

Prior Authorization Group Description	Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ADAGEN	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	
AMEVIVE	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).
AMITIZA	AMITIZA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		MEDICATIONS TRIED AND FAILED FOR CONSTIPATION			1 YEAR	
AMPYRA	AMPYRA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	AMPYRA IS NOT A COVERED BENEFIT FOR PATIENTS WITH SEIZURE DISORDERS.	EXPANDED DISABILITY SCALE SCORE, BASELINE 25 FOOT WALK, CREATININE CLEARANCE.		PRESCRIPTION MUST BE WRITTEN BY A NEUROLOGIST	INITIAL AUTHORIZATION FOR 12 WEEKS, 6 MONTHS THEREAFTER	PATIENT MUST BE AMBULATORY.
ARANESP	ARANESP	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		MEDICAL CONDITION ASSOCIATED WITH ANEMIA, HEMOGLOBIN AND HEMACRIT LEVELS			6 MONTHS (CHEMOTHERAPY), 1 YEAR (RENAL FAILURE)	
ARIXTRA	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	
AVONEX	AVONEX	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.				PRESCRIPTION MUST BE WRITTEN BY A NEUROLOGIST	1 YEAR	
BETASERON	BETASERON	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.				PRESCRIPTION MUST BE WRITTEN BY A NEUROLOGIST	1 YEAR	
BVD ADMIN ONLY	ABELCET ACYCLOVIR SODIUM ADRIAMYCIN AMBISOME AMPHOTEC AMPHOTERICIN B ANZEMET ATTENUVAX VACCINE WITH DILUENT AZATHIOPRINE AZATHIOPRINE SODIUM BLEOMYCIN SULFATE CELLCEPT CLADRIBINE CYCLOPHOSPHAMIDE CYCLOSPORINE CYCLOSPORINE MODIFIED CYTARABINE CYTOVENE DOXORUBICIN HCL EMEND ENGERIX-B FLUOROURACIL GAMMAGARD LIQUID GAMUNEX GENGRAF GRANISETRON HCL HAVRIX HERCEPTIN MYCOPHENOLATE MOFETIL MYFORTIC ONDANSETRON HCL ONDANSETRON ODT PROGRAF RAPAMUNE RECOMBIVAX HB REMODULIN TACROLIMUS TETANUS TOXOID ADSORBED VINCRISTINE SULFATE ZENAPAX	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
BYETTA	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	
CEREDASE	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	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	
COPAXONE	COPAXONE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.				PRESCRIPTION MUST BE WRITTEN BY A NEUROLOGIST	1 YEAR	
ENBREL	ENBREL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.				PRESCRIPTION MUST BE WRITTEN BY A RHEUMATOLOGIST OR DERMATOLOGIST	1 YEAR	
EPOGEN / PROCRIT	EPOGEN 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.
FABRAZYME	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	

Prior Authorization Group Description	Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
GLEEVEC	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.
GROWTH HORMONE	NORDITROPIN NORDIFLEX 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)	
HEPATITIS B TREATMENT - BARACLUDE, EPIVIR-HBV, HEPSERA, TYZEKA	BARACLUDE HEPSERA 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	
HEPATITIS C TREATMENT - INTRON A, INFERGEN, PEG-INTRON, RIBAVIRIN, ROFERON-A	INFERGEN INTRON A PEGINTRON PEGINTRON REDIPEN REBETOL RIBAPAK RIBASPHERE RIBAVIRIN VIRAZOLE	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	
INCRELEX	INCRELEX	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIAGNOSIS			6 MONTHS	
IRESSA	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.
KINERET	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.
NEULASTA	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.
NEXAVAR	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 248-443-8855.
ORENCIA	ORENCIA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.				PRESCRIPTION MUST BE WRITTEN BY A RHEUMATOLOGIST	1 YEAR	
ORFADIN	ORFADIN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIAGNOSIS			6 MONTHS	
PANRETIN	PANRETIN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NOT INDICATED WHEN SYSTEMIC ANTI-KS THERAPY IS REQUIRED.				6 MONTHS	
PEGASYS	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 HEP C INITIAL APPROVAL 12 WEEKS	INTERFERON PRODUCTS WHEN USED FOR THE TREATMENT OF HEPATITIS C ARE COVERED ONLY WHEN CO-ADMINISTERED WITH RIBAVIRIN.
PRISTIQ	PRISTIQ	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		OTHER ANTIDEPRESSANT TRIED AND FAILED.			1 YEAR	
REMICADE	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	
SPRYCEL	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	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	SYMLIN SYMLINPEN 120 SYMLINPEN 60	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	

Prior Authorization Group Description	Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SYNAGIS	SYNAGIS	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		GESTATIONAL AGE, CHRONOLOGICAL AGE, RISK FACTORS FOR RSV AS DEFINED BY THE AAP	UP TO 24 MONTHS DEPENDING ON RISK FACTORS		RSV SEASON (NOVEMBER THROUGH APRIL)	
TARCEVA	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	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	
TRELSTAR DEPOT, TRELSTAR LA	TRELSTAR	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIAGNOSIS		PRESCRIPTION MUST BE WRITTEN BY AN ONCOLOGIST.	6 MONTHS AT A TIME	
TYKERB	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
XOLAIR	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	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.
ZYVOX	ZYVOX	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		CULTURES AND SENSITIVITIES, OTHER ANTIBIOTIC TRIALS / FAILURES			28 DAYS	