin or nail abnormalities, previous foot ulcer 			Maximum: 5 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			amputation).				
Relistor	All FDA approved indications not otherwise excluded from Part D. Methadone-induced constipation in non-palliative setting.		Opioid-induced Constipation (palliative care): 1. Patients with advanced illness and receiving palliative care; AND 2. Confirmed diagnosis of opioid-induced constipation; AND 3. Failure to an osmotic laxative (eg, polyethylene glycol, lactulose). Methadone-induced constipation in non-palliative setting: 1. Confirmed diagnosis of opioid-induced constipation; AND 2. Failure to an osmotic laxative (eg, polyethylene glycol, lactulose).	18 years and older		6 months	
Remicade	All FDA approved indications not otherwise excluded from Part D		Rheumatoid Arthritis: 1. Diagnosis of moderate-to-severe RA 2. Concurrently on methotrexate or failure to methotrexate or 2 DMARDs (azathioprine, cyclosporine, gold, hydroxychloroquine, leflunomide, penicillamine, sulfasalazine) for 3 months. Psoriatic Arthritis: 1. Diagnosis of active Psoriatic arthritis 2. Failure or contraindication to methotrexate or 2 of the following for 3 months: cyclosporine, gold, leflunomide, or sulfasalazine for 3 months. Ankylosing Spondylitis (AS): 1. Diagnosis of AS 2. Failed 2 NSAIDs for 3 months Plaque Psoriasis: 1. Diagnosis of moderate-to-severe (greater than 6 months) plaque psoriasis; AND 2. Failure, contraindication, or intolerance to one of the following: methotrexate, cyclosporine, acitretin, hydroxyurea, sulfasalazine, 6-thioguanine, mycophenolate.	RA, PsA, AS, Plaque Psoriasis, FCD, UC: 18 years and older. Crohn's Disease: 6 years and older.	RA, AS: Prescribed or recommended by a rheumatologist. PsA: Prescribed or recommended by a rheumatologist. Crohn's Disease, Fistulizing Crohn's Disease, UC: Prescribed by a gastroenterologist or by gastroenterologist consult. Plaque Psoriasis:	12 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>Crohn's Disease (CD): 1. Moderate to severe CD; AND 2. Failed one of the following: corticosteroids, 6-mercaptopurine, azathioprine, methotrexate, aminosalicilate</p> <p>Fistulizing Crohn's Disease (FCD): 1. Draining fistulas for 3 months; AND 2. On or failed one of the following: 6-mercaptopurine, azathioprine, antibiotics, oral corticosteroids, methotrexate</p> <p>Ulcerative Colitis (UC): 1. Moderate to severe UC; AND 2. Failed on one of the following: corticosteroids, 5-aminosalicylic acid, azathioprine, 6-mercaptopurine, cyclosporine</p> <p>Sarcoidosis: Failed one steroid and one immunosuppressant.</p> <p>Reauthorization: Demonstration of clinical response to therapy</p> <p>All uses: Verification that the patient has been evaluated for tuberculosis (TB) and treated accordingly.</p>		<p>Prescribed or recommended by a dermatologist</p> <p>Sarcoidosis: Prescribed or recommended by a pulmonologist</p>		
Remodulin	All FDA approved indications not otherwise excluded from Part D		<p>Pulmonary Arterial Hypertension Patients with a confirmed diagnosis of pulmonary arterial hypertension (modified WHO Group I) which is symptomatic.</p>			12 months	Remodulin is subject to Part B vs. Part D review.
Revatio	All FDA approved indications not otherwise excluded from Part D	<p>Pulmonary Arterial Hypertension (PAH): Patients using organic nitrates.</p>	<p>Pulmonary Arterial Hypertension: Patients with a confirmed diagnosis of pulmonary arterial hypertension which is symptomatic.</p>			12 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Revatio Injection	All FDA approved indications not otherwise excluded from Part D	Pulmonary Arterial Hypertension (PAH): Patients using organic nitrates.	Pulmonary Arterial Hypertension: 1. Patients with a confirmed diagnosis of pulmonary arterial hypertension which is symptomatic, AND 2. Unable to take oral Revatio.			12 months	
Revlimid	All FDA approved indications not otherwise excluded from Part D		Myelodysplastic Syndrome (MDS): 1. Diagnosis of myelodysplastic syndrome associated with a deletion 5q cytogenic abnormality; AND 2. Patient is transfusion dependent. OR 1. Diagnosis of myelodysplastic syndrome without a deletion 5q cytogenic abnormality; AND 2. Failure of initial treatment with epoetin alfa or darbopoetin alfa, hypomethylating agents (e.g., Vidaza, Dacogen), or immunosuppressive therapy (e.g., antithymocyte globulin, cyclosporine). Chronic Lymphocytic Leukemia (CLL): Relapsed or refractory to one prior therapy for CLL.		MDS, Multiple Myeloma, CLL: Prescribed by an oncologist or hematologist or by oncology or hematology consult.	MDS, Multiple Myeloma, CLL: 6 months	Revlimid will be approved for continuation of prior therapy.
Ribasphere, ribavirin	All FDA approved indications not otherwise excluded from Part D		Hepatitis C: Adults with a diagnosis of Hepatitis C without decompensated liver disease, and verification of concurrent use with an alfa-interferon product.			12 months	
Ribavirin (Brand)	All FDA approved indications not otherwise excluded from Part D		Hepatitis C: 1. Adults with a diagnosis of Hepatitis C without decompensated liver disease, and verification of concurrent use with an alfa-interferon product, AND 2. Failure to generic ribavirin			12 months	
Rituxan	All FDA approved		Non-Hodgkin's Lymphoma: One of the following:	RA: 18 years and	RA: Prescribed by	All uses except RA:	Rituxan will be approved for

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	<p>indications not otherwise excluded from Part D</p> <p>Chronic Lymphocytic Leukemia</p> <p>Immune or idiopathic thrombocytopenic purpura</p> <p>Waldenstrom's macroglobulinemia</p>		<ol style="list-style-type: none"> 1. As first-line treatment of diffuse large B-cell, CD20-positive, non-Hodgkin's lymphoma in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or other anthracycline-based chemotherapy regimens 2. As first-line treatment of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma in combination with chemotherapy 3. As a single-agent maintenance therapy for the treatment of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma in patients achieving a complete or partial response to Rituxan in combination with chemotherapy 4. For the treatment of low-grade, CD20-positive, B-cell non-Hodgkin's lymphoma in patients with stable disease or who achieve a partial or complete response following first-line treatment with CVP chemotherapy 5. Confirmed diagnosis of relapsed or refractory, low grade or follicular CD20-positive, B-cell non-Hodgkin's lymphoma. <p>Initial Therapy for Rheumatoid Arthritis (RA):</p> <ol style="list-style-type: none"> 1. Diagnosis of moderate/severe RA; AND 2. Used in combination with or failure to methotrexate; AND 3. Failure to a TNF antagonist. <p>Reauthorization for Rheumatoid Arthritis:</p> <ol style="list-style-type: none"> 1. Documentation of clinical improvement from ongoing therapy; AND 2. At least 16 weeks since last Rituxan treatment. 	older.	a rheumatologist.	<p>1 year</p> <p>RA: 1 treatment</p>	continuation of prior therapy.
Rosiglitazone	All FDA-approved indications not otherwise excluded from Part D.		<p>Diabetes:</p> <ol style="list-style-type: none"> 1. Trial on one drug within each of the following classes: <ol style="list-style-type: none"> a. biguanide, b. sulfonylurea, c. insulin, d. incretin mimetic, e. DPP-4 inhibitor, 			12 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			f. and pioglitazone.				
Sabril	All FDA approved indications not otherwise excluded from Part D		<p>Complex Partial Seizures (CPS): For use as adjunctive therapy in patients who have failed two formulary anticonvulsants.</p> <p>Infantile Spasms (IS): Diagnosis of infantile spasms.</p>	<p>IS: One month to two years of age.</p> <p>CPS: 18 years or older</p>		12 months	Approve for continuation of prior therapy.
Samsca	All FDA approved indications not otherwise excluded from Part D		<p>Initial therapy for hyponatremia (hypervolemic and euvolemic):</p> <ol style="list-style-type: none"> 1. Diagnosis of significant hyponatremia (euvolemic or hypervolemic); AND 2. Treatment has been initiated or re-initiated in a hospital setting prior to discharge. <p>Reauthorization for hypervolemic and euvolemic hyponatremia:</p> <ol style="list-style-type: none"> 1. Documentation of clinical benefit; AND 2. Treatment has been initiated or re-initiated in a hospital setting prior to discharge. 		Prescribed by an endocrinologist or nephrologist or by consultation with an endocrinologist or nephrologist	<p>Initial: 1 month.</p> <p>Reauth: 3 months</p>	
octreotide acetate	<p>All FDA approved indications not otherwise excluded from Part D</p> <p>Chemotherapy Induced Diarrhea.</p> <p>AIDS-Related Diarrhea.</p>		<p>Acromegaly:</p> <ol style="list-style-type: none"> 1. Inadequate response to surgery and/or radiotherapy or patients who are not a surgical and/or radiotherapy candidate 2. Diagnosis of acromegaly by one of the following: <ol style="list-style-type: none"> a. Serum growth hormone (GH) level greater than 1 ng/mL after a 2-hour oral glucose tolerance test b. Elevated serum IGF-1 levels as compared to normal reference values by age and gender. <p>Carcinoid Tumors: Diagnosis of metastatic carcinoid tumor for symptomatic treatment of severe diarrhea or flushing.</p> <p>Vasoactive Intestinal Peptide Tumors: Diagnosis of metastatic vasoactive peptide tumor, for symptomatic treatment of diarrhea associated with vasoactive peptide tumor.</p>			<p>Acromegaly: 12 months</p> <p>Tumors: 6 months</p> <p>Chemotherapy induced diarrhea: 7 days</p> <p>AIDS-related diarrhea: 28 days</p>	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>Cancer Chemotherapy Induced Diarrhea: 1. Diagnosis of diarrhea due to concurrent cancer chemotherapy; OR 2. Both of the following: a. Diagnosis of complicated diarrhea due to concurrent cancer chemotherapy b. History of failure to standard therapy.</p> <p>AIDS-related Diarrhea: 1. Diagnosis of AIDS-related diarrhea. 2. History of failure to standard therapy</p>				
Sandostatin (Brand)	<p>All FDA approved indications not otherwise excluded from Part D</p> <p>Chemotherapy Induced Diarrhea.</p> <p>AIDS-Related Diarrhea.</p>		<p>Acromegaly: 1. Inadequate response to surgery and/or radiotherapy or patients who are not a surgical and/or radiotherapy candidate 2. Diagnosis of acromegaly by one of the following: a. Serum growth hormone (GH) level greater than 1 ng/mL after a 2-hour oral glucose tolerance test b. Elevated serum IGF-1 levels as compared to normal reference values by age and gender. 3. Failure to generic octreotide.</p> <p>Carcinoid Tumors: Diagnosis of metastatic carcinoid tumor for symptomatic treatment of severe diarrhea or flushing, and failure to generic octreotide.</p> <p>Vasoactive Intestinal Peptide Tumors: Diagnosis of metastatic vasoactive peptide tumor, for symptomatic treatment of diarrhea associated with vasoactive peptide tumor, and failure to generic octreotide.</p> <p>Cancer Chemotherapy Induced Diarrhea: 1. Diagnosis of diarrhea due to concurrent cancer chemotherapy; OR 2. Both of the following: a. Diagnosis of complicated diarrhea due to concurrent cancer chemotherapy</p>			<p>Acromegaly: 12 months</p> <p>Tumors: 6 months</p> <p>Chemotherapy induced diarrhea: 7 days</p> <p>AIDS-related diarrhea: 28 days</p>	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			b. History of failure to standard therapy. 3. Failure to generic octreotide. AIDS-related Diarrhea: 1. Diagnosis of AIDS-related diarrhea. 2. History of failure to standard therapy 3. Failure to generic octreotide.				
Sandostatin LAR	All FDA approved indications not otherwise excluded from Part D		Acromegaly: 1. Inadequate response to surgery and/or radiotherapy or patients who are not a surgical and/or radiotherapy candidate. 2. Patient has shown to respond to and tolerate octreotide injection for at least 2 weeks. Carcinoid Tumors: 1. Diagnosis of metastatic carcinoid tumor, for symptomatic treatment of severe diarrhea or flushing; AND 2. Patient has been shown to respond to and tolerate octreotide. Vasoactive Intestinal Peptide Tumors: 1. Diagnosis of metastatic vasoactive peptide tumor, for symptomatic treatment of diarrhea associated with vasoactive peptide tumor; AND 2. Patient has been shown to respond to and tolerate octreotide.			Acromegaly: 12 months Tumors: 6 months	
Serostim	All FDA-approved indications not otherwise excluded from Part D		Initial Therapy for AIDS associated cachexia or wasting: 1. Documented AIDS-associated cachexia or wasting defined as one of the following: a. 10% unintentional weight loss over 12 months b. 7.5% unintentional weight loss over 6 months c. 5% body cell mass (BCM) loss within 6 months, or body mass index (BMI) less than 20 kg/m ² d. In men, BCM less than 35% of TBW and BMI less than 27 kg/m ² e. In women, BCM less than 23% of TBW			AIDS wasting: 3 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>and BMI less than 27 kg/m²</p> <ul style="list-style-type: none"> . AND 2. Nutritional evaluation since onset of wasting first occurred. 3. Other causes of HIV-associated wasting have been ruled out. 4. Target or goal weight, BCM, or BMI. <p>3. For male patients: Screen for hypogonadism (obtain free testosterone levels)</p> <p>4. For male patients: Failure to respond to testosterone replacement therapy in patients with hypogonadism.</p> <p>Reauthorization for AIDS associated cachexia or wasting:</p> <ul style="list-style-type: none"> 1. Positive response to therapy based on greater than or equal to 2% increase in body weight and/or BCM. 2. Target or goal weight, BCM, BMI has not been achieved. <p>Reinitiation of therapy for AIDS associated cachexia or wasting:</p> <ul style="list-style-type: none"> 1. Positive response to therapy based on greater than or equal to 2% increase in body weight and/or BCM in a previous treatment. 2. Evidence of HIV-associated cachexia or wasting (as defined above) after an 8-week observation period. 				
Simponi	All FDA-approved indications not otherwise excluded from Part D		<p>Rheumatoid Arthritis (RA):</p> <ul style="list-style-type: none"> 1. Diagnosis of moderate-to-severe RA; AND 2. Concurrently on methotrexate or failed methotrexate or 2 DMARDs (azathioprine, cyclosporine, gold, hydroxychloroquine, leflunomide, penicillamine, sulfasalazine) for 3 months. <p>Psoriatic Arthritis (PsA):</p> <ul style="list-style-type: none"> 1. Diagnosis of active PsA. 2. Failure or contraindication to methotrexate or 2 of the following for 3 months: cyclosporine, gold, leflunomide, or 	RA, PsA, AS: 18 years and older	RA (Initial) or AS (Initial): Prescribed or recommended by a rheumatologist. PsA: Prescribed or recommended by a	Initial Therapy: 12 months. Reauthorization (all uses): 12 months.	All diagnoses require verification that the patient has been evaluated for tuberculosis and has been treated accordingly

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>sulfasalazine.</p> <p>Ankylosing Spondylitis (AS): 1. Diagnosis of AS. 2. Failed 2 NSAIDs for 3 months.</p> <p>Reauthorization (all diagnoses): Demonstration of clinical response to therapy.</p>		rheumatologist or dermatologist		
Solaraze	All FDA-approved indications not otherwise excluded from Part D		<p>Initial Therapy of Actinic Keratosis: Diagnosis of Actinic Keratosis.</p> <p>Reauthorization of Actinic Keratosis: Incomplete healing of the lesions and at least 30 days since cessation of Solaraze therapy.</p>			90 days	
Somatuline	All FDA-approved indications not otherwise excluded from Part D		<p>Acromegaly: 1. Patients who require long-term treatment due to: a. Inadequate response to surgery and/or radiotherapy; OR b. Who are not surgical and/or radiotherapy candidates. AND 2. Diagnosis of acromegaly by one of the following: a. Serum growth hormone level greater than 1 ng/mL after a 2-hour oral glucose tolerance test; OR b. Elevated serum IGF-1 levels as compared to normal reference values by age and gender.</p>			12 months	
Somavert	All FDA-approved indications not otherwise excluded from Part D		<p>Initial Therapy for Acromegaly: 1. One of the following: a. Inadequate response to surgery and/or radiation therapy b. Not a candidate for surgery or radiation. AND 2. Inadequate response or intolerance to octreotide, or lanreotide, or IGF-1 value greater than 900 ng/mL.</p> <p>Reauthorization for Acromegaly: Serum IGF-1 level within the age-adjusted normal range.</p>			<p>Acromegaly (initial): 12 weeks</p> <p>Acromegaly (reauthorization): 12 months</p>	
Sprycel	All FDA		Chronic Myeloid Leukemia (CML):		Prescribed by	12 months	Sprycel will be

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	approved indications not otherwise excluded from Part D		<ol style="list-style-type: none"> 1. Diagnosis of Philadelphia chromosome positive or BCR-ABL positive chronic, accelerated, or myeloid or lymphoid blast phase chronic myeloid leukemia; AND 2. Failure to Gleevec. <p>Acute Lymphoblastic Leukemia (ALL):</p> <ol style="list-style-type: none"> 1. Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia; AND 2. Failure to Gleevec. 		oncologist and/or hematologist		approved for continuation of prior therapy.
Stelara	All FDA approved indications not otherwise excluded from Part D		<p>Initial Therapy of Plaque Psoriasis</p> <ol style="list-style-type: none"> 1. Diagnosis moderate-to-severe plaque psoriasis. 2. Failed systemic therapy with one of the following: methotrexate, cyclosporine, acitretin, hydroxyurea, sulfasalazine, 6-thioguanine, or mycophenolate. 3. Failed one TNF blocker. 4. Verification that the patient has been evaluated for TB and has been treated accordingly. <p>Authorization will be issued for 45 mg (for patients weighing less than or equal to 100 kg) or 90 mg (for patients weighing more than 100 kg) initially and 4 weeks later followed by 45 mg (for patients weighing less than or equal to 100 kg) or 90 mg (for patients weighing more than 100 kg) every 12 weeks for 12 months.</p> <p>Reauthorization of Plaque Psoriasis: Demonstration of clinical response to therapy.</p>	Age greater than or equal to 18 years.	Prescribed or recommended by a dermatologist	12 months	
Sutent	All FDA approved indications not otherwise excluded from Part D		<p>Gastrointestinal Stromal Tumor (GIST):</p> <ol style="list-style-type: none"> 1. Diagnosis of GIST 2. Disease progression on or intolerance to Gleevec. <p>Renal Cell Carcinoma: One of the following:</p> <ol style="list-style-type: none"> 1. Diagnosis of renal cell carcinoma with relapse following surgical excision 2. Diagnosis of renal cell carcinoma with medically or surgically unresectable tumor 		Prescribed by an oncologist.	12 months	Sutent will be approved for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			3. Diagnosis of Stage IV renal cell carcinoma.				
Symlin, Symlinpen	All FDA approved indications not otherwise excluded from Part D	Diagnosis of gastroparesis.	Diabetes Mellitus: 1. Type 1 or type 2 diabetes 2. Concurrent use of insulin therapy	18 years and older.		12 months	
Synarel	All FDA approved indications not otherwise excluded from Part D		CPP: Diagnosis confirmed by sex hormone levels and pubertal LH response upon stimulation by GnRH	Female is less than 8 and male less than 9 years old		12 months	
Tabloid	All FDA approved indications not otherwise excluded from Part D				Prescribed by an oncologist or hematologist.	12 months	Approve for continuation of prior therapy,
Tarceva	All FDA approved indications not otherwise excluded from Part D First line for Non-Small Cell Lung Cancer (NSCLC). Metastatic RCC.		Non-Small Cell Lung Cancer (1st Line): 1. Patients diagnosed with locally advanced or metastatic NSCLC 2. One of the following: a. Known activated EGFR mutation b. Known mutated EGFR gene amplification c. Never smoked Non-Small Cell Lung Cancer (2nd Line): Patients diagnosed with locally advanced or metastatic NSCLC after failure of at least one prior chemotherapy regimen. Pancreatic Cancer: 1. Patient diagnosed with locally advanced, unresectable or metastatic pancreatic cancer. 2. Used in combination with gemcitabine. Metastatic RCC: 1. Diagnosis of metastatic RCC 2. Used in combination with bevacizumab		Prescribed by an oncologist.	6 months	Tarceva will be approved for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Targretin	All FDA approved indications not otherwise excluded from Part D		Definitive diagnosis of cutaneous T-cell lymphoma (CTCL)			12 months	Targretin will be approved for continuation of prior therapy.
Testim	All FDA-approved indications not otherwise excluded from Part D.		<p>Hypogonadism:</p> <p>1. Diagnosis of hypogonadism in men with one of the following:</p> <ul style="list-style-type: none"> a. pre-treatment testosterone level of less than 280 ng/dL or less than 9.7 nmol/L or below the normal reference level provided by the physician's laboratory b. pre-treatment free testosterone level of less than 50 pg/dL or less than 5 ng/dL or less than 0.17 nmol/L or below the normal reference level provided by the physician's laboratory <p>2. Failure to Androgel</p>			12 months	
Testosterone injectable, Depot Testosterone, Delatestryl	All FDA-approved indications not otherwise excluded from Part D.		<p>Hypogonadism:</p> <p>1. Diagnosis of hypogonadism in men with one of the following:</p> <ul style="list-style-type: none"> a. pre-treatment testosterone level of less than 280 ng/dL or less than 9.7 nmol/L or below the normal reference level provided by the physician's laboratory b. pre-treatment free testosterone level of less than 50 pg/dL or less than 5 ng/dL or less than 0.17 nmol/L or below the normal reference level provided by the physician's laboratory <p>Delayed puberty: Diagnosis of delayed puberty in males.</p> <p>Breast Cancer: Diagnosis for the palliative treatment of inoperable breast cancer in women.</p>			<p>Hypogonadism, Breast Cancer: 12 months</p> <p>Delayed puberty: 6 months</p>	
Topical testosterone: Androderm, Androgel 1%, Androgel	All FDA-approved indications not otherwise excluded from Part D.		<p>Hypogonadism:</p> <p>1. Diagnosis of hypogonadism in men with one of the following:</p> <ul style="list-style-type: none"> a. pre-treatment testosterone level of less than 280 ng/dL or less than 9.7 nmol/L or below the normal reference level provided 			12 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
1.62%, Axiron			by the physician's laboratory b. pre-treatment free testosterone level of less than 50 pg/dL or less than 5 ng/dL or less than 0.17 nmol/L or below the normal reference level provided by the physician's laboratory				
Thalomid	All FDA-approved indications not otherwise excluded from Part D. Waldenstrom's Macroglobulinemia (WM) Aphthous stomatitis or ulcers (AS) Crohn's Disease, Graft-versus-Host Disease (GVHD) Primary Brain Tumors AIDS-related cachexia or wasting Renal Cell Carcinoma		Erythema Nodosum Leprosum (ENL): Confirmed diagnosis of moderate to severe ENL. Aphthous stomatitis (AS) or ulcers: 1. One of the following: a. Diagnosis of HIV-associated aphthous ulcers b. Recurrent aphthous stomatitis in immunocompromised patients. AND 2. Failure to alternative therapies. Crohn's Disease: Failure to all of the following standard treatment regimens: 1. Corticosteroids 2. 5-aminosalicylic acid 3. Immunomodulators 4. Remicade. Graft-versus-Host Disease (GVHD): 1. Diagnosis of chronic or refractory GVHD; AND 2. Failure to corticosteroid or one of the following: a. Azathioprine b. Tacrolimus c. Cyclosporine d. Antithymocyte globulin e. Mycophenolate Primary Brain Tumors: 1. As adjuvant therapy to current cytotoxic therapies; OR 2. Previous failure to cytotoxic therapies and/or tumor resection. Initial Therapy for AIDS-related cachexia or			ENL, MM: 1 year WM, GVHD, and Primary Brain Tumors, RCC: 6 months Other Uses: 3 months	Thalomid will be approved for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>wasting:</p> <ol style="list-style-type: none"> 1. Diagnosis of AIDS wasting or cachexia defined as chronic unremitting weight loss of more than 10% body weight in the previous 4 months; AND 2. Nutritional evaluation since onset of wasting first occurred. Screened for hypogonadism; AND 3. Failure to respond to hormone replacement therapy in patients with hypogonadism; AND 4. Failure, contraindication or intolerance to standard treatments. <p>Reauthorization for AIDS-related cachexia or wasting: Weight has stabilized or improved but not at goal weight.</p> <p>Advanced Renal Cell Carcinoma:</p> <ol style="list-style-type: none"> 1. Confirmed diagnosis of metastatic renal cell carcinoma; AND 2. Failure to two of the following: <ol style="list-style-type: none"> a. Interferon-alfa-2b b. Interleukin-2 c. Sorafenib d. Sunitanib e. Temsirolimus f. Pazopanib 				
<p>Topical Retinoids: Atralin, Avita, Retin A, Retin A Micro, Tretin-X, tretinoin</p>	<p>All FDA approved indications not otherwise excluded from Part D</p>	<p>Treatment for cosmetic purposes.</p>				<p>12 months</p>	
<p>Treanda</p>	<p>All FDA approved indications not otherwise excluded from Part D</p>		<p>Non-Hodgkin's Lymphoma (NHL):</p> <ol style="list-style-type: none"> 1. Diagnosis of indolent B-cell NHL. 2. Progression of NHL during or within 6 months of treatment with rituximab or a rituximab-containing regimen. 			<p>6 months</p>	<p>Treanda will be approved continuation of prior therapy.</p>

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Trisenox	All FDA approved indications not otherwise excluded from Part D				Prescribed by an oncologist or hematologist.	12 months	Approve for continuation of prior therapy,
Tykerb	All FDA approved indications not otherwise excluded from Part D		Breast Cancer: 1. Diagnosis of HER2-positive advanced or metastatic breast cancer 2. Confirmation of normal left ventricular ejection fraction.			12 months	Tykerb will be approved for continuation of prior therapy.
Tysabri	All FDA approved indications not otherwise excluded from Part D	Multiple Sclerosis: Used in combination with Avonex, Betaseron, Copaxone, Extavia, or Rebif. Crohn's: Receiving immunosuppressants or TNF-blockers.	Relapsing forms of Multiple Sclerosis (MS): Failure to one of the following: Avonex, Betaseron, Copaxone, Extavia, or Rebif. Initial Therapy for Crohn's Disease (CD): 1. Moderate-to-severe Crohn's disease with evidence of inflammation; AND 2. History of conventional therapy. 3. History of a TNF blocker. Reauthorization for Crohn's Disease: Demonstrated remission or significant clinical response to Tysabri.	Initial therapy for Initial Therapy for CD: 18 years and older.	Relapsing MS: Prescribing physician is enrolled in the TOUCH Prescribing Program. Initial Therapy - CD: Prescribing physician is enrolled in the CD TOUCH Prescribing Program.	Initial Therapy: Tysabri will be authorized for 1 year for MS and 3 months for CD Reauthorization for CD: Tysabri will be reauthorized for 6 months for patients on steroids. Otherwise, 3 months.	
Vandetanib	All FDA approved indications not otherwise excluded from Part D		Initial Therapy for Thyroid Cancer: 1. Confirmed diagnosis of locally advanced or metastatic medullary thyroid cancer 2. Unresectable disease 3. Symptomatic disease or evidence of progressive disease.		Prescribed by an oncologist or endocrinologist	12 months	Vandetanib will be approved for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Vectibix	All FDA approved indications not otherwise excluded from Part D		Colorectal Cancer: 1. Diagnosis of metastatic colorectal cancer. 2. Relapsed, refractory, or disease progression on one standard chemotherapy regimen containing a fluoropyrimidine, oxaliplatin, or irinotecan. 3. Tumor expresses wild-type KRAS gene.		Prescribed by an oncologist	6 months	Vectibix will be approved for continuation of prior therapy.
Velcade	All FDA approved indications not otherwise excluded from Part D		Mantle Cell Lymphoma: Diagnosis of mantle cell lymphoma and at least 1 prior therapy.		Prescribed by an oncologist or hematologist.	12 months	Velcade will be approved for continuation of prior therapy,
Ventavis	All FDA approved indications not otherwise excluded from Part D		Pulmonary Arterial Hypertension Patients with a confirmed diagnosis of pulmonary arterial hypertension (modified WHO Group I) which is symptomatic.			12 months	Ventavis is subject to Part B vs. Part D review.
Victrelis	All FDA-approved indications not otherwise excluded from Part D.	Failure with a previous treatment regimen that includes Victrelis or other HCV NS3/4A protease inhibitor [ie, Incivek (telaprevir)], coinfection with HIV, coinfection with hepatitis B virus, and post-organ transplant.	Initial Therapy for Hepatitis C: 1. Diagnosis of chronic hepatitis C genotype 1 infection; AND 2. Positive HCV RNA antibody; AND 3. HCV RNA level measurement; AND 4. Patient without decompensated disease; AND 5. Used in combination with peginterferon alfa and ribavirin Reauthorization for Hepatitis C: 1. Evidence of undetectable HCV RNA at treatment week 24; AND 2. HCV RNA level measurement at treatment week 8; AND 3. Used in combination with peginterferon alfa and ribavirin.	Hep C: 18 year and older	Hep C: Prescribed by a hepatologist, gastroenterologist, or ID specialist	Hep C: (Init) 24 wks (Reauth) 8 or 20 wks	Reauthorization will be issued for 8 weeks in the following patients: Previously treatment-naive patients with detectable HCV RNA at treatment week 8 or previous partial responders or relapsers to peginterferon alfa and ribavirin therapy. Reauthorization will be issued for 20 weeks in the following patients: Patients with compensated cirrhosis, previous null responders to peginterferon alfa and ribavirin therapy, or

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							poor interferon responsiveness as determined at treatment week 4.
Vidaza	All FDA-approved indications not otherwise excluded from Part D.				Prescribed by an oncologist or hematologist.	12 months	Vidaza will be approved for continuation of prior therapy,
Vimpat	All FDA-approved indications not otherwise excluded from Part D.		Partial-onset seizure: 1. Used as adjunctive therapy for the diagnosis of partial-onset seizure. 2. Unable to swallow oral Vimpat tablets.			3 months	Vimpat will be approved for continuation of prior therapy.
Votrient	All FDA-approved indications not otherwise excluded from Part D		Renal cell carcinoma: Diagnosis of advanced renal cell cancer.		Prescribed by an oncologist.	1 year	Prior authorization applies to new starts only
Vpriv	All FDA-approved indications not otherwise excluded from Part D		Gaucher's disease 1. Confirmed diagnosis of Type 1 Gaucher's disease. 2. Symptomatic disease defined by one of the following: a. moderate to severe anemia b. thrombocytopenia c. bone disease d. hepatomegaly e. splenomegaly.			12 months	
Xenazine	All FDA approved indications not otherwise excluded from Part D. Tardive dyskinesia. Tourette's syndrome.		Initial therapy for Huntington's Disease: Diagnosis of chorea in patients with Huntington's disease. Initial therapy for Tardive dyskinesia and Tourette's syndrome: 1. Stereotypes associated with tardive dyskinesia; OR 2. Both of the following: a. Tics associated with Tourette's syndrome; AND b. Failure, contraindication, or intolerance	Tardive dyskinesia: 18 years and older	Huntington: Prescribed by a neurologist. Tardive dyskinesia, Tourette: Prescribed by neurologist or psychiatrist.	Initial Therapy: 3 months. Reauthorization: 12 months.	Should not be used in patients who have inadequately treated depression, or patients who are actively suicidal.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>to Haldol (haloperidol)</p> <p>Reauthorization for Huntington’s Disease, Tardive dyskinesia, and Tourette’s syndrome: Documented clinical response and benefit from therapy.</p>				
Xgeva	All FDA-approved indications not otherwise excluded from Part D.	Prevention of skeletal-related events in patients with multiple myeloma.	<p>Prevention of skeletal-related events: Used for prevention of skeletal-related events in patients with bone metastases from solid tumors.</p>			12 months	
Xolair	All FDA approved indications not otherwise excluded from Part D		<p>Initial Therapy for Allergic Asthma:</p> <ol style="list-style-type: none"> 1. Diagnosis of moderate-to-severe persistent allergic asthma, defined by one of the following: <ol style="list-style-type: none"> a. Daily asthmatic symptoms b. Daily use of inhaled short-acting beta agonists c. Exacerbations affect/limit activity d. Exacerbations 2 or more times per year e. Nocturnal symptoms once a week or more f. Forced expiratory volume in one second or peak expiratory flow less than or equal to 80% of predicted g. PEF variability greater than 30% h. Measures of asthma control indicate uncontrolled asthma (eg, Asthma Control Test [ACT] score ≤19) AND 2. Baseline IgE level greater than or equal to 30 IU/mL; AND 3. Documented failure to combination therapy with an inhaled corticosteroid at the maximum dosage and a long-acting beta-agonist, or to one combination inhaled corticosteroid/long-acting beta agonist. <p>Reauthorization for Allergic Asthma:</p> <ol style="list-style-type: none"> 1. Documentation of clinical benefit with Xolair treatment (eg, reduction in the frequency of 	<p>Initial treatment: 12 years and older.</p> <p>Continuation of therapy: 6 years and older.</p>	<p>Initial Therapy: Prescribed by a pulmonologist or allergist/immunologist.</p>	6 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			asthma exacerbations, reduction in the use of rescue medications or inhaled corticosteroids, improvement in FEV1, reduction in the frequency of nocturnal symptoms, improvement in asthma control questionnaire).				
Xyrem						12 months	
Zofran (Brand)	All FDA approved indications not otherwise excluded from Part D		Failure to generic ondansetron.			6 months	Zofran is subject to Part B vs. Part D review.
Zolinza	All FDA approved indications not otherwise excluded from Part D		Cutaneous T-cell Lymphoma 1. Definitive diagnosis of cutaneous T-cell lymphoma (CTCL) 2. Failure to two systemic therapies.			12 months	Zolinza will be approved for continuation of prior therapy.
Zorbtive	All FDA approved indications not otherwise excluded from Part D		Short Bowel Syndrome (SBS): 1. All of the following: a. Diagnosis of SBS. b. BMI 17 to 28 kg/m2. d. At least 2 months post-resection. e. Patient is currently on parenteral nutrition f. Patient is able to ingest some food g. Intact stomach and duodenum			4 weeks	
Zortress	All FDA-approved indications not otherwise excluded from Part D. Cardiac Transplant.		Transplant: Patient received a renal or cardiac transplant.			12 months	Subject to Part B vs. Part D review. Approve for continuation of prior therapy if Part D.
Zytiga	All FDA-approved indications not otherwise excluded from Part D.		Prostate cancer: Confirmed diagnosis of metastatic hormone-refractory or castration-resistant prostate cancer, used in combination with prednisone, documented disease progression, and one of the following: patient is			12 months	Approve for continuation of prior therapy

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Prostate cancer: Asymptomatic/ minimally symptomatic without visceral disease. Symptomatic or has visceral disease, and not a candidate for docetaxel-based chemotherapy.		asymptomatic/minimally symptomatic without visceral disease, or both of the following: patient is symptomatic or has visceral disease, and has previous treatment with docetaxel-based chemotherapy or is not a candidate for docetaxel-based chemotherapy.				
Zyvox (oral)	All FDA approved indications not otherwise excluded from Part D Chronic osteomyelitis. Prosthetic joint infection.		Infections: One of the following: 1. Infections caused by vancomycin-resistant enterococci (VRE) documented by culture and sensitivity (C/S) report. 2. Nosocomial pneumonia caused by methicillin-resistant Staphylococcus aureus (MRSA) documented by C/S report. 3. Nosocomial or community acquired pneumonia (CAP) caused by methicillin susceptible Staphylococcus aureus (MSSA) or Streptococcus pneumoniae documented by C/S report and failure to 2 (or resistance to all) first line antibiotics. 4. Complicated skin and skin structure infections (SSI), including diabetic foot infections, without osteomyelitis caused by MRSA documented by C/S report. 5. Uncomplicated SSI caused by MRSA documented by C/S report or empirical treatment of patients with uncomplicated or community-acquired complicated SSI without osteomyelitis where MRSA infection is likely, in patients who have failed one or has resistance to all of the following: trimethoprim-sulfamethoxazole, tetracycline, doxycycline, minocycline,		Chronic osteomyelitis, prosthetic joint infection, cutaneous or systemic Nocardiosis: Prescribed by an infectious disease specialist or by consultation with an infectious disease specialist.	Non-MRSA nosocomial or community acquired pneumonia, SSI: 14 days Chronic osteomyelitis, prosthetic joint Infection: 6 weeks Cutaneous Nocardiosis: 3 months Systemic Nocardiosis: 12 months Other uses: 28 days	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>clindamycin</p> <p>6. Uncomplicated or complicated SSI without osteomyelitis caused by MSSA, Streptococcus pyogenes, or Streptococcus agalactiae (complicated SSI only) documented by C/S report and failure to two or resistance to all first line antibiotics.</p> <p>7. Chronic osteomyelitis or prosthetic joint infection due to MRSA or methicillin-resistant Staphylococcus epidermidis (MRSE), and failure to two or resistance to all first line antibiotics.</p> <p>8. Cutaneous or systemic infection caused by Nocardia (nocardiosis) and failure to 2 (or resistance to all) first line antibiotics.</p> <p>9. For all indications except CAP and SSI, allow for continuation of therapy when transitioning from intravenous daptomycin, intravenous vancomycin, or intravenous Zyvox therapy. For CAP, allow for continuation of therapy when transitioning from intravenous daptomycin, intravenous vancomycin, intravenous Zyvox, or intravenous tigecycline therapy. For SSI, allow for continuation of therapy when transitioning from intravenous daptomycin, intravenous vancomycin, intravenous Zyvox, intravenous tigecycline, or intravenous televancin therapy.</p>				

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
Zyvox (IV)	<p>All FDA approved indications not otherwise excluded from Part D</p> <p>Chronic osteomyelitis.</p> <p>Prosthetic joint infection.</p>		<p>Infections:One of the following:</p> <ol style="list-style-type: none"> 1. Infections caused by vancomycin-resistant enterococci (VRE) documented by culture and sensitivity (C/S) report. 2. Nosocomial pneumonia caused by methicillin-resistant Staphylococcus aureus (MRSA) documented by C/S report. 3. Nosocomial or community acquired pneumonia (CAP) caused by methicillin susceptible Staphylococcus aureus (MSSA) or Streptococcus pneumoniae documented by C/S report and failure to 2 (or resistance to all) first line antibiotics. 4. Complicated skin and skin structure infections (SSI), including diabetic foot infections, without osteomyelitis caused by MRSA documented by C/S report. 5. Uncomplicated SSI caused by MRSA documented by C/S report or empirical treatment of patients with uncomplicated or community-acquired complicated SSI without osteomyelitis where MRSA infection is likely, in patients who have failed one or has resistance to all of the following: trimethoprim-sulfamethoxazole, tetracycline, doxycycline, minocycline, clindamycin 6. Uncomplicated or complicated SSI without osteomyelitis caused by MSSA, Streptococcus pyogenes, or Streptococcus agalactiae (complicated SSI only) documented by C/S report and failure to two or resistance to all first line antibiotics. 7. Chronic osteomyelitis or prosthetic joint infection due to MRSA or methicillin-resistant Staphylococcus epidermidis (MRSE), and failure to two or resistance to all first line antibiotics. 8. Cutaneous or systemic infection caused by Nocardia (nocardiosis) and failure to 2 (or resistance to all) first line antibiotics. 9. For all indications except CAP and SSI, allow for continuation of therapy when transitioning from intravenous daptomycin, intravenous vancomycin, or intravenous Zyvox therapy. For CAP, allow for continuation of therapy when transitioning from intravenous daptomycin, intravenous vancomycin, intravenous Zyvox, or intravenous tigecycline therapy. For SSI, allow for continuation of therapy when transitioning from intravenous daptomycin, intravenous vancomycin, intravenous Zyvox, intravenous tigecycline, or intravenous televancin therapy. 10. Patient is unable to take oral Zyvox. 		<p>Chronic osteomyelitis, prosthetic joint infection, cutaneous or systemic Nocardiosis: Prescribed by an infectious disease specialist or by consultation with an infectious disease specialist.</p>	<p>Non-MRSA nosocomial or community acquired pneumonia, SSI: 14 days</p> <p>Chronic osteomyelitis, prosthetic joint Infection: 6 weeks</p> <p>Cutaneous Nocardiosis: 3 months</p> <p>Systemic Nocardiosis: 12 months</p> <p>Other uses: 28 days</p>	

The following drugs 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:

• Abelcet	• Emla	• Ondansetron
• Accuneb	• Engerix-B	• Ondansetron ODT
• Acetylcysteine	• Epogen	• Orthoclone OKT3
• Acyclovir	• Fluorouracil	• Perforomist
• Adriamycin	• Forteo	• Premasol
• Albuterol	• Foscarnet	• Privilgen
• Ambisome	• Freamine HBC	• Procalamine
• Aminosyn	• Freamine III	• Procrit
• Amphotec	• Gamastan S/D	• Prograf
• Amphotericin	• Gammagard Liquid	• Prosol
• Anzemet	• Gamunex	• Pulmicort
• Aranesp	• Gengraf	• Pulmozyme
• Aredia	• Granisetron	• Rapamune
• Atgam	• Granisol	• Recombivax HB
• Bleomycin	• Hectoral	• Remodulin
• Boniva Inj	• Hepatamine	• Renamin
• Brovana	• Hepatasol	• Rocaltrol
• Budesonide	• Humulin R U-500	• Sandimmune
• Calcijex	• Imovax	• Simulect
• Calcitriol	• Intralipid	• Synera
• Carimune NF	• Ipratropium bromide	• Tacrolimus
• Carnitor	• Ipratropium bromide/albuterol sulfate	• Thymoglobulin
• Cellcept	• Kytril	• Tobi
• Cesamet	• Levalbuterol	• Travasol
• Cladribine	• Levocarnitine	• Trophamine
• Clinimix	• Lidocaine Ointment/Inj	• Vancomycin Inj
• Clinimix E	• Lidocaine/prilocaine	• Ventavis
• Clinisol SF	• Liposyn II	• Vinblastine
• Cromolyn Sodium	• Liposyn III	• Vincasar PFS
• Cubicin	• Marinol	• Vincristine
• Cyclophosphamide	• Miacalcin	• Vivaglobin
• Cyclosporine	• Mycophenolate	• Xopenex
• Cyclosporine Modified	• Myfortic	• Xylocaine Inj
• Cytarabine	• Nebupent	• Zemplar
• Doxil	• Nephramine	• Zenapax
• Doxorubicin	• Novamine	• Zofran
• Dronabinol	• Fluorouracil	• Zofran ODT
• Duoneb	• Forteo	• Zuplenz
• Emend	• Foscarnet	