



Prior Authorization Criteria

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
ABELCET	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
ACYCLOVIR SODIUM	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
ADAGEN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DOCUMENTATION OF ADA DEFICIENCY AND WHETHER THE PATIENT IS A SUITABLE CANDIDATE FOR A BONE MARROW TRANSPLANT.		1 YEAR	



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ADRIAMYCIN	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
AMBISOME	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					



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AMEVIVE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIAGNOSIS, PRIOR TREATMENTS, AND AFFECTED BODY SURFACE AREA	PRESCRIPTION MUST BE WRITTEN BY A RHEUMATOLOGIST OR DERMATOLOGIST	3 MONTHS AT A TIME, RENEWABLE IF A RESPONSE IS DEMONSTRATED	GREATER THAN 10% OF BODY SURFACE AREA NEEDS TO BE COVERED AND THE PATIENT HAS TO HAVE HAD LESS THAN 50% OF AFFECTED BODY SURFACE AREA CLEARED WITH ATLEAST ONE 30 TREATMENT COURSE OF PHOTOCHEMOTHERAPY: PSORALAN PLUS ULTRAVIOLET A (PUVA) OR PHOTOTHERAPY ULTRAVIOLET B (UVB).



Prior Authorization Criteria

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
AMINOSYN II	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
AMINOSYN II /DEXTROSE	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
AMINOSYN-HF	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					



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AMITIZA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		MEDICATIONS TRIED AND FAILED FOR CONSTIPATION		1 YEAR	
AMPHOTEC	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
AMPHOTERICIN B	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					



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ANZEMET	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
ARANESP	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		MEDICAL CONDITION ASSOCIATED WITH ANEMIA, HEMOGLOBIN AND HEMACRIT LEVELS		6 MO. - 1 YEAR	
ARIXTRA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		MEDICAL REASONING FOR NOT USING LOVENOX IS REQUIRED		TWO 5-DAY FILLS OR 30 DAYS IF REQUIRED FOR PROPHYLAXIS	



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ATTENUVAX	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
AVONEX	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			PRESCRIPTION MUST BE WRITTEN BY A NEUROLOGIST	1 YEAR	
AZATHIOPRINE	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					



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Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
AZATHIOPRINE SODIUM	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
BARACLUDE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		TREATMENT CONSIDERATION IS BASED ON HBEAG, HBV DNA QUANTITY, AND ALT LEVEL	PRESCRIPTION MUST BE WRITTEN BY A GASTROENTEROLOGIST, HEPATOLOGIST, OR INFECTIOUS DISEASE SPECIALIST	1 YEAR	
BETASERON	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			PRESCRIPTION MUST BE WRITTEN BY A NEUROLOGIST	1 YEAR	



Prior Authorization Criteria

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
BLEOMYCIN SULFATE	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
BYETTA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		HBA1C AND CURRENT DIABETES MEDICATIONS	PRESCRIPTION MUST BE WRITTEN BY AN ENDOCRINOLOGIST	1 YEAR	
CELLCEPT	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					



Prior Authorization Criteria

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
CEREDASE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NOT APPROVED FOR TYPE II OR TYPE III GAUCHER'S DISEASE.	POSITIVE DIAGNOIS OF TYPE I GAUCHER'S DISEASE AND WEIGHT		1 YEAR	
CEREZYME	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NOT APPROVED FOR TYPE II OR TYPE III GAUCHER'S DISEASE.	POSITIVE DIAGNOSIS OF TYPE I GAUCHER'S DISEASE AND WEIGHT		1 YEAR	
CLADRIBINE	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					



Prior Authorization Criteria

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CLINIMIX / DEXTROSE	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
CLINIMIX E /DEXTROSE	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
COPAXONE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			PRESCRIPTION MUST BE WRITTEN BY A NEUROLOGIST	1 YEAR	



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CYCLOPHOSPHAMID E	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
CYCLOSPORINE	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
CYTARABINE	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					



Prior Authorization Criteria

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CYTOVENE	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
DOXORUBICIN HCL	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
EMEND	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					



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Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
ENBREL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			PRESCRIPTION MUST BE WRITTEN BY A RHEUMATOLOGIST OR DERMATOLOGIST	1 YEAR	
ENGERIX-B	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					



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Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
EPOGEN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	EPOETIN ALFA IS NOT A COVERED BENEFIT FOR PATIENTS WITH UNCONTROLLED HYPERTENSION OR PATIENTS WITH SOLID OR NON-MYELOID HEMATOLOGICAL MALIGNANCIES WHO ARE ACTIVELY RECEIVING MYELOSUPPRESSIVE CHEMOTHERAPY AND/OR RADIATION	DIAGNOSIS, HGB / HCT, IF ANEMIA IS DUE TO MYELOSUPPRESSIVE ANTICANCER CHEMOTHERAPY, LIST CHEMOTHERAPY REGIMEN AND DATES. DOCUMENTATION OF ADEQUATE IRON STORES		1 YEAR	FOR AZT-INDUCED ANEMIA AND CKD INCLUDING ESRD TARGET HGB LESS THAN OR EQUAL TO 12G/DL. FOR ONCOLOGY PATIENTS RECEIVING MYELOSUPPRESSIVE CHEMOTHERAPY, HGB MUST BE LESS THAN 10G/DL AT THE START OF EPO THERAPY AND MUST NOT EXCEED 12G/DL.



Prior Authorization Criteria

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
FABRAZYME	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		FOR MALES: ACTIVITY LEVEL OF ALPHA-GALACTOSIDASE A IN PLASMA OR IN LEUKOCYTES. FOR FEMALES: MOLECULAR STUDY INDICATING ALPHA-GALACTOSIDE A ENZYME MUTATION AND EXHIBITION OF CLINICAL MANIFESTATIONS		1 YEAR	
FLUOROURACIL	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					



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Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
GAMMAGARD LIQUID	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
GAMUNEX	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
GENGRAF	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					



Prior Authorization Criteria

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
GLEEVEC	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		INITIAL FLUORESCENCE IN SITU HYBRIDIZATION (FISH) REQUIRED FOR CML INDICATIONS. INITIAL MEASUREMENT OF TUMOR VIA IMAGING FOR GIST.		6 MONTHS	FOR SUBSEQUENT REQUESTS, RESULTS OF FISH MUST SHOW IMPROVEMENT OR LACK OF PROGRESSION.
GRANISETRON HCL	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
HEPATASOL	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					



Prior Authorization Criteria

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
HEPSERA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		TREATMENT CONSIDERATION IS BASED ON HBEAG, HBV DNA QUANTITY, AND ALT LEVEL	PRESCRIPTION MUST BE WRITTEN BY A GASTROENTEROLOGIST, HEPATOLOGIST, OR INFECTIOUS DISEASE SPECIALIST	1 YEAR	
INCRELEX	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIAGNOSIS		6 MONTHS	



Prior Authorization Criteria

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
INFERGEN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	INTERFERON PRODUCTS USED FOR THE TREATMENT OF HEPATITIS C WILL ONLY BE COVERED WHEN CO-ADMINISTERED WITH RIBAVIRIN. RIBAVIRIN WILL ONLY BE COVERED WHEN CO-ADMINISTERED WITH AN INTERFERON PRODUCT.	PATIENT WEIGHT, GENOTYPE, HCV-RNA QUANTITY AND DATE OF TEST, PRESENCE OF CIRRHOSIS (Y/N), THERAPY NAIVE PATIENT (Y/N), RELAPSER OR NON-RESPONDER (Y/N)	PRESCRIPTION MUST BE WRITTEN BY A GASTROENTEROLOGIST, DERMATOLOGIST, ONCOLOGIST, OR HEPATOLOGIST	INITIAL APPROVAL 12 WEEKS	
INTRALIPID	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					



Prior Authorization Criteria

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
INTRON-A	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					
IRESSA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DOCUMENTED FAILURE WITH ATLEAST ONE CHEMOTHERAPY REGIMEN.	PRESCRIPTION MUST BE WRITTEN BY AN ONCOLOGIST	3 MONTHS AT A TIME	GEFITINIB IS A COVERED BENEFIT WHEN USED AS MONO-THERAPY. IMAGING STUDIES DOCUMENTING DISEASE STABILITY OR REGRESSION ARE REQUIRED AT THE END OF 3 MONTHS.



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Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
KINERET	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.				1 YEAR	RHEUMATOID ARTHRITIS PATIENTS MUST HAVE FAILED A THERAPEUTIC TRIAL OF METHOTREXATE OF ATLEAST 3 MONTHS DURATION OR HAVE HAD INTOLERABLE SIDE EFFECTS OR CONTRAINDICATIONS TO METHOTREXATE.
LIPITOR	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		LDL AND LIPID MEDICATIONS THAT PATIENT HAS TRIED AND FAILED		1 YEAR	



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Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
MYFORTIC	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
NEULASTA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIAGNOSIS AND PRIOR THERAPIES TRIED AND FAILED.		THROUGH CHEMO CYCLE	USE OF NEULASTA IS RESERVED FOR PATIENTS WHO HAVE HAS INTOLERABLE ADVERSE EFFECT(S) TO FILGRASTIM THAT DO NOT CROSS-REACT WITH PEGFILGRSTIM.



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Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
NEUTREXIN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.				21 DAYS	NEUTREXIN (TRIMETREXATE GLUCURONATE FOR INJECTION) MUST BE ADMINISTERED WITH CONCURRENT LEUCOVORIN (LEUCOVORIN PROTECTION) TO AVOID POTENTIALLY SERIOUS OR LIFE-THREATENING TOXICITIES. LEUCOVORIN THERAPY MUST EXTEND FOR 72 HOURS PAST THE LAST DOSE OF NEUTREXIN.
NEXAVAR	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIAGNOSIS AND PRIOR TREATMENT HISTORY	PRESCRIPTION MUST BE WRITTEN BY AN ONCOLOGIST.	3 MONTHS	FAX MEDICATION EXCEPTION REPORT FORM TO PLAN FOR CASE MANAGEMENT AT (313) 664-8195.



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NORDITROPIN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIAGNOSIS. THE GROWTH CHART WITH HEIGHT AND WEIGHT PLOTTED FOR AT LEAST 6 MONTHS WITH HEIGHTS AND WEIGHTS USED TO PLOT THE GROWTH CHART AS WELL AS THE FOLLOWING LAB VALUES - A. GH LEVEL B. IGF-1. C. IGF-BP LEVEL, SUBMIT NORMAL RANGE FOR LAB ASSAY.	PRESCRIPTION MUST BE WRITTEN BY AN ENDOCRINOLOGIST OR NEPHROLOGIST	6 MONTHS (AIDS-RELATED CACHEXIA), 1 YEAR (GROWTH HORMONE DEFICIENCY)	



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NUTROPIN ; NUTROPIN AQ	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIAGNOSIS. THE GROWTH CHART WITH HEIGHT AND WEIGHT PLOTTED FOR AT LEAST 6 MONTHS WITH HEIGHTS AND WEIGHTS USED TO PLOT THE GROWTH CHART AS WELL AS THE FOLLOWING LAB VALUES - A. GH LEVEL B. IGF-1. C. IGF-BP LEVEL, SUBMIT NORMAL RANGE FOR LAB ASSAY.	PRESCRIPTION MUST BE WRITTEN BY AN ENDOCRINOLOGIST OR NEPHROLOGIST	6 MONTHS (AIDS-RELATED CACHEXIA), 1 YEAR (GROWTH HORMONE DEFICIENCY)	
ONDANSETRON HCL	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					



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Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
ORENCIA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			PRESCRIPTION MUST BE WRITTEN BY A RHEUMATOLOGIST	1 YEAR	
ORFADIN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIAGNOSIS		6 MONTHS	
PANRETIN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NOT INDICATED WHEN SYSTEMIC ANTI-KS THERAPY IS REQUIRED.			6 MONTHS	



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Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
PEGASYS	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		INDICATE WHETHER GENOTYPE 1,2, OR 3 AND HCV-RNA FOR HEPATITIS C PATIENTS. CONSIDERATION FOR HEPATITIS B PATIENTS IS BASED ON THE HBEAG STATUS, HBV DNA QUANTITY, AND ALT LEVEL.	PRESCRIPTION MUST BE WRITTEN BY A GASTROENTEROLOGIST, DERMATOLOGIST, ONCOLOGIST, OR HEPATOLOGIST	1 YEAR FOR INDICATIONS OTHER THAN HEPC, HEP C INITIAL APPROVAL 12 WEEKS	INTERFERON PRODUCTS WHEN USED FOR THE TREATMENT OF HEPATITIS C ARE COVERED ONLY WHEN CO-ADMINISTERED WITH RIBAVIRIN.
PEG-INTRON	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					
PREMASOL	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					



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PRISTIQ	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		OTHER ANTIDEPRESSANT TRIED AND FAILED.		1 YEAR	
PROCRIT	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	EPOETIN ALFA IS NOT A COVERED BENEFIT FOR PATIENTS WITH UNCONTROLLED HYPERTENSION OR PATIENTS WITH SOLID OR NON-MYELOID HEMATOLOGICAL MALIGNANCIES WHO ARE ACTIVELY RECEIVING MYELOSUPPRESSIVE CHEMOTHERAPY AND/OR RADIATION	DIAGNOSIS, HGB / HCT, IF ANEMIA IS DUE TO MYELOSUPPRESSIVE ANTICANCER CHEMOTHERAPY, LIST CHEMOTHERAPY REGIMEN AND DATES. DOCUMENTATION OF ADEQUATE IRON STORES		1 YEAR	FOR AZT-INDUCED ANEMIA AND CKD INCLUDING ESRD TARGET HGB LESS THAN OR EQUAL TO 12G/DL. FOR ONCOLOGY PATIENTS RECEIVING MYELOSUPPRESSIVE CHEMOTHERAPY, HGB MUST BE LESS THAN 10G/DL AT THE START OF EPO THERAPY AND MUST NOT EXCEED 12G/DL.



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PROGRAF	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
RAPAMUNE	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					



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RAPTIVA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIAGNOSIS, PRIOR TREATMENTS, AND AFFECTED BODY SURFACE AREA	PRESCRIPTION MUST BE WRITTEN BY A RHEUMATOLOGIST OR DERMATOLOGIST	3 MONTHS	GREATER THAN 10% OF BODY SURFACE AREA NEEDS TO BE COVERED AND THE PATIENT HAS TO HAVE HAD LESS THAN 50% OF AFFECTED BODY SURFACE AREA CLEARED WITH ATLEAST ONE 30 TREATMENT COURSE OF PHOTOCHEMOTHERAPY: PSORALAN PLUS ULTRAVIOLET A (PUVA) OR PHOTOTHERAPY ULTRAVIOLET B (UVB).



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REBETOL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					
RECOMBIVAX HB	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
REMICADE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIAGNOSIS, PRIOR TREATMENTS, AND AFFECTED BODY SURFACE AREA IF USING FOR PLAQUE PSORIASIS	PRESCRIPTION MUST BE WRITTEN BY A RHEUMATOLOGIST, GASTROENTEROLOGIST, OR DERMATOLOGIST	1 YEAR (RA), 3 MONTHS FOR PLAQUE PSORIASIS EXTENDED AN ADDITIONAL 9 MONTHS BASED UPON RESPONSE	



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REMODULIN	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
RIBAPAK	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					
RIBASPHERE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					
RIBATAB	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					



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RIBAVIRIN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					
SPRYCEL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		CYTOGENETIC TEST RESULTS	PRESCRIPTION MUST BE WRITTEN BY AN ONCOLOGIST	6 MONTHS AT A TIME	
SUTENT	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		IMAGING STUDY REPORTS AND FAILURE OF GLEEVEC (GIST) OR FAILURE OF CYTOKINE-BASED THERAPY (RCC)		12 WEEKS (GIST), 6 MONTHS (RCC)	GIST PATIENTS REQUIRE A FOLLOW-UP CT SCAN BETWEEN 8 AND 12 WEEKS.
SYMLIN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	GASTROPARESIS OR USE OF DRUGS TO STIMULATE GASTROINTESTINAL MOTILITY.	HBA1C AND CURRENT DIABETES MEDICATIONS	PRESCRIPTION MUST BE WRITTEN BY AN ENDOCRINOLOGIST.	1 YEAR	



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Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
SYNAGIS	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		GESTATIONAL AGE, CHRONOLOGICAL AGE, RISK FACTORS FOR RSV AS DEFINED BY THE AAP		RSV SEASON (NOVEMBER THROUGH APRIL)	
TARCEVA	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ERLOTINIB IS NOT A COVERED BENEFIT WHEN CO-ADMINISTERED WITH GEFITINIB OR OTHER PLATINUM BASED CHEMOTHERAPY.	IMAGING STUDY REPORTS	PRESCRIPTION MUST BE WRITTEN BY AN ONCOLOGIST	6 MONTHS AT A TIME	FOR TREATMENT OF NSCLC, PATIENT MUST HAVE DOCUMENTED FAILURE WITH AT LEAST ONE CHEMOTHERAPY REGIMEN.
TRACLEER	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		MEAN PULMONARY ARTERY PRESSURE DETERMINED THROUGH RIGHT HEART CATHETERIZATION	PRESCRIPTION MUST BE WRITTEN BY A PULMONOLOGIST SPECIALIZING IN PAH	1 YEAR	



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Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
TRAVASOL	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
TRELSTAR DEPOT ; TRELSTAR LA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIAGNOSIS	PRESCRIPTION MUST BE WRITTEN BY AN ONCOLOGIST.	6 MONTHS AT A TIME	
TROPHAMINE	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					



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Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
TYKERB	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIAGNOSIS OF HER2 ADVANCED METASTATIC BREAST CANCER, PRIOR THERAPIES TRIED AND FAILED, IMAGING STUDY REPORTS	PRESCRIPTION MUST BE WRITTEN BY AN ONCOLOGIST	6 MONTHS AT A TIME	PATIENT MUST BE USING XELODA CONCOMITANTLY
TYZEKA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		TREATMENT CONSIDERATION IS BASED ON HBEAG, HBV DNA QUANTITY, AND ALT LEVEL	PRESCRIPTION MUST BE WRITTEN BY A GASTROENTEROLOGIST, HEPATOLOGIST, OR INFECTIOUS DISEASE SPECIALIST	1 YEAR	
VAQTA	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					



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Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
VINCASAR PFS	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
VINCRISTINE SULFATE	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
VIRAZOLE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					



Prior Authorization Criteria

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
XOLAIR	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	PATIENT MUST BE A NON-SMOKER.	PATIENT WEIGHT, SERUM IGE CONCENTRATION, ALLERGEN TEST, BASELINE FEV1, FEV1 FOLLOWING BRONCHODILATOR, ASTHMA MEDICAL HISTORY (INCLUDING MEDICATIONS, EMERGENCY DEPARTMENT VISITS, AND HOSPITALIZATIONS)		INITIAL FILL FOR 3 MONTHS, 1 YEAR THEREAFTER	
ZAVESCA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIAGNOSIS AND REASON WHY (ERT) WOULD NOT BE APPROPRIATE.		1 YEAR	USE OF ZAVESCA IS RESERVED FOR THOSE WHOM ENZYME REPLACEMENT THERAPY (ERT) IS NOT AN OPTION.



Prior Authorization Criteria

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Prescriber Restrictions	Coverage Duration	Other Criteria
ZENAPAX	THIS DRUG MAY QUALIFY FOR COVERAGE UNDER PART B; INFORMATION MAY BE REQUIRED TO MAKE AN INITIAL PART B VS. D DETERMINATION.					
ZYVOX	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		CULTURES AND SENSITIVITIES, OTHER ANTIBIOTIC TRIALS / FAILURES		28 DAYS	