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Prior Authorization Group Description	Actimmune
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Chronic granulomatous disease: patients that have experienced failure to or do not have an intolerance to preventative anti-infectives.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 3 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Actiq
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient that does not have a oncology diagnosis or is not currently receiving and is tolerant to opioid therapy.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of oncologist or pain management specialist.
Coverage Duration	Approve 6 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Adoxa
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient that has not tried and failed treatment with, or does not have a contraindication to non-extended release generic doxycycline or minocycline products.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 12 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Afinitor
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient has not tried or failed Sutent or Nexavar or has a contraindication to Afinitor.
Required Medical Information	Diagnosis of Advanced Renal Cell Carcinoma
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of hematologist or oncologist
Coverage Duration	Approve initial 4 months followed by 4 and 6 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Alpha-Proteinase Inhibitor
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 12 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Amevive
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Psoriasis has not been present for over 12 months, or psoriasis does not affect at least 10 percent of the body or does not have involvement of palms, soles, neck, or genitalia.
Required Medical Information	N/A
Age Restrictions	Patient age 18 or older
Prescriber Restrictions	Patient under care of dermatologist.
Coverage Duration	Approve 3 months followed by 3 months thereafter.
Other Criteria	No authorization provided beyond 24 weeks of therapy.

Prior Authorization Group Description	Ampyra
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient that has a history of seizure disorder or a creatinine clearance less than 50ml per min.
Required Medical Information	Diagnosis, EDSS Expanded Disability Status Scale score ranging from 2.5 to 6.5, TRIAL or FAILURE OF ANY ONE of the following Avonex, Betaseron, Copaxone, Extavia, Rebif or Tysabri
Age Restrictions	Patient is 18 years or older
Prescriber Restrictions	Neurologist or certified MS Specialist
Coverage Duration	Approve 6 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Apokyn
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient that has not been previously treated with standard dopaminergic therapy.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 6 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Aracalyst
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 6 months followed by 6 months thereafter.
Other Criteria	Also requires Part B vs. Part determination.

Prior Authorization Group Description	Blood Formation Products (ESA's)
Covered Uses	All FDA-approved indications not otherwise excluded from part D, anemia associated with antiviral therapy in patient treated for chronic hepatitis C, anemia caused by myelodysplastic syndrome, preoperative treatment of patients with anemia, anemia due to prematurity, symptomatic anemia with a hematocrit less than 36% in patients with severe pulmonary disease, severe hypotension, congestive heart failure, or cerebrovascular disease.
Exclusion Criteria	Treatment of anemia associated with myelosuppressive chemotherapy when the anticipated outcome is a cure.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 6 weeks to 12 months based on indication. On-going renewal for same duration as original approval.
Other Criteria	N/A

Prior Authorization Group Description	Chorionic Gonadotropins
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 6 months followed by 6 months thereafter.
Other Criteria	Documentation that medication is not being used as part of an infertility treatment regimen.

Prior Authorization Group Description	D.H.E. Injection
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient has not tried and failed treatment with standard therapy and is not receiving ongoing prophylactic therapy
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of headache specialist.
Coverage Duration	Approve 1 month followed by every 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	DDAVP
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient that has not tried and failed treatment with or is able to receive treatment with oral or nasal desmopressin.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 6 months followed by every 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Desoxyn
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 6 months followed by every 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Doryx
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient that has not had previous trial of immediate release doxycycline or minocycline products.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 12 months followed by every 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Embeda
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with a known hypersensitivity to morphine, morphine salts, naltrexone; OR patients that are opioid naïve
Required Medical Information	Patient has documented moderate-to-severe pain that requires continual, around-the-clock therapy for an extended period of time AND the treating physician suspects that potential abuse opioids by the patient or the patient's care-givers exists or the patient has a history of opioid drug abuse or diversion
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of oncologist or pain management specialist.
Coverage Duration	Approve 6 months followed by every 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Enbrel
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient whose psoriasis has not been present for over 12 months, patient whose psoriasis does not affect at least 10 percent of the body or does not have involvement of palms, soles, neck, or genitalia.
Required Medical Information	N/A
Age Restrictions	Patient age 4 or older.
Prescriber Restrictions	Patient under care of rheumatologist or dermatologist.
Coverage Duration	Psoriasis: approve 6 months followed by 6 months thereafter. Other diagnosis: approve 6 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Endometrin
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 6 months.
Other Criteria	Documentation that medication is not being used as part of an infertility treatment regimen must be provided.

Prior Authorization Group Description	Fentora
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient that is not taking a chronic opioid pain medication, patient that has not tried and failed treatment with or does not have a contraindication to Actiq or one other agent for management of breakthrough pain.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of oncologist or pain management specialist.
Coverage Duration	Approve 6 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Forteo
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient that has not experienced a treatment failure to a bisphosphonate or Evista.
Required Medical Information	Dexa T-score of -2.5 or less
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 6 months followed by 12 months thereafter.
Other Criteria	Treatment failure with a bisphosphonate or Evista is defined as intolerance due to adverse events or contraindication, progression of bone loss or occurrence of an osteoporotic fracture.

Prior Authorization Group Description	Gleevec
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pediatric patient with a diagnosis of Philadelphia chromosome positive chronic phase CML that is not resistant to interferon alfa therapy or that has not had their disease recur following a stem cell transplant.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of hematologist or oncologist.
Coverage Duration	Approve 6 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	GNRH Antagonists
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prostate cancer and precocious puberty: approve every 12 months; endometriosis: approve 6 months followed by 6 months thereafter; fibroids: approve 3 months followed by 3 months thereafter; endo thin: approve 3 months
Other Criteria	N/A

Prior Authorization Group Description	Human Growth Hormone
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient with diagnosis of AIDS wasting syndrome that has not had an involuntary weight loss of more than 10 percent, has not experienced 30 days or more of diarrhea or weakness and fever, and is not receiving antiretroviral therapy; adult patients that do not have one of the following conditions: childhood-onset deficiency, pituitary or hypothalamic disease, panhypopituitarism, surgery, trauma, or radiation therapy.
Required Medical Information	Patient with diagnosis of pediatric growth hormone deficiency. Need baseline height, growth rate, result of one provocative stimulus test and serum growth hormone; patient with diagnosis of adult growth hormone deficiency require results of one growth hormone stimulation test.
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of endocrinologist for diagnosis growth hormone deficiency, growth failure in children small for gestational age, patient under care of endocrinologist or nephrologist for diagnosis pediatric growth failure due to chronic renal failure. No restriction for other diagnosis.
Coverage Duration	Approve 12 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Humira
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient whose psoriasis has not been present for over 12 months, patient whose psoriasis does not affect at least 10 percent of the body or does not have involvement of palms, soles, neck, or genitalia.
Required Medical Information	N/A
Age Restrictions	Patient age 4 or older.
Prescriber Restrictions	Patient under care of gastroenterologist, rheumatologist, or dermatologist.
Coverage Duration	Approve 6 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Immune Globulin Subcutaneous
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 6 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Infergen
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve initial 6 months followed by 12 months to 18 months total treatment.
Other Criteria	N/A

Prior Authorization Group Description	Insulin-like Growth Factor (IGF-1) Analogues
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient with presence of active neoplasia, patient with closed epiphyses.
Required Medical Information	Growth hormone level must be normal or elevated, basal IGF-1 standard deviation score must be less than or equal to -3.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 6 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Intron A
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve initial 6 months; followed by additional 12 months to 24 months based on diagnosis.
Other Criteria	Requires Part B vs. D determination also.

Prior Authorization Group Description	Istodax
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve initial 6 months; followed by additional 12 months to 24 months based on diagnosis.
Other Criteria	Requires Part B vs. D determination also.

Prior Authorization Group Description	IV Immune Globulins
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, immune neutropenia, Guillain-Barre syndrome, myasthenia gravis, bone marrow transplant, solid organ transplant, autoimmune mucocutaneous blistering disease.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 6 months followed by 12 months thereafter.
Other Criteria	Requires Part B vs. D determination also.

Prior Authorization Group Description	Kineret
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient that has not tried and failed treatment with conventional therapy and two of the following agents: Humira, Remicade, or Enbrel.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of rheumatologist.
Coverage Duration	Approve 6 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Kuvan
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient who does not show a response to Kuvan after at least 30 days of therapy.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 2 months followed by every 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Letairis
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient not received a baseline liver function test, female patients that have not received a pregnancy test prior to therapy, female patient not on two forms of birth control or sterilization or IUD.
Required Medical Information	Diagnosis of primary for secondary pulmonary arterial hypertension confirmed by right heart catheterization, echocardiography with Doppler ultrasound, or electrocardiogram.
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of cardiologist or pulmonologist.
Coverage Duration	May be approved for up to 28 days.
Other Criteria	Approve 6 months followed by 12 months thereafter.

Prior Authorization Group Description	Miacalcin
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient that has not tried and failed treatment with Actonel, Fosamax, Evista, or Boniva.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 6 months followed by 6 months thereafter.
Other Criteria	Treatment failure with an oral agent is defined as intolerance due to adverse events or contraindication, progression of bone loss or occurrence of an osteoporotic fracture.

Prior Authorization Group Description	Mozobil
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Part B coverage
Required Medical Information	Diagnosis: harvesting of peripheral blood stem cells in patients with non-Hodgkin's lymphoma and multiple myeloma; patient's weight for dosage determination; concurrent treatments: used in combination with granulocyte-colony stimulating factor
Age Restrictions	Patient age 18 or older.
Prescriber Restrictions	N/A
Coverage Duration	Approve for 12 months.
Other Criteria	N/A

Prior Authorization Group Description	Multiple Sclerosis Agents
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of neurologist.
Coverage Duration	Approve 6 months followed by 6 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Nexavar
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of hematologist or oncologist.
Coverage Duration	Approve 4 months followed by 4 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Noxafil
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with a diagnosis of oropharyngeal candidiasis that is not refractory to treatment with fluconazole.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Consultation with an Infectious Disease Specialist will be required for persons beginning therapy in the ambulatory setting.
Coverage Duration	Approve for 4 months.
Other Criteria	Severely immunocompromised defined as patient with diagnosis of HIV/AIDS, solid organ, tissue, or cell transplant and being maintained on immunosuppressive therapy, patient currently receiving or within 30 days of receiving chemotherapy regimen, individuals with inborn immunodeficiency syndromes.

Prior Authorization Group Description	Nuvigil
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient without a confirmed diagnosis of narcolepsy with or without cataplexy, patient with a confirmed diagnosis of excessive daytime sleepiness due to obstructive sleep apnea/hypopnea that has not tried and failed an adequate trial of regular use of continuous positive airway pressure (CPAP); patient that has not tried and failed adequate trial of Provigil (modafinil).
Required Medical Information	N/A
Age Restrictions	Patient age 16 or older.
Prescriber Restrictions	N/A
Coverage Duration	Approve for 6 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Oracea
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient that has not tried and failed treatment with, or does not have a contraindication to extended release generic doxycycline or minocycline products.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 12 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Oral Ribavirin Agents
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients not currently receiving treatment with interferon alfa for the treatment of hepatitis C infections.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve initial 6 months followed by additional 6 months for responders and 3 months for non-responders.
Other Criteria	Initial 6 months; if response, additional 6 months to 24 months total. No response – additional 3 months to 9 total.

Prior Authorization Group Description	Orencia
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient that has not tried and failed a three month trial of at least one DMARD and Enbrel and Humira.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of rheumatologist.
Coverage Duration	Approve 6 months followed by 6 months thereafter.
Other Criteria	Requires Part B vs. D determination also.

Prior Authorization Group Description	Pegasys
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve for 12 months (48 weeks).
Other Criteria	N/A

Prior Authorization Group Description	PEG-Intron
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve for 12 months (48 weeks).
Other Criteria	N/A

Prior Authorization Group Description	Promacta
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient has not tried or failed conventional treatments such as corticosteroids, immunoglobulins, or splenectomy.
Required Medical Information	Diagnosis of idiopathic thrombocytopenia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve for initial 2 months, followed by 6 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Provigil
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, fatigue associated by multiple sclerosis.
Exclusion Criteria	Patient without a confirmed diagnosis of narcolepsy with or without cataplexy, patient with diagnosis of fatigue associated with MS that has not tried and failed treatment of an alternative agent, patient with a confirmed diagnosis of excessive daytime sleepiness due to OSA that has not tried and failed an adequate trial of regular use of continuous positive airway pressure (CPAP).
Required Medical Information	N/A
Age Restrictions	Patient age 16 or older.
Prescriber Restrictions	N/A
Coverage Duration	Approve for 6 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Qualaquin
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient that is prescribed Qualaquin for any indication other than the treatment of malaria.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve for 3 months followed by 3 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Relistor
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient does not have a terminal illness with a life expectancy of less than 6 months or has not experienced opioid-induced constipation for which a laxative regimen at the highest acceptable dose has been unsuccessful in achieving results.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve for 4 months followed by every 2 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Remicade
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient has not tried and failed treatment with conventional therapy, patient with diagnosis of psoriasis that has not tried and failed treatment or does not have a contraindication with Enbrel, Humira, Raptiva, or Amevive; patient whose psoriasis does not affect at least 10 percent of the body or does not have involvement of palms, soles, neck, or genitalia.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of gastroenterologist, rheumatologist, or dermatologist.
Coverage Duration	Approve for 6 months followed by 12 months thereafter.
Other Criteria	Requires Part B vs. D determination also.

Prior Authorization Group Description	Retinoic Acid Dermatological Acne Products
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient for whom requested indication is cosmetic in nature.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve for 12 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Revatio
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve for 12 months.
Other Criteria	N/A

Prior Authorization Group Description	Revlimid
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Female patients that have not received a pregnancy test within 24 hours of beginning therapy weekly during the first week and monthly thereafter; patient that has not tried and failed treatment or has a contraindication to one other approved medication for multiple myeloma.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve for 12 months.
Other Criteria	Physician must be registered with REVassist program.

Prior Authorization Group Description	Rilutek
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve for 12 months.
Other Criteria	N/A

Prior Authorization Group Description	Rituxan
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient with diagnosis of rheumatoid arthritis that has not tried and failed treatment or has a contraindication to treatment with at least one injectable TNF antagonist; patient that is not receiving concurrent methotrexate therapy.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of rheumatologist or hematologist or oncologist.
Coverage Duration	Approve 1 month followed by 6 months thereafter.
Other Criteria	Requires Part B vs. D determination also.

Prior Authorization Group Description	Samsca
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients requiring urgent intervention to raise serum sodium acutely; OR patients who are unable to sense or to respond appropriately to thirst; OR patients with hypovolemic hyponatremia; OR patients who are anuric as no benefit is expected.
Required Medical Information	Patient location (Samsca must be initiated and re-initiated in hospital); and serum sodium level
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve for 6 months followed by 12 months thereafter
Other Criteria	N/A

Prior Authorization Group Description	Sandostatin
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve for 12 months.
Other Criteria	N/A

Prior Authorization Group Description	Solodyn
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient that has not tried and failed treatment with or does not have a contraindication to non-extended release generic doxycycline or minocycline.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve for 12 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Somatuline
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient does not have acromegaly that has been unresponsive to surgery and or radiation, unless otherwise unable to tolerate surgery or radiation
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve for 6 months, followed by every 12 months thereafter.
Other Criteria	Requires Part B vs. D determination also.

Prior Authorization Group Description	Sprycel
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient that has not tried and failed or has an intolerance to treatment with prior therapy including Gleevec.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of hematologist or oncologist.
Coverage Duration	May be approved for up to 28 days.
Other Criteria	Approve for 6 months followed by 12 months thereafter.

Prior Authorization Group Description	Stelara
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For the treatment of moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy.
Age Restrictions	PATIENT AGE 18 OR OLDER
Prescriber Restrictions	N/A
Coverage Duration	Approve for 12 months.
Other Criteria	N/A

Prior Authorization Group Description	Sutent
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient with diagnosis of GIST that has not tried and failed treatment with Gleevec, patient diagnosis of renal cell carcinoma that has not tried and failed treatment with a cytokine-based chemotherapy.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of hematologist or oncologist.
Coverage Duration	Approve for 6 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Symlin
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient not also receiving insulin therapy, patient with A1C over 9, patient with a diagnosis of gastroparesis, patient receiving medications that stimulate gastric motility, patient is unable to recognize signs and symptoms of hypoglycemia, patient experienced severe hypoglycemic episode that required assistance within past 6 months.
Required Medical Information	N/A
Age Restrictions	Patient age 18 or older.
Prescriber Restrictions	N/A
Coverage Duration	Approve for 12 months.
Other Criteria	N/A

Prior Authorization Group Description	Tarceva
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with locally advanced or metastatic NSCLC who are receiving concurrent administration of Tarceva with platinum-based chemotherapy (carboplatin and paclitaxel or gemcitabine and cisplatin), pancreatic cancer patients who are not receiving or have not received concurrent therapy with gemcitabine.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of hematologist or oncologist.
Coverage Duration	Approve for 6 months followed by every 6 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Tasigna
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients that have not tried and failed treatment with or that are not contraindicated for treatment with Gleevec
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of hematologist or oncologist.
Coverage Duration	Approve for 6 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Thalomid
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, erythematosis, systemic lupus, Behcet syndrome, HIV associated wasting syndrome, aphthous stomatitis, discoid lupus, prostate cancer.
Exclusion Criteria	Patient not receiving treatment for cutaneous manifestations in erythema nodosum leprosum, patient not using Thalomid in combination with docetaxel in prostate cancer, female patient without taking pregnancy test within 24 hours of beginning Thalomid weekly during the first week and monthly thereafter.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve for 6 months followed by 12 months thereafter.
Other Criteria	Physician registered with system for Thalomid education and prescribing safety program.

Prior Authorization Group Description	Tracleer
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient taking glyburide or cyclosporine, patient not received baseline liver function test, patient not received pregnancy test prior to therapy, patient not on effective birth control during therapy.
Required Medical Information	Diagnosis of primary or secondary pulmonary arterial hypertension confirmed by right heart catheterization, echocardiography with Doppler ultrasound, or electrocardiogram.
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of cardiologist or pulmonologist.
Coverage Duration	Approve for 6 months followed by 12 months thereafter.
Other Criteria	N/A

Prior Authorization Group Description	Votrient
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of hematologist or oncologist.
Coverage Duration	Approve for 6 months followed by 12 months thereafter.
Other Criteria	N/A

**Prior Authorization
Group Description****Part B vs. D**

These 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.

ACETYLCYST SOL 10%
ACETYLCYST SOL 20%
ACTEMRA INJ
ALIMTA INJ 500MG
ANZEMET INJ 20MG/ML
ANZEMET TAB 100MG
ANZEMET TAB 50MG
ARZERRA INJ
AZATHIOPRINE TAB 50MG
BONIVA KIT 3MG/3ML
BUDESONIDE SUS 0.25MG/2ML
BUDESONIDE SUS 0.5MG/2ML
CELLCEPT SUS 200MG/ML
CELLCEPT TAB 500MG
CIPRO I.V. SOL 200MG
COMVAX INJ
CROMOLYN SOD NEB 20MG/2ML
CYCLOPHOSPH TAB 25MG
CYCLOPHOSPH TAB 50MG
CYCLOSPORINE CAP 100MG MD
CYCLOSPORINE CAP 50MG MOD
CYKLOKAPRON INJ 100MG/ML
CYTOXAN INJ 2GM
CYTOXAN INJ 500MG
DEPACON INJ 100MG/ML
DILAUDID-HP INJ 10MG/ML
DORIBAX INJ 500MG
ELLENCEN INJ 2MG/ML
ELOXATIN INJ 100MG
EMEND CAP 125MG
EMEND CAP 40MG
EMEND CAP 80-125MG
EMEND CAP 80MG
ETOPOPHOS INJ 100MG
GEMZAR INJ 1 GM
GENGRAF CAP 100MG
GENGRAF CAP 25MG
GENGRAF SOL 100MG/ML
HALDOL DECAN INJ 100MG/ML

HALDOL DECAN INJ 50MG/ML
HALDOL INJ 5MG/ML
HYCAMTIN INJ 4MG
INVANZ INJ 1GM
ISTODAX INJ 10MG
KYTRIL INJ 0.1MG/ML
KYTRIL INJ 1MG/ML
KYTRIL TAB 1MG
LEUCOVOR CA TAB 10MG
LEUCOVOR CA TAB 15MG
LEUCOVOR CA TAB 5MG
MARINOL CAP 10MG
MARINOL CAP 2.5MG
MARINOL CAP 5MG
MESNEX INJ 1GM
MYCOPHENOLAT CAP 250MG
MYCOPHENOLAT TAB 500MG
MYFORTIC TAB 180MG
MYFORTIC TAB 360MG
NEORAL CAP 100MG
NEORAL CAP 25MG
NEORAL SOL 100MG/ML
NEXIUM I.V. INJ 20MG
NEXIUM I.V. INJ 40MG
NORFLEX INJ 30MG/ML
ONDANSETRON SOL 4MG/5ML
ONXOL INJ 30MG/5ML
PACLITAXEL INJ
PEPCID I.V. INJ 20MG/2ML
PEPCID PREM SOL 20MG/50M
PLATINOL AQ INJ 100MG
PROLEUKIN INJ 22MU
PROTONIX INJ 40MG
PULMICORT SUS 0.25MG/2
PULMICORT SUS 0.5MG/2
PULMICORT SUS 1MG/2ML
RAPAMUNE SOL 1MG/ML
RAPAMUNE TAB 1MG
RAPAMUNE TAB 2MG
RECOMBIVA-HB INJ 10MCG/ML
RECOMBIVA-HB INJ 40MCG/ML
ROCEPHIN INJ 1GM
ROCEPHIN/ DEX INJ
SANDIMMUNE CAP
SANDIMMUNE INJ
SANDIMMUNE SOL 100MG/ML
SOTALOL HCL INJ 150/10ML
TACROLIMUS CAP

TAXOTERE
TOBI NEB 300/5ML
TORISEL SOL
VIBATIV INJ
VENTAVIS SOL
VINCASAR PFS INJ
VINCRISTINE INJ
VPRIV INJ
ZANTAC INJ
ZENAPAX INJ
ZOFRAN INJ
ZOFRAN ODT TAB
ZOFRAN SOL 4MG/5ML
ZOFRAN TAB
ZYPREXA RELP INJ

