

**Unison Advantage® (HMO)**

**Dual SNP Plans:**

Unison Advantage® Plus (HMO)  
 Unison Advantage® Plus Integrated Care (HMO)



**PrescriptionSolutions®**

A UnitedHealth Group Company

**PRIOR AUTHORIZATION CRITERIA – Formulary 4**

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Abilify Disc Tablet	All FDA-approved indications not otherwise excluded from Part D		Patients must have a chart documented compliance issue (ex: cheeking traditional dosage forms) OR chart documentation of difficulty or inability to swallow traditional dosage forms.			1 year	Approve for continuation of prior therapy.
Abilify Injection	All FDA-approved indications not otherwise excluded from Part D		Patients must have a chart documented compliance issue (ex: cheeking traditional dosage forms) OR chart documentation of difficulty or inability to swallow traditional dosage forms.			1 year	Approve for continuation of prior therapy.
Abraxane	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED				Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.

*The federal government has approved Unison Advantage® Plus (HMO) or Unison Advantage® Plus Integrated Care (HMO) as a Special Needs Plan for people with Medicare (Parts A and B) and Medicaid.*

**Unison Advantage® (HMO)**



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	BY THE STATUTORY PART D COMPENDIA.						
Actimmune	All FDA-approved indications not otherwise excluded from Part D	NON COVERAGE Actimmune is NOT covered for members with the following criteria: A. Hypersensitivity to E.Coli derived products and/or interferon gamma.	Actimmune is covered for members who meet the following criteria: A. Documented Chronic Granulomatous Disease or Severe Malignant Osteopetrosis B. AND have had CBC, differential, and platelet counts to illustrate Hepatic levels WNL. Tests need to be administered in three month intervals to avoid hepatic toxicity C. AND no history of myelosuppression.			3 months	
Adagen	All FDA-approved indications not otherwise excluded from Part D	NON COVERAGE Adagen is NOT covered for members with the following criteria: A. Immunodeficiencies that do not have an association with adenosine deaminase B. Patient has diagnosis of severe thrombocytopeni			Prescribed by an Endocrinologist	Length of therapy	

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		a C. Use for preparatory or support therapy for bone marrow transplantation					
Adderall XR	All FDA-approved indications not otherwise excluded from Part D					All uses: 1 year	
Afinitor	All FDA-approved indications not otherwise excluded from Part D				Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.
Aldara	All FDA-approved indications not otherwise excluded from Part D			Patients should be at least 12 years of age.		Requests will be approved as requested by prescriber up to 16 weeks.	

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Aldurazyme	All FDA-approved indications not otherwise excluded from Part D	<p>NON COVERAGE</p> <p>Aldurazyme is NOT covered for members with the following criteria:</p> <p>A. The diagnosis is NOT documented as Hurler syndrome, Hurler-Scheie syndrome or Scheie syndrome.</p> <p>B. If the diagnosis is Scheie syndrome and they do not have at least two mild-to-moderate severe symptoms.</p> <p>C. If the diagnosis has NOT been confirmed by diagnostic method or antenatal diagnosis.</p> <p>D. If the patient has previously received at least 26 weeks of Aldurazyme therapy and they have not shown an Improvement in lung function [FVC].</p>	<p>Aldurazyme is covered for members who meet the following criteria: A. Diagnosis is documented as Hurler syndrome (MPS 1H) or Hurler-Scheie syndrome (MPS IS). B. OR the diagnosis is documented as Scheie syndrome (MPS IS). " AND the patient has at least two of the listed moderate-to-severe symptoms. Impaired vision, Recurrent otitis media, Recurrent sinopulmonary infections, Impaired hearing, Upper airway obstruction, Malaise and reduced endurance, Corneal clouding, Macrocephaly Reduced joint range of motion, Progressively coarse facial features, Coarse facial features, Umbilical and inguinal hernias, Carpal tunnel syndrome, Delayed or regressed mental development, Hepatosplenomegaly, Cardiac abnormalities and valvular disease, Communicating hydrocephalus, Spinal cord compression, Sleep apnea, Short stature, Reduced pulmonary function, Bone deformities</p> <p>C. AND diagnosis has been confirmed by diagnostic method (measurement of alpha-iduronidase activity) or antenatal diagnosis (enzymatic assay). D. AND if the patient has previously received at least 26 weeks of Aldurazyme therapy, they must show an improvement in lung function (forced vital capacity [FVC] from when therapy was started</p>		Prescribed by an Endocrinologist	Length of therapy	
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Alimta	All FDA-approved indications not otherwise excluded from Part D.		Malignant Pleural Mesothelioma: Disease is unresectable or patient is not a candidate for curative surgery. Used in combination with cisplatin. Non-Small Cell Lung Cancer: Confirmed diagnosis of locally advanced or metastatic nonsquamous NSCLC. Prior history of first-line chemotherapy treatment for NSCLC or used in combination with cisplatin.			MPM, NSCLC: Length of Therapy	Approve for continuation of prior therapy.
Amnesteem	All FDA-approved indications not otherwise excluded from Part D. Isotretinoin is indicated for the treatment of severe nodular acne that is unresponsive to conventional therapy.	Contraindicated if Pregnant. Non-FDA approved or not medically accepted uses.	Because of safety concerns, Isotretinoin is not recommended as a first line agent for the treatment of acne and is used for a short duration. Patient must have a diagnosis of severe (recalcitrant) nodular acne. Documentation that previous treatment attempts with incomplete success must be reported. Patient must have documented failures to a minimum of two of the following formulary medications: Topical antibiotics, Topical retinoids, Tetracycline, Minocycline, Doxycycline, Erythromycin or Cephalexin Requests for Renewal: Documentation that the patient has been off of therapy for at least 8 weeks after a 20 week treatment course with isotretinoin. Confirmation that the patient's acne improved while on isotretinoin is required. The patient must have received less than 10 months of therapy previously.			Initial: 5 months Renewal: 5 months (not to exceed 10 months of therapy total)	
Amphetamine	All FDA-approved indications not otherwise excluded from Part D					All uses: 1 year	

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Ampyra Effective 6/1/2010	All FDA approved indications not otherwise excluded from Part D		<p><b>Initial Therapy for Multiple Sclerosis:</b> 1. Diagnosis of multiple sclerosis. 2. Physician confirmation that patient has difficulty walking.</p> <p><b>Reauthorization for Multiple Sclerosis:</b> Physician confirmation that the patient's walking improved with Ampyra therapy.</p>			<p><b>Initial Therapy:</b> 3 months.</p> <p><b>Re-authorization:</b> 1 year.</p>	
Anadrol-50	All FDA-approved indications not otherwise excluded from Part D		Acquired Aplastic Anemia: History of failure, or used in combination with, antilymphocyte globulin or both antilymphocyte globulin and corticosteroid treatment. Hypoplastic Anemia: Diagnosis of hypoplastic anemia due to myelotoxic drugs. Failure to an erythropoietic stimulating agent. Pure Red Cell Aplasia: Failure to immunosuppressive therapy. Chronic Renal Failure: Failure to an erythropoietic stimulating agent.			All uses: 12 months. Except Hypoplastic Anemia: Length of therapy.	
Apokyn	All FDA-approved indications not otherwise excluded from Part D.		Advanced Parkinson's Disease: Confirmed diagnosis of advanced Parkinson's disease. Unable to control "off" symptoms with adequate combinations of conventional oral therapy. Used in combination with a non-5-HT3 antagonist antiemetic for initial therapy. Not used in combination with 5-HT3 antagonists.			PD: 1 year	Apokyn will only be approved for intermittent subcutaneous injection.
Aralast	All FDA-approved indications not otherwise excluded from Part D					1 year	Approve for continuation of prior therapy.

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Aranesp	All FDA-approved indications not otherwise excluded from Part D.	Anemia Due to Chronic Renal Failure: Patient is on dialysis (covered under Part B). Anemia in cancer patients on chemotherapy: Patient is not receiving cancer chemotherapy or patient has malignancy for which therapy with Aranesp is contraindicated. For other off-label requests: Hgb greater than 10 g/dL or Hct greater than 30%	Anemia Due to Chronic Renal Failure (Initial): Hct less than 33% or Hgb less than 11 gm/dl. Verification of iron evaluation for adequate iron stores. CRF (Reauthorization): Verification that average Hct was below 36% over a 3-month period. Verification of iron evaluation for adequate iron stores. One of the following: Hct reached target range (30% to 36%), decrease in blood transfusion, or Hgb is 1 g/dL or greater from pre-treatment level. Anemia in cancer patients on chemotherapy (Initial): Verification that other causes of anemia have been ruled out. Verification of iron evaluation for adequate iron stores. Hct less than 30% or Hgb less than 10 gm/dl. Verification that the cancer is a non-myeloid malignancy. Verification that the patient is concurrently on chemotherapy, will be on concomitant chemotherapy for 2 months, or that the anemia is caused by cancer chemotherapy. Chemotherapy (Reauthorization): Hct less than 36% or Hgb less than 12 gm/dl. Hct reached target range (30% to 36%), decrease in blood transfusion, or Hgb is 1 g/dL or greater from pre-treatment level. Verification that the patient is concurrently on chemotherapy, will be on concomitant chemotherapy for 2 months, or that the anemia is caused by cancer chemotherapy. Refractory anemia in Myelodysplastic Syndrome (Initial): Hct less than 33% or Hgb less than 11 g/dL. Serum erythropoietin of 500 mU/mL or less, or diagnosis of transfusion-dependent MDS. Verification of adequate iron stores. MDS (Reauthorization): Verification that average Hct			Chemo, MDS (Initial): 3 mo. CRF (Initial): 6 mo. CRF (Reauth), MDS (Reauth):12 mo.	Subject to Part B vs. Part D review. Chemotherapy-Induced Anemia: Hb/Hct levels collected within prior two weeks of request. All other uses Hb/Hct levels collected within prior 30 days of request.

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			was below 36% over a 3 month period. One of the following: verification that Hct reached target (30% to 36%), or decrease in blood transfusion, or Hgb increase 1 g/dL or more from pre-treatment level.				
Arcalyst	All FDA-approved indications not otherwise excluded from Part D.			12 years and older		Indefinite, long term therapy (open-ended).	
Arixtra	All FDA-approved indications not otherwise excluded from Part D					Length of therapy	
Arranon	All FDA-approved indications not otherwise excluded from Part D		If drug requested is limited as a second line agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent.		Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.
Arzerra Effective 3/1/2010	All FDA-approved indications not otherwise excluded from Part D		Confirmed diagnosis of chronic lymphocytic leukemia (CLL). Refractory to both Campath and Fludara, or relapsed or refractory to two first-line CLL regimens containing Campath, Treanda, Leukeran, Cytoxan, Fludara, Nipen, or Rituxan			24 weeks	Prior authorization applies to new starts only
Avastin	All FDA-approved indications not otherwise excluded from	Non-Small Cell Lung Cancer: Squamous cell histology. History of hemoptysis.	Colorectal Cancer: Diagnosis of metastatic colorectal cancer. Used in combination with 5-FU, or oxaliplatin plus capecitabine, or capecitabine. Non-Small Cell Lung Cancer: Diagnosis of unresectable locally advanced		Renal Cell Cancer, Breast Cancer: Prescribed by or in consultation	Colorectal Cancer, NSCLC, Renal Cell Cancer, Breast Cancer, ARMD:	Approve for continuation of prior therapy.

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	Part D.	CNS metastases. On-going therapeutic anticoagulation.	recurrent or metastatic NSCLC. Used in combination with paclitaxel and carboplatin. Renal Cell Cancer: Diagnosis of metastatic renal cell cancer. Used in combination with interferon-alpha or refractory to either interferon alpha or interleukin-2. Breast Cancer: Diagnosis of metastatic breast cancer. Used in combination with paclitaxel. Age-related Macular Degeneration: Failure to FDA-approved therapies or likely to have greater benefit from the use of intravitreal bevacizumab.		with an oncologist. ARMD: Prescribed or recommended by retina specialist	Length of therapy.	
Avonex	All FDA-approved indications not otherwise excluded from Part D.		Relapsing MS: Recent history of a first clinical demyelinating event. MRI-detected brain lesions consistent with MS.			Relapsing MS: 1 year.	
Banzel	All FDA-approved indications not otherwise excluded from Part D		Patient must be using as adjunctive therapy for Lennox-Gastaut syndrome and have had an inadequate response or intolerance to a minimum of 2 formulary agents. Formulary agents include lamotrigine, topiramate, felbamate, clonazepam.			1 year	Approve for continuation of prior therapy.
Betaseron	All FDA-approved indications not otherwise excluded from Part D.		Relapsing MS: Patients with relapsing form of MS or patients with secondary progressive MS who continue to experience relapses.			Relapsing MS: 1 year.	

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BiCNU	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.		If drug requested is limited as a second line agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent.		Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.
Botox Effective 7/12/10	All FDA approved indications not otherwise excluded from Part D		<p><b>Initial Therapy for Primary Axillary Hyperhidrosis:</b></p> <ol style="list-style-type: none"> <li>History of failure to topical prescription strength drying agents; AND</li> <li>One of the following:                             <ol style="list-style-type: none"> <li>Score of 3 or 4 on the Hyperhidrosis Disease Severity Scale (HDSS); OR</li> <li>Skin maceration with secondary infection.</li> </ol> </li> </ol> <p><b>Reauthorization for Hyperhidrosis:</b> At least a 2-point improvement in HDSS.</p> <p><b>Initial Therapy for Migraine:</b></p> <ol style="list-style-type: none"> <li>Failure or contraindication to 5-HT1 agonists; AND</li> <li>At least two prophylactic therapies for migraine; AND</li> <li>Submission of chart documentation documenting complete evaluation of the patient.</li> </ol>	<b>VII cranial nerve disorders:</b> ≥ 12 years of age	<p><b>Initial therapy for Migraine :</b> Prescribed by a neurologist or pain specialist.</p> <p><b>Initial Therapy for Chronic Back Pain:</b> Prescribed by a neurologist, neuro-surgeon, orthopedist, or pain specialist.</p>	<p><b>Hyperhidrosis:</b> One prescription</p> <p><b>Back Pain:</b> One treatment (may be reauthorized for a maximum of two treatments per year).</p> <p><b>Other uses:</b> 6 months</p>	

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			<p><b>Reauthorization for Migraine:</b></p> <ol style="list-style-type: none"> <li>1. Reduction in headache frequency; AND</li> <li>2. Submission of chart notes documenting decreased utilization of pain medications or triptans, or a reduction in the number of emergency room visits.</li> </ol> <p><b>Initial Therapy for Achalasia:</b></p> <ol style="list-style-type: none"> <li>1. High risk of complication from pneumatic dilation or surgical myotomy; OR</li> <li>2. Failure to prior pneumatic dilation or surgical myotomy; OR</li> <li>3. Prior dilation caused esophageal perforation; OR</li> <li>4. Patient has an epiphrenic diverticulum or hiatal hernia.</li> </ol> <p><b>Reauthorization for Achalasia:</b></p> <ol style="list-style-type: none"> <li>1. Documentation of improvement or reduction in symptoms of achalasia.</li> </ol> <p><b>Initial Therapy for Anal Fissure:</b></p> <ol style="list-style-type: none"> <li>1. Failure of two conventional therapies.</li> </ol> <p><b>Reauthorization for Anal Fissure:</b></p> <ol style="list-style-type: none"> <li>1. Incomplete healing of fissure or recurrence of fissure; AND</li> <li>2. Improved symptoms with prior treatment with Botox.</li> </ol> <p><b>Initial Therapy for Chronic Back Pain:</b></p> <ol style="list-style-type: none"> <li>1. Confirmed history of persistent low back pain &gt; 6 months duration; AND</li> <li>2. Failure to NSAIDs and opioids.</li> </ol>				

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			<p><b>Reauthorization for Back Pain:</b> Confirmed improvement in symptoms with initial Botox treatment.</p> <p><b>Initial Therapy for Urinary Incontinence:</b> 1. Failure to two oral anticholinergic agents; AND 2. One of the following conditions: a. Detrusor sphincter dyssynergia; OR b. Neurogenic detrusor overactivity</p> <p><b>Reauthorization for Urinary Incontinence:</b> 1. Confirmed improvement in symptoms with initial Botox treatment; AND 2. At least 6 months has elapsed since the last Botox treatment.</p>				
Buphenyl	All FDA-approved indications not otherwise excluded from Part D.	NON COVERAGE Buphenyl is NOT covered for members with the following criteria: A. To treat hyperammonemia	Buphenyl is covered for members who meet the following criteria: A. Buphenyl is used to treat urea cycle disorders diagnosed by FDA approved indications as stated in covered uses.		Prescribed by an Endocrinologist	Requests will be approved as requested by prescriber up to 1 year	
Byetta	All FDA-approved indications not otherwise excluded from Part D	NON COVERAGE Byetta is NOT covered for members who meet the following criteria: A. The patient has NOT been	Byetta is indicated as adjunctive therapy to improve glycemic control in patients with type 2 diabetes mellitus who are taking metformin, a sulfonylurea, or a combination of metformin and a sulfonylurea or a thiazolidinedione, but who have not achieved adequate glycemic control. The patient must have failed to achieve adequate glycemic control despite previous therapies including: Minimum dose of			1 year	

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		diagnosed as having type-2 diabetes. B. The patient's current drug therapy does NOT include metformin (eg. Metformin, Metformin ER, Avandimet, or ActoPlus Met) and therapy has NOT been escalated to the highest tolerated dose. OR if the patient is unable to take metformin due to clinical contraindications they have NOT substituted the metformin requirement with a maximum tolerated dose of a sulfonylurea (chlorpropamide, tolazamide, glipizide, glimepiride, or glyburide) or thiazolidinedione (Avandia or Actos) OR the	metformin of at least 1500 mg daily AND Maximum tolerated dose of a sulfonylurea OR Maximum tolerated dose of a thiazolidinedione (Minimum requirement of 90 days of therapy required in order to evaluate clinical response) For renewal, the patient must have shown a clinical improvement to therapy based upon new HbA1c value and has not started on insulin therapy.				

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		patient is unable to take a TZD due to contraindications. C. Current use of insulin. D. Non-FDA approved or not medically accepted uses.					
Campath	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.		If drug requested is limited as a second line agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent.		Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.
Cancidas	All FDA-approved indications not otherwise excluded from Part D		Patient has had a trial and failure or is intolerant to fluconazole if appropriate for diagnosis.			Length of therapy	
Cerezyme	FDA-APPROVED INDICATIONS Cerezyme (imiglurase) is	NON COVERAGE Cerezyme is NOT covered for members with the	Clinical information to support request including diagnosis (confirmed by bone marrow histology, DNA testing or measurement of enzyme activity), labwork, medication, strength, directions and duration requested. List of		Prescribed by an Endocrinologist	1 year	

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	indicated: A. For long-term enzyme replacement therapy for pediatric and adult patients with a confirmed diagnosis of type-1 Gaucher disease that results in one or more of the following conditions: Anemia, thrombocytopenia, bone disease, hepatomegaly or splenomegaly.	following criteria: A. The patient does not have at least one of the following conditions: Anemia, thrombocytopenia, bone disease, hepatomegaly or splenomegaly. B. If the patient has previously received 24 months of Cerezyme therapy and they have NOT shown a decrease in liver and spleen volume and/or increases in platelet count and/or increases in hemoglobin concentration since starting therapy.	medications that were previously used for this indication including dose, duration and outcome.				
Chorionic Gonadotropin	All FDA-approved indications not otherwise excluded from Part D	NON COVERAGE Novarel is NOT covered for members of the following criteria: A. The member is				Requests will be approved as requested by prescriber up to 1 year	

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		female B. If the patient does NOT have a diagnosis of prepubertal cryptorchidism not due to anatomic obstruction or hypogonadism secondary to a pituitary deficiency.					
Claravis	All FDA-approved indications not otherwise excluded from Part D. Isotretinoin is indicated for the treatment of severe nodular acne that is unresponsive to conventional therapy.	Contraindicated if Pregnant. Non-FDA approved or not medically accepted uses.	Because of safety concerns, Isotretinoin is not recommended as a first line agent for the treatment of acne and is used for a short duration. Patient must have a diagnosis of severe (recalcitrant) nodular acne. Documentation that previous treatment attempts with incomplete success must be reported. Patient must have documented failures to a minimum of two of the following formulary medications: Topical antibiotics, Topical retinoids AND At least one of the following oral formulary medications: Tetracycline, minocycline, doxycycline, erythromycin or cephalexin Requests for Renewal: Documentation that the patient has been off of therapy for at least 8 weeks after a 20 week treatment course with isotretinoin. Confirmation that the patient's acne improved while on isotretinoin is required. The patient must have received less than 10 months of therapy previously.			Initial: 5 months Renewal: 5 months (not to exceed 10 months of therapy total)	
Concerta	All FDA-approved					All uses: 1 year	

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	indications not otherwise excluded from Part D						
Copaxone	All FDA-approved indications not otherwise excluded from Part D.		Relapsing-remitting form of multiple sclerosis: For patients with relapsing-remitting form of multiple sclerosis.			RRMS: 1 year.	
Cosmegen	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.		If drug requested is limited as a second line agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent (carboplatin and paclitaxel or carboplatin and docetaxel).		Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.
Cystadane	All FDA-approved indications not otherwise excluded from					Requests will be approved as requested by prescriber up to 1 year	

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	Part D						
Cystagon	All FDA-approved indications not otherwise excluded from Part D					Requests will be approved as requested by prescriber up to 1 year	
Dextroamphetamine	All FDA-approved indications not otherwise excluded from Part D					All uses: 1 year	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Dronabinol	All FDA-approved indications not otherwise excluded from Part D.		Nausea and Vomiting Associated with Cancer Chemotherapy (CINV): Patient is receiving cancer chemotherapy. Failure to 5HT-3 receptor antagonist. Failure to one of the following agents: antihistamine, corticosteroid, prokinetic agent, antipsychotic. AIDS anorexia: Diagnosis of anorexia with weight loss in patients with AIDS.			CINV: 6 months. AIDS anorexia: Length of therapy.	Subject to Part B vs. Part D review. CINV: Approve for continuation of therapy for treatment covered under Part B when patient is receiving chemotherapy.
Elaprase	All FDA-approved indications not otherwise excluded from Part D					Requests will be approved as requested by prescriber up to 1 year	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Elitek	All FDA-approved indications not otherwise excluded from Part D				Prescribed by an Oncologist or Hematologist	Requests will be approved as requested by prescriber up to 1 year	
Eloxatin	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.		If drug requested is limited as a second line agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent.		Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.
Enbrel	All FDA-approved indications not otherwise excluded from Part D.		Rheumatoid Arthritis: Dx of mod-to-sev RA. Failed MTX or 2 DMARDs for 3 mo. Juvenile Idiopathic Arthritis: Dx of mod-to-sev polyarticular-course JIA Failed NSAID or steroid and methotrexate for three months. PsA: Dx of active PsA. Failed MTX or 2 DMARDs for 3 mo. Ankylosing Spondylitis: Dx of AS. Failed 2 NSAIDs for 3 mo. Plaque Psoriasis: Dx mod-to-sev chronic (greater than 6 months) plaque psoriasis. Failed phototherapy and systemic therapy with one of the following: MTX, cyclosporine, acitretin, hydroxyurea,	RA, PsA, AS, Plaque Psoriasis: 18 years and older. JIA: 2 years and older.	RA (Initial), JIA (Initial), PsA (Initial), AS (Initial): Prescribed or recommended by a rheumatologist. Plaque Psoriasis (Initial): Prescribed or recommended by a dermatologist.	Initial Auth: 12 months for all except Plaque Psoriasis: 3 mo. Reauth: All uses: 12 mo.	Plaque Psoriasis (Reauth) Enbrel dosage is 50 mg or less per week or less. All diagnoses: Verification that the pt has been evaluated for

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			sulfasalazine, 6-thioguanine, or mycophenolate. Reauthorization: demonstration of clinical response to therapy.				TB and treated accordingly.
Epirubicin	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.		If drug requested is limited as a second line agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent.		Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.
Epoetin alfa	All FDA-approved indications not otherwise excluded from Part D.	Anemia in cancer patients on chemotherapy: Patient is not receiving cancer chemotherapy or patient has malignancy for which therapy with epoetin is contraindicated. CRF: Patient is on dialysis (covered under Part B). For other off-label requests: Hgb greater than 10	Anemia Due to Chronic Renal Failure: Hct less than 33% or Hgb less than 11 gm/dl. CRF (Reauth): Avg Hct was below 36% over 3-mo. 1 of the following: Hct reached target (30% to 36%), decr in blood transfusion, or Hgb is 1 g/dL or greater from pre-tx level. HIV: Anemia is d/t zidovudine tx or d/t HIV infection. Hgb less than 12 g/dL or Hct less than 36%. PtD-HIV (Reauth): Hct was below 36% over 3 mo. 1 of the following: Hct reached target (30% to 36%), decr in blood transfusion, or Hgb is 1 g/dL or greater from pre-tx level. Chemo: Verify other causes of anemia have been ruled out. Hct less than 30% or Hgb less than 10 gm/dl. Cancer is a non-myeloid malignancy. Concurrently on chemo, will be on concomitant chemo for 2 mo or anemia is caused by cancer chemo. Chemo (Reauth): Hct less than 36% or			Pre-op: 1 mo. Chemo, HCV, MDS: 3 mo. HCV (Reauth): 3 mo CRF, HIV: 6 mo Others: 12 mo.	Subject to Part B vs. Part D review. Chemotherapy-Induced Anemia: Hb/Hct levels collected within prior two weeks of request. All other indications: Hb/Hct levels collected within prior 30 days of request.

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		g/dL or Hct greater than 30%	Hgb less than 12 gm/dl. Hct reached target (30% to 36%), decr in blood transfusion, or Hgb is 1 g/dL or greater from pre-tx level. Concurrently on chemo will be on concomitant chemo for 2 mo or anemia is caused by cancer chemo. Pre-op: Hgb greater than 10 to less than 13 g/dL scheduled to undergo elective, non-cardiac/vascular surgery to reduce blood transfusions or at high risk for perioperative transfusions with expected blood loss of 2 units or greater. MDS: Hct less than 33% or Hgb less than 11 g/dL. Serum erythropoietin of 500 mU/mL or less, or dx of transfusion-dependent MDS. MDS (Reauth): Avg Hct was below 36% over a 3 mo. 1 of the following: Hct reached target (30% to 36%), or decr in blood transfusion, or Hgb incr 1 g/dL or more from pre-tx level. HCV: Hgb less than 11 g/dL or Hct less than 33%. Is concurrently on ribavirin and interferon or peg-interferon alfa for the tx of HCV and the anemia is d/t tx. HCV (Reauth): Avg Hct was below 36% over a 3 mo. Hct reached target (30% to 36%), decr in blood transfusion, or Hgb is 1 g/dL or greater from pre-tx level. All uses: Verify Fe evaluation for adequate Fe stores.				
Erbix	All FDA-approved indications not otherwise excluded from Part D.		Head and Neck Cancer: Confirmed diagnosis of locally or regionally advanced squamous cell carcinoma of the head and neck or recurrent or metastatic squamous cell head and neck cancer. Used in combination with radiation therapy, or after failure of platinum-based chemotherapy. Colorectal Cancer: Confirmed diagnosis of metastatic carcinoma of the colon or rectum. Used in combination with irinotecan-			Head and Neck Cancer, Colorectal Cancer: Length of therapy.	Approve for continuation of prior therapy.

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			based chemotherapy or intolerance to irinotecan-based chemotherapy or failure of irinotecan or oxaliplatin-based chemotherapy regimens.				
Exjade	All FDA-approved indications not otherwise excluded from Part D. Exjade is indicated for the treatment of chronic iron toxicity secondary to transfusional iron overload (e.g. due to transfusional hemosiderosis in patients with chronic anemias such as thalassemia and sickle cell anemia)		Exjade is covered for members who meet the following criteria: A. Patient has a diagnosis of transfusion-dependent anemia (-thalassemia, sickle cell disease, Diamond-Blackfan anemia, or myelodysplastic syndrome) and chronic iron overload due to blood transfusions, evidenced by serum ferritin 1,000-8,000ng/mL. B. Patient failed Desferal therapy due to compliance or is unable to use it (documentation of noncompliance, adverse effects, and/or contraindications).		Prescribed by a Hematologist	3 months	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Extavia Effective 3/1/2010	All FDA-approved indications not otherwise excluded from Part D					12 Months	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Fabrazyme	FDA-APPROVED INDICATIONS Fabrazyme is indicated for use in patients with Fabry disease	NON COVERAGE Fabrazyme is NOT covered for members with the following criteria: The diagnosis of Fabry disease has not been confirmed with an enzyme assay measuring the deficient activity of alpha-galactosidase enzyme.	Clinical information to support request including diagnosis, labwork (enzyme assay measuring the deficient activity of alpha-galactosidase enzyme), medication, strength, directions and duration requested. List of medications that were previously used for this indication including dose, duration and outcome.			Requests will be approved as requested by prescriber up to 1 year	
Faslodex	All FDA-approved indications not otherwise excluded from Part D		Diagnosis of hormone receptor positive metastatic breast cancer. Confirmation that patient is post menopausal. Documentation that the patient has had disease progression despite therapy with anastrozole.		Prescribed by an Oncologist	1 year	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Fazaclo	All FDA-approved indications not otherwise excluded from Part D		Patient must be unable to swallow tablets.			1 year	

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Fentanyl Citrate	All FDA-approved indications not otherwise excluded from Part D		Patient is unable to use topical fentanyl agents.			Requests will be approved as requested by prescriber up to 1 year	
Forteo	All FDA-approved indications not otherwise excluded from Part D.	Osteoporosis: History of Paget's disease, bone metastases of skeletal malignancies, radiation therapy, metabolic bone disease other than osteoporosis. Concurrent use of bisphosphonate.	Osteoporosis: BMD T score of -3.0 or less and a previous fracture resulting from minimal trauma, or both of the following: failure to a formulary bisphosphonate and patient has a history of fracture resulting from minimal trauma or BMD T score of -2.5 or less.			Osteoporosis: 2 years.	Subject to Part B vs. Part D review.
Gamastan	All FDA-approved indications not otherwise excluded from Part D		Hepatitis A: For use before or soon after exposure. Measles: For use in susceptible individuals exposed fewer than 6 days previously. Varicella: For use in immunocompromised patients. Rubella: For pregnant women who will not consider a therapeutic abortion.			Hepatitis A, Measles, Varicella, Rubella: Length of therapy.	
Gardasil	All FDA-approved indications not otherwise excluded from Part D	NON COVERAGE for males		Females only, ages 9-26		3 doses over 6 months	
Gemzar	FDA-		If drug requested is limited as a second line		Prescribed by an	Length of	Approve for

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.		agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent.		Oncologist	therapy	continuation of prior therapy.
Geodon Injection	All FDA-approved indications not otherwise excluded from Part D		Patients must have a chart documented compliance issue (ex: cheeking traditional dosage forms) OR chart documentation of difficulty or inability to swallow traditional dosage forms.			1 year	Approve for continuation of prior therapy.
Gleevec	All FDA-approved indications not otherwise excluded from Part D.		Chronic Myeloid Leukemia (Adults): Diagnosis of Philadelphia chromosome positive CML. CML (Children): Diagnosis of Philadelphia chromosome positive (Ph+) chronic phase CML. Not candidates for stem cell transplantation, disease has recurred after stem cell transplant, or for patients who are resistant to interferon-alfa therapy. Acute Lymphoblastic Leukemia: Adult patients with Philadelphia chromosome positive ALL. Myelodysplastic/myeloproliferative diseases: Adults diagnosed with MDS/MPD diseases associated with platelet-derived growth factor receptor gene rearrangements. Aggressive systemic mastocytosis: Adults diagnosed with aggressive systemic mastocytosis. Patient is			All diagnoses: Length of therapy.	Approve for continuation of prior therapy.

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			without the D816V c-Kit mutation or c-Kit mutation status unknown. Hypereosinophilic syndrome and chronic eosinophilic leukemia: Adults diagnosed with HES or CEL. Dermatofibrosarcoma protuberans: Adults with unresectable, recurrent and/or metastatic DFSP. Gastrointestinal Stromal Tumors: Patients with a confirmed diagnosis of unresectable and/or metastatic GIST.				
Growth Hormones	All FDA-approved indications not otherwise excluded from Part D: Growth Hormone Deficiency (GHD) in Children, Prader-Willi Syndrome (PWS) or Small for Gestational Age (SGA), Turner Syndrome (TS) or Noonan Syndrome (NS), Growth Retardation associated with Chronic Renal	COGHDA: Males with bone age greater than 17 yrs or females with bone age greater than 15 years, closed epiphyses on bone radiograph, growth velocity less than 2 cm/year during previous year of treatment unless COGHD criteria are met. <b><u>Idiopathic short stature is not a covered diagnosis.</u></b>	GHD (Child): Dx GH deficiency based on 2 GH stimulation tests or low IGF-1 levels. Demonstrate growth failure based on growth velocity or ht shorter than 2 SD below the mean ht for age. PWS, SGA: Dx of PWS confirmed by genetic testing or Dx of SGA confirmed by birth wt of less than 2500g at gestation of more than 37 wks or at birth wt or length below the 3rd percentile for gestational age who failed to catch up by 2 yrs of age. TS, NS: Tx of short stature in females w/bone age less than 15 yrs associated w/TS or NS or for tx of short stature in males w/bone age less than 17 yrs associated w/NS. GRCRF: Dx of chronic renal insufficiency. Ht shorter than or equal to 2 SD below the median age for children or where growth velocity falls to below 4.5 cm/yr. GHD (Child), PWS, SGA, TS, NS, GRCRF (Reauth): Incr in growth velocity of at least 2 cm/yr during previous yr of tx. Males w/bone age less than 17 yrs or females w/bone age less than 15 yrs. AOGHD: Pts who have GHD alone or multiple hormone deficiencies b/c of pituitary disease/insult, hypothalamic disease, surgery, or radiation tx. IGF-1 level less than 77 mcg/L or 2 SD below the mean value, matched by age		GH Deficiency (Child), Turner Syndrome or Noonan Syndrome (Initial), GRCRF, AOGH, Childhood Onset GH Deficiency in Adults, Isolated GH Deficiency in Adults: Prescribed by an endocrinologist.	All uses: 1 year. Except GH Deficiency in Adults: Length of therapy.	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Insufficiency (GRCRF), Adult Onset GH Deficiency (AOGH), Childhood Onset GH Deficiency in Adults (COGHDA), Isolated GH Deficiency in Adults (IGHDA)		and gender. COGHDA: Childhood onset in pts who were GH deficient during childhood who have GH deficiency confirmed as an adult before replacement tx w/GH is started. Persistent deficiency of GH documented by GH stimulation tests. IGHDA: Documented deficiency of GH documented by 2 GH stimulation tests.				
Herceptin	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.		If drug requested is limited as a second line agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent.		Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.
Hexalen	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART		If drug requested is limited as a second line agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent (carboplatin and paclitaxel or carboplatin and docetaxel).		Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.

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	D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.						
Humira	All FDA-approved indications not otherwise excluded from Part D.		Moderate to severe active RA: Dx of mod-to-sev RA. Failed MTX or 2 DMARDs for 3 mo. Juvenile Idiopathic Arthritis: Dx of mod-to-sev polyarticular-course JIA. Failed NSAID or steroid and methotrexate for three months. Psoriatic Arthritis: Dx of active PsA. Failed MTX or 2 DMARDs for 3 mo. Ankylosing Spondylitis: Dx of AS. Failed 2 NSAIDs for 3 mo. Plaque Psoriasis: Dx mod-to-sev plaque psoriasis. Failed phototherapy and systemic therapy. Crohn's disease: Dx of mod-to-sev CD. Failed one conventional therapy. Reauthorization: demonstration of clinical response to therapy.	RA, PsA, CD, AS, Plaque Psoriasis: 18 years and older. JIA: 4 years and older.	RA, PsA, AS, JIA: Prescribed or recommended by a rheumatologist. Plaque Psoriasis: Prescribed or recommended by a dermatologist. CD: Prescribed or recommended by a gastroenterologist.	Initial Auth: 6 months for all except Plaque Psoriasis: 4 mo. Reauth for all 12 mo.	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. Plaque Psoriasis: Humira dosage is 40 mg every other week. All diagnoses: Verification that the patient has been evaluated for

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							TB and treated accordingly.
Hycamtin	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.		If drug requested is limited as a second line agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent.		Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.
Ifosfamide	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.		If drug requested is limited as a second line agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent.		Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.
Immune Globulin	All FDA-approved indications not otherwise		ITP: For patients with ITP who require a rapid temporary increase in platelet count or to control excessive bleeding. KD: Confirmed diagnosis of KD. CLL: Documented		MG: Prescribed by a neurologist.	BMT: 100 days after transplant KD: 1 mo. MG, GBS: 1 tx course	Subject to Part B vs. Part D review. For Part D: For

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D.		hypogammaglobulinemia (IgG less than 600mg/dL) or history of bacterial infections associated with B-cell CLL. BMT: Confirmed allogeneic BMT within the last 100 days. Documented severe hypogammaglobulinemia (IgG less than 400 mg/dL). Dermatomyositis and Polymyositis: Failure or intolerance to one of the following: corticosteroid therapy, MTX, AZA, or cyclophosphamide. HIV: Documented hypogammaglobulinemia (IgG less than 400 mg/dL). GBS: Confirmed diagnosis of severe GBS. Patients with severe disease requiring aid to walk. Onset of muscle weakness within the last 4 weeks. LEMS: Confirmed diagnosis of Lambert-Eaton myasthenic syndrome (LEMS). MG: Confirmed diagnosis of acute myasthenia gravis with myasthenic exacerbation, defined by either difficulty swallowing, acute respiratory failure, or major functional disability responsible for the discontinuation of physical activity. MS: Confirmed diagnosis of relapsing remitting form of MS. Failure to two of the following: Betaseron, Avonex, Rebif, Copaxone, Tysabri. Stiff Person Syndrome: Chart documentation confirming a diagnosis of stiff-person syndrome.			ITP, LEMS: 6 mo. Other uses: 1yr	patients in which immune globulin is administered in the patient's home.
Infergen	All FDA-approved indications not otherwise excluded from Part D.		Hep C - Treatment Naive Patients: For patients with Chronic Hepatitis C with compensated liver disease with positive HCV antibody and HCV RNA. Hep C - Continuation of Therapy: For genotypes 2,3,5, or 6: loss of detectable HCV RNA from serum or 100 fold drop or more in HCV RNA level.	Hep C - Treatment Naive Patients: 18 years and older.		Tx Naive: genotypes 2,3,5,6: 6 mo. genotypes 1, 4 or HIV/HCV: 12 mo Con't: genotypes 2,3,5,6: 6 mo	
Insulin-like	All FDA-		IGF-1 deficiency: Diagnosis of severe primary			IGF-1 deficiency,	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Growth Factor (Increlex)	approved indications not otherwise excluded from Part D.		IGF-1 deficiency. Height standard deviation score of -3.0 or less. Basal IGF-1 standard deviation score of -3.0 or less. Normal or elevated growth hormone. Open finger epiphyses on last bone radiograph. GH gene deletion: Diagnosis of growth hormone gene deletion who have developed neutralizing antibodies to GH and have open finger epiphyses on last bone radiograph.			GH gene deletion: 1 year.	
Intron-A	All FDA-approved indications not otherwise excluded from Part D		Hep B - HBeAg positive: HBsAg positive for at least 6 months. HBV DNA level greater than 100,000 copies/mL. Compensated liver disease. One of the following: persistent ALT 2 times ULN or moderate to severe hepatitis or fibrosis on biopsy. Hep B - HBeAg negative: HBsAg positive for at least 6 months. HBV DNA level of 2000 IU/mL or more or 11,200 copies/mL. Compensated liver disease. One of the following: persistent ALT 2 times ULN or moderate to severe hepatitis or fibrosis on biopsy. Hep C - Treatment Naive Patients (monotherapy): For patients with Chronic Hepatitis C with compensated liver disease with positive HCV antibody and HCV RNA. Hep C - Treatment Naive Patients (in combination with ribavirin): For patients with Chronic Hepatitis C with compensated liver disease with positive HCV antibody and HCV RNA. Hep C - Continuation of Therapy: For genotypes 2,3,5, or 6: loss of detectable HCV RNA from serum or 100 fold drop or more in HCV RNA level. Non-Hepatitis Diagnoses: Diagnosis of one of the following: Malignant Melanoma, Hairy cell leukemia, Stage III or IV follicular Non-Hodgkin's Lymphoma, condylomata	Hep B - HBeAg positive, Hep B - HBeAg negative: 1 year of age or older. Hep C - Treatment Naive Patients, Non-Hepatitis Diagnoses, Acute Hep C: 18 years old and older. Hep C - Treatment Naive Patients (in combinatio		HepB+: 6mo.(-):1yr.HepC:(2,3,5,6) 6mo(1,4,HIV/HC V):12mo.AcuteHepC,HCL,Kaposi :6mo.warts:3wk. Other:1yr	Approve for continuation of prior therapy for neoplastic diseases.

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			acuminata, AIDS-related Kaposi's sarcoma, Multiple Myeloma. Acute Hep C: Patients with acute hepatitis C.	n with ribavirin): 3 years of age and older.			
Invega Sustenna Effective 3/1/2010	All FDA-approved indications not otherwise excluded from Part D		Patients must have a chart documented compliance issue (ex: cheating traditional dosage forms) OR chart documentation of difficulty or inability to swallow traditional dosage forms.			1 year	Approve for continuation of prior therapy.
Istodax Effective 5/1/2010	All FDA approved indications not otherwise excluded from Part D		<b>Cutaneous T-Cell Lymphoma (CTCL):</b> Confirmed diagnosis of CTCL. Failure to one systemic therapy.			12 months	Istodax will be approved for continuation of prior therapy.
Ixempra	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.		If drug requested is limited as a second line agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent.		Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.
Kepivance	All FDA-approved					6 days	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded from Part D						
Kepra	All FDA-approved indications not otherwise excluded from Part D					1 year	Approve for continuation of prior therapy.
Kineret	All FDA-approved indications not otherwise excluded from Part D.		RA (Initial): Diagnosis of moderate to severe active RA. Failure with a TNF-alpha-blocker. Failure on either methotrexate or at least 1 DMARD for at least 3 months. RA (Reauthorization): Submission of chart documentation demonstrating positive clinical response.	RA: 18 years or older	RA: Prescribed or recommended by a rheumatologist.	RA (Initial): 12 months. RA (Reauth): 1 year.	
Kuvan	All FDA-approved indications not otherwise excluded from Part D.		Baseline Phe level. Requests will be approved initially for 1 month, in order to show a 30% decrease in phenylalanine blood levels. Patients who do not respond after 1 month are considered a non-responder, and Kuvan should be discontinued. Subsequent requests must include the current Phe level and display at least a 30% decrease from baseline for a reauthorization.	Patients should be at least 4 years of age.		Initial: 1 month. Responders: approved as requested by prescriber up to 1 year	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Letairis	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.			PAH: Length of therapy.	
Leukine	All FDA-approved indications not otherwise excluded from Part D.		BMSCT: For pts with non-myeloid malignancies undergoing myeloablative chemo followed by autologous or allogeneic BMT, or for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis, or for peripheral stem cell transplant pts who have received myeloablative chemotherapy. AML: For pts with AML following induction or consolidation chemotherapy. NDDC: Patient is receiving NCI's Breast Intergroup, INT C9741 dose dense chemo protocol for primary breast cancer or a dose-dense regimen for which the incidence of febrile neutropenia is unknown. CFN: Patient is receiving a chemotherapy regimen associated with more than 20% incidence of febrile neutropenia, or patient is receiving a chemotherapy regimen associated with 10-20% incidence of febrile neutropenia and has risk factors associated with chemotherapy-induced infection, febrile neutropenia or neutropenia. FN: For patients			BMSCT: 3 mo. NDDC, CFN, FN, AML, SCN, HCN, HIVN: tx dur.	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			receiving myelosuppressive anticancer drugs associated with neutropenia. Pt either has febrile neutropenia at high risk for infection-associated complications or has a history of febrile neutropenia during a previous course of chemotherapy. SCN: For pts with severe chronic neutropenia. HCN: Neutropenia in Hepatitis C virus infected pts undergoing treatment with Peg-Intron or Pegasys after dose reduction, or for pts with HIV co-infection, or status post liver transplant, or established cirrhosis who experience interferon-induced neutropenia due to treatment with Peg-Intron or Pegasys. HIVN: HIV-infected pts with an ANC less than or equal to 1,000 cells/mm3 with or without one or more risk factors for developing chronic neutropenia.				
Leuprolide	All FDA-approved indications not otherwise excluded from Part D		Patient has a documented diagnosis of endometriosis. that has been confirmed through tissue sampling or laproscopic procedure OR Documentation has been submitted that the patient has been treated with at least (1) different non-steroidals for symptom relief (for at least 4 weeks with agent).AND Patient has been treated with an adequate trial of oral contraceptives (at least 12 weeks) or there are contraindications to the use of oral contraceptives in the patient. Patient has a diagnosis of advanced prostatic cancer and Lupron is intended for use as palliative treatment where orchiectomy or estrogen replacement is not indicated or unacceptable to the patient. Patient has a diagnosis of central precocious puberty (CPP). Patient has a diagnosis of leiomyoma uteri (fibroids).	For use in endometriosis or leiomyoma uteri (fibroids) patient must be 18		Endometriosis - 6 months, Prostate CA and CPP - 12 months, Fibroids 3 months	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Lidoderm	All FDA-approved indications not otherwise excluded from Part D					Requests will be approved as requested by prescriber up to 1 year	
Lotronex	All FDA-approved indications not otherwise excluded from Part D.	IBS (Initial): Male gender.	IBS (Initial): Confirmed diagnosis of (IBS) with diarrhea predominant symptoms for at least 6 months. Failure to an antispasmodic and an anti-diarrheal agent. IBS (Reauth): Recurrence of diarrhea-predominant IBS. Documentation of positive clinical response while on Lotronex.	IBS (Initial): 18 years and older.	IBS (Initial): Verification that physician has enrolled in the GlaxoSmithKline Prescribing Program.	IBS (Initial): 12 weeks IBS (Reauthorization): 6 months.	
Lovenox	All FDA-approved indications not otherwise excluded from Part D		If the request is for an extension of enoxaparin therapy beyond the initial authorization for a patient who was initiated on warfarin therapy with the following documentation: Date warfarin therapy was started, Current PT/INR reading, and Detailed treatment plan to withdraw enoxaparin and transition to warfarin within the next 7 days			TKA-14 d;THA-21 d;Acute DVT-17 d;Pregnancy/cancer w/VTE risk-length of tx;STEMI-8 d;All others-14 d.	
Lupron Depot	All FDA-approved indications not otherwise excluded from Part D		Patient has a documented diagnosis of endometriosis. that has been confirmed through tissue sampling or laproscopic procedure OR Documentation has been submitted that the patient has been treated with at least (1) different non-steroidals for symptom relief (for at least 4 weeks with agent).AND Patient has been treated with an adequate trial of oral contraceptives (at least 12 weeks) or there are contraindications to the use of oral contraceptives in the patient. Patient has a diagnosis of advanced prostatic cancer and Lupron is intended for use as palliative	For use in endometriosis or leiomyoma uteri (fibroids) patient must be 18		Endometriosis - 6 months, Prostate CA and CPP - 12 months, Fibroids 3 months	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			treatment where orchiectomy or estrogen replacement is not indicated or unacceptable to the patient. Patient has a diagnosis of central precocious puberty (CPP). Patient has a diagnosis of leiomyoma uteri (fibroids).				
Lupron Depot-Ped	All FDA-approved indications not otherwise excluded from Part D		Patient has a documented diagnosis of endometriosis. that has been confirmed through tissue sampling or laproscopic procedure OR Documentation has been submitted that the patient has been treated with at least (1) different non-steroidals for symptom relief (for at least 4 weeks with agent).AND Patient has been treated with an adequate trial of oral contraceptives (at least 12 weeks) or there are contraindications to the use of oral contraceptives in the patient. Patient has a diagnosis of advanced prostatic cancer and Lupron is intended for use as palliative treatment where orchiectomy or estrogen replacement is not indicated or unacceptable to the patient. Patient has a diagnosis of central precocious puberty (CPP). Patient has a diagnosis of leiomyoma uteri (fibroids).	For use in endometriosis or leiomyoma uteri (fibroids) patient must be 18		Endometriosis - 6 months, Prostate CA and CPP - 12 months, Fibroids 3 months	
Lyrica	All FDA-approved indications not otherwise excluded from Part D.		Seizure Disorder: History of failure to a formulary anticonvulsant. As add-on therapy for the diagnosis of partial seizure. Diabetic Neuropathy: Diagnosis of Diabetes Mellitus. Diagnosis of peripheral neuropathy. Failure to gabapentin. Post-herpetic Neuropathic Pain: Failure to gabapentin.			All uses: Length of therapy.	Approve for continuation of prior therapy.
Methylin	All FDA-approved indications not otherwise excluded from					All uses: 1 year	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D						
Methylin ER	All FDA-approved indications not otherwise excluded from Part D					All uses: 1 year	
Methylphenidate	All FDA-approved indications not otherwise excluded from Part D					All uses: 1 year	
Mozobil Effective 4/1/2010	All FDA-approved indications not otherwise excluded from Part D.		Used in combination with granulocyte-colony stimulating factor (G-CSF).		Prescribed by a hematologist/ oncologist	One course of therapy up to 4 days	
Mylotarg	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.		If drug requested is limited as a second line agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent.		Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Myozyme	All FDA-approved indications not otherwise excluded from Part D				Prescribed by an Endocrinologist	Requests will be approved as requested by prescriber up to 1 year	
Naglazyme	All FDA-approved indications not otherwise excluded from Part D	NON COVERAGE Naglazyme is NOT covered for members with the following criteria: A. Diagnosis has NOT been confirmed by enzymatic assay that shows a deficiency in N-acetylgalactosamine activity. B. The patient does NOT have at least one of the listed symptoms of MPS VI. C. If the patient has previously received Naglazyme therapy and they have not shown an improvement	Naglazyme is covered for members who meet the following additional criteria: A. The patient has at least one of the listed MPS VI symptoms. Impaired vision Recurrent otitis media. Recurrent sinopulmonary infections. Impaired hearing. Upper airway obstruction. Malaise and reduced endurance. Corneal clouding. Macrocephaly. Reduced joint range of motion. Progressively coarse facial features. Short stature. Umbilical and inguinal hernias. Carpal tunnel syndrome. Communicating hydrocephalus. Hepatosplenomegaly. Cardiac abnormalities and valvular disease. Spinal cord compression. Sleep apnea. Reduced pulmonary function. Hepatosplenomegaly. Dysostosis mutiplex B. AND if the patient has previously received Naglazyme therapy, they must show an improvement in walking and/or stair-climbing capacity since initiating therapy.		Prescribed by an Endocrinologist	Requests will be approved as requested by prescriber up to 1 year	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		in walking or stair-climbing capacity.					
Neulasta	All FDA-approved indications not otherwise excluded from Part D		Verification that the cancer is a non-myeloid malignancy. Patient is receiving myelosuppressive chemotherapy associated with an expected incidence of febrile neutropenia greater than or equal to 17%.			Chemotherapy-induced neutropenia prophylaxis: 6 months	
Neumega	All FDA-approved indications not otherwise excluded from Part D	Patients with myeloablative chemotherapy.	Thrombocytopenia following chemotherapy: Verification that the cancer is a non-myeloid malignancy. Platelet count is less than 50,000 cells/microliter. Patients with one or more of the following risk factors: extensive prior cytotoxic chemotherapy, prior severe chemotherapy-induced thrombocytopenia, or receiving chemotherapy regimens associated with high risk for thrombocytopenia.			Thrombocytopenia following chemotherapy: 3 week intervals for up to 6 cycles post-chemotherapy.	
Neupogen	All FDA-approved indications not otherwise excluded from Part D		BMSCT: For pts with non-myeloid malignancies undergoing myeloablative chemo followed by autologous or allogeneic BMT, or for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis, or for peripheral stem cell transplant pts who have received myeloablative chemotherapy. AML: For pts with AML following induction or consolidation chemotherapy. NDDC: Patient is receiving NCI's Breast Intergroup, INT C9741 dose dense chemo protocol for primary breast cancer or a dose-dense regimen for which the incidence of febrile neutropenia is unknown. CFN: Patient is receiving a chemotherapy regimen associated with more than 20% incidence of febrile neutropenia, or patient is			BMSCT: 3 mo. NDDC, CFN, FN, AML, SCN, HCN, HIVN: tx dur.	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			receiving a chemotherapy regimen associated with 10-20% incidence of febrile neutropenia and has risk factors associated with chemotherapy-induced infection, febrile neutropenia or neutropenia. FN: For patients receiving myelosuppressive anticancer drugs associated with neutropenia. Pt either has febrile neutropenia at high risk for infection-associated complications or has a history of febrile neutropenia during a previous course of chemotherapy. SCN: For pts with severe chronic neutropenia. HCN: Neutropenia in Hepatitis C virus infected pts undergoing treatment with Peg-Intron or Pegasys after dose reduction, or for pts with HIV co-infection, or status post liver transplant, or established cirrhosis who experience interferon-induced neutropenia due to treatment with Peg-Intron or Pegasys. HIVN: HIV-infected pts with an ANC less than or equal to 1,000 cells/mm <sup>3</sup> with or without one or more risk factors for developing chronic neutropenia.				
Neurontin solution	All FDA-approved indications not otherwise excluded from Part D		Patient must be unable to swallow tablets or capsules.			1 year	
Neutrexin	FDA-APPROVED INDICATIONS Neutrexin is indicated for the treatment of moderate-	NON COVERAGE Neutrexin is NOT covered for members who meet the following criteria:				21 days	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	to-severe pneumocystis pneumonia (PCP) in immunocompromised patients	A. The patient is NOT immunocompromised B. The patient has NO previous trials with sulfamethoxazole /trimethoprim AND pentamidine C. The patient is NOT taking leucovorin with treatment					
Nexavar	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.				Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.
Octreotide	All FDA-approved indications not otherwise excluded from Part D. Cancer Chemotherapy		Acromegaly: Inadequate response to surgery and/or radiotherapy, or who are not a surgical and/or radiotherapy candidate. Patient has been shown to respond to and tolerate octreotide injection for at least 2 weeks. Carcinoid tumors: diagnosis of metastatic carcinoid tumor, for symptomatic treatment of			Acromegaly: long-term approval Tumors: 6 mo. Diarrhea: 3 mo.	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Induced Diarrhea, AIDS-related Diarrhea.		severe diarrhea or flushing. Patient has been shown to respond to and tolerate octreotide. AIDS-related Diarrhea: history of failure or intolerance to standard therapy. Cancer Chemotherapy Induced Diarrhea: uncomplicated diarrhea due to concurrent cancer chemotherapy and failure of standard therapy, or complicated diarrhea associated with cancer chemotherapy. Vasoactive Intestinal Peptide Tumors: Diagnosis of metastatic vasoactive intestinal peptide tumor, for symptomatic treatment of diarrhea associated with vasoactive intestinal peptide tumor. For Sandostatin LAR: Patient has been shown to respond to and tolerate octreotide.				
Oncaspar	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.				Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Ontak	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.				Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.
Onxol	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.				Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.
Orfadin	All FDA-approved indications not otherwise excluded from Part D		Orfadin is covered for members who meet the following criteria: The patient must have documented treatment protocol of protein-restricted diet that is low in phenylalanine.		Prescribed by an Endocrinologist	Requests will be approved as requested by prescriber up to 1 year	
Oxsoalolen-UL	FDA-				Prescribed by a	Requests will be	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	APPROVED INDICATIONS Oxсорalen is indicated: A. For the treatment of cutaneous T-cell lymphoma B. For the treatment of psoriasis or all FDA approved indications not otherwise excluded from Part D.				Dermatologist or Oncologist	approved as requested by prescriber up to 1 year	
Paclitaxel	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.					Length of therapy	Approve for continuation of prior therapy.
Panretin	All FDA-approved indications not otherwise excluded from	Non-FDA approved or not medically accepted uses. Evidence that	Patient must have an FDA approved diagnosis.	product is indicated only for adults		Requests will be approved as requested by prescriber up to 1 year	Approve for continuation of prior therapy.

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	Part D	systemic therapy is medically necessary.					
Pegasys	All FDA-approved indications not otherwise excluded from Part D.		Hep B - HBeAg positive: HBsAg positive for at least 6 months. HBV DNA level greater than 100,000 copies/mL. Compensated liver disease and one of the following: ALT 2 times ULN or moderate-to-severe hepatitis or fibrosis on biopsy. Hep B - HBeAg negative: HBsAg positive for at least 6 months. HBV DNA level of 2000 IU/mL or more or 11,200 copies/mL. Compensated liver disease and one of the following: ALT 2 times ULN or moderate-to-severe hepatitis or fibrosis on biopsy. Hep C - Treatment Naive Patients: Chronic Hepatitis C with compensated liver disease. Positive HCV antibody HCV RNA. HCV RNA level measurement. Genotype test result. For patients who have not previously been treated with interferon. Hep C - Continuation of Therapy: For genotypes 5 or 6: loss of detectable HCV RNA from serum or 100 fold drop or more in HCV RNA level. For genotype 1: undetectable HCV RNA after 24 weeks of therapy and one of the following: HCV RNA more than 50 IU/mL at 4 weeks into treatment or less than 100 fold drop or detectable HCV RNA 12 weeks into therapy. For genotype 3: baseline HCV RNA more than 600,000 IU/mL and steatosis or advanced fibrosis on liver biopsy. Hep C Retreatment: Retreatment in patients who have failed or relapsed following standard or pegylated interferon monotherapy, or for nonresponders or relapsers who have significant fibrosis or cirrhosis who have	Hep B - HBeAg positive, Hep B - HBeAg negative, Hep C - Treatment Naive Patients: 18 years and older		HepB:1yr. HepC(5,6):12 wk, (2,3): 24wk, (1,4,HIV/HCV):4 8wk.con't(1,3):24 wk, (5,6):36wk.Retreat:1yr	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			undergone previous regimens of treatment using non-pegylated interferon, or retreatment in patients with genotype 2 or 3 who have relapsed following 6 month treatment of pegylated interferon plus ribavirin combination therapy. Used in combination with ribavirin.				
PEG-Intron	All FDA-approved indications not otherwise excluded from Part D.		Hepatitis C - Treatment Naive Patients: Chronic Hepatitis C with compensated liver disease. Positive HCV antibody HCV RNA. HCV RNA level measurement. Genotype test result. For patients who have not previously been treated with interferon. Hep C (Continuation): For genotypes 5 or 6: loss of detectable HCV RNA from serum or 100 fold drop or more in HCV RNA level. For genotype 1: undetectable HCV RNA after 24 weeks of therapy and one of the following: HCV RNA more than 50 IU/mL at 4 weeks into treatment or less than 100 fold drop or detectable HCV RNA 12 weeks into therapy. For genotype 3: baseline HCV RNA more than 600,000 IU/mL and steatosis or advanced fibrosis on liver biopsy. Hep C (Retreatment): Retreatment in patients who have failed or relapsed following standard or pegylated interferon monotherapy, or for nonresponders or relapsers who have significant fibrosis or cirrhosis who have undergone previous regimens of treatment using non-pegylated interferon, or retreatment in patients with genotype 2 or 3 who have relapsed following 6 month treatment of pegylated interferon plus ribavirin combination therapy. Used in combination with ribavirin.	Hepatitis C - Treatment Naive Patients: 3 years and older.		Type5,6: 12 wk, type2,3: 24wk, type1,4,HIV/HC V: 48wk.Con't: type1,3: 24wk type5,6: 36wk.Retreat: 1yr	
Pentostatin	FDA-APPROVED		If drug requested is limited as a second line agent by the compendia of current literature		Prescribed by an Oncologist	Length of therapy	Approve for continuation of

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.		described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent.				prior therapy.
Photofrin	All FDA-approved indications not otherwise excluded from Part D		If drug requested is limited as a second line agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent.			Length of therapy	
Prolastin	All FDA-approved indications not otherwise excluded from Part D					Requests will be approved as requested by prescriber up to 1 year	
Proleukin	All FDA-approved		Metastatic Renal Cell Carcinoma or Metastatic Melanoma: Measurable, histologically	Metastatic Renal Cell		Metastatic Renal Cell Carcinoma	All uses: For continuation of

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded from Part D		confirmed metastatic renal cell carcinoma or metastatic melanoma. Good neurologic or ambulatory performance status. Adequate organ function: normal cardiac stress test results, FEV1 greater than 2 L on pulmonary function tests, creatinine concentration 1.5 mg/dL or less or calculated creatinine clearance of greater than 60 ml/min, bilirubin concentration of 1.5 mg/dL or less, SGOT/AST less than 150 IU or 4x upper limit of normal. Platelet count greater than or equal to 100,000 / mL. Hemoglobin greater than or equal to 10 g/dL. WBC greater than or equal to 3,500 / mL. At least 7 weeks since prior therapy and complete recovery from therapy-related side effects.	Carcinoma or Metastatic Melanoma : 18 years and older		or Metastatic Melanoma: three months	prior therapy. Metastatic Renal Cell Carcinoma or Metastatic Melanoma: Administered in a hospital setting. Additional courses of treatment should be given to patients only if there is some tumor shrinkage following the last course and if retreatment is not contraindicated.
Promacta	All FDA-approved indications not otherwise excluded from Part D	Patients with thrombocytopenia due to chemotherapy. For the purpose of increasing platelet counts in patients with hepatitis C. For the purpose of	Chronic ITP: Platelet count less than or equal to 30,000 OR Platelet count less than or equal to 50,000 with significant mucous membrane bleeding or risk factors for bleeding. Failure of or contraindication to treatment with corticosteroids, immune globulin, or splenectomy.	Patients should be at least 18 years old.	Prescribed by a Hematologist	Initial Auth: 4 months. Reauth: 1 year	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		increasing platelet counts in patients that do not have immune thrombocytopenic purpura.					
Provigil	All FDA-approved indications not otherwise excluded from Part D.	SWSD (Initial): Symptoms do not meet criteria for any other sleep disorder producing insomnia or excessive sleepiness.	Narcolepsy: Submission of sleep study confirming the diagnosis of narcolepsy. OSAHS (Initial): More than 5 obstructive apneas, each greater than 10 seconds in duration, per hour of sleep confirmed by a sleep study. Frequent arousals from sleep associated with apneas, or bradycardia, or arterial oxygen desaturation in association with apneas. Fully compliant and concurrently using continuous positive airway pressure (CPAP). Symptoms of excessive daytime sleepiness. OSAHS (Reauthorization): Patient continues to be fully compliant on concurrent CPAP and is experiencing relief of symptomatic hypersomnolence with Provigil use. SWSD (Initial): 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, or sleep study demonstrating loss of a normal sleep-wake pattern. Sleep disturbance causes significant distress or significant impairment. No other disorder accounts for the symptoms. SWSD (Reauthorization): Patient is experiencing relief with use of Provigil for excessive sleepiness. Sleep disturbance continues to cause clinically significant distress or significant impairment in occupational functioning. Idiopathic Hypersomnia: Submission of sleep study confirming the			All uses: 12 months	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			diagnosis of Idiopathic Hypersomnia as defined by the International Classification of Sleep Disorders.				
Qualaquin	All FDA-approved indications not otherwise excluded from Part D.	Chloroquine-sensitive and resistant malaria: Severe or complicated P. falciparum malaria. Prevention of Malaria. For treatment or prevention of nocturnal leg cramps.	Chloroquine-sensitive malaria: Diagnosis of Malaria. History of failure, contraindication or intolerance to chloroquine. Chloroquine-resistant malaria: Diagnosis of malaria.			7 days	
Rebif	All FDA-approved indications not otherwise excluded from Part D.		Relapsing-remitting form of multiple sclerosis: For patients with relapsing-remitting form of multiple sclerosis.			RRMS: 1 year.	
Regranex	All FDA-approved indications not otherwise excluded from Part D.		Diabetic Neuropathic Ulcers: Diabetic patient with ulcer wound. Debridement being performed as needed. At least two of the following are present: Stage III or IV wound, wound at least 1 cm x 1 cm, long-standing wound that does not heal with standard care, or patients at high risk for amputation (peripheral neuropathy, peripheral vascular disease, skin or nail abnormalities, previous foot ulcer amputation).			Diabetic Neuropathic Ulcers: Maximum 6 months.	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Relistor	All FDA-approved indications not otherwise excluded from Part D		Opioid-induced Constipation: Adult patients with advanced illness and receiving palliative care. Confirmed diagnosis of opioid-induced constipation. Failure to polyethylene glycol or lactulose.	18 years and older		6 months	
Remicade	All FDA-approved indications not otherwise excluded from Part D.		Rheumatoid Arthritis: Dx of mod-to-sev active RA. Patient concurrently on MTX or failed MTX or 2 DMARDs (azathioprine, cyclosporine, gold, hydroxychloroquine, leflunomide, penicillamine, sulfasalazine) for 3 mo. Psoriatic Arthritis (PsA): Dx of active PsA. Failure or contraindication to methotrexate or 2 of the following for 3 months: cyclosporine, gold, leflunomide, or sulfasalazine. Ankylosing Spondylitis (AS): Dx of AS. Failed 2 NSAIDs for 3 mo. Plaque Psoriasis: Dx mod-to-sev chronic (greater than 6 months) plaque psoriasis. Failure, contraindication, intolerance or unavailability of phototherapy and one of the following: methotrexate, cyclosporine, acitretin, hydroxyurea, sulfasalazine, 6-thioguanine, mycophenolate. Crohn's Disease (CD): Mod to severe CD, failed one of the following: corticosteroids, 6-mercaptopurine, azathioprine, methotrexate, aminosalicilate. Fistulizing Crohn's Disease (FCD): Draining fistulas for 3 mo. On or failed one of the following: 6-mercaptopurine, azathioprine, antibiotics, oral corticosteroids, methotrexate. Ulcerative Colitis (UC): Mod to severe UC. Failed on one of the following: corticosteroids, 5-aminosalicylic acid, azathioprine, 6-	RA, PsA, AS, Plaque Psoriasis, FCD, UC: 18 years and older. Crohn's Disease: 6 years and older.	RA, AS, 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: Prescribed or recommended by a dermatologist. Sarcoidosis: Prescribed or recommended by a pulmonologist.	12 months	Verification that the patient has been evaluated for TB and treated accordingly.

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			mercaptopurine, cyclosporine. Sarcoidosis: Failed one steroid and one immunosuppressant. Reauthorization: demonstration of clinical response to therapy.				
Remodulin	All FDA-approved indications not otherwise excluded from Part D.		PAH: Patients with a confirmed diagnosis of pulmonary arterial hypertension (modified WHO Group I) which is symptomatic.			PAH: Length of therapy.	Subject to Part B vs. Part D review.
Restasis	All FDA-approved indications not otherwise excluded from Part D.		Patient must have an FDA approved diagnosis.	Patients should be at least 16 years old.		1 year	
Revatio	All FDA-approved indications not otherwise excluded from Part D.	PAH: Patients using organic nitrates.	PAH: Confirmed diagnosis of pulmonary arterial hypertension (modified WHO group I) which is symptomatic.			PAH: Length of therapy.	
Revlimid	All FDA-approved indications not otherwise excluded from Part D		MDS: Diagnosis of myelodysplastic syndrome associated with a deletion 5q cytogenic abnormality and patient is transfusion dependent. OR Diagnosis of myelodysplastic syndrome without deletion 5q cytogenic abnormality and failure of initial treatment with epoetin alfa or darbopoetin alfa, hypomethylating agents (e.g., Vidaza, Dacogen), or immunosuppressive therapy (e.g., antithymocyte globulin, cyclosporine). Multiple Myeloma: Used in combination with dexamethasone. Chronic Lymphocytic		MDS, Multiple Myeloma, CLL: Prescribed by an oncologist or hematologist or by oncology or hemoatology consult.	MDS, Multiple Myeloma: 6 months.	Approve for continuation of prior therapy.

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Leukemia: Relapsed or refractory to one prior therapy for CLL.				
Ribavirin	All FDA-approved indications not otherwise excluded from Part D.		Hepatitis C: Adults with a diagnosis of Hepatitis C with compensated liver disease, and verification of concurrent use with an alfa interferon product.			Hepatitis C: Length of therapy.	
Risperdal Consta	All FDA-approved indications not otherwise excluded from Part D		Patients must have a chart documented compliance issue (ex: cheeking traditional dosage forms) OR chart documentation of difficulty or inability to swallow traditional dosage forms.			1 year	Approve for continuation of prior therapy.
Risperdal M	All FDA-approved indications not otherwise excluded from Part D					1 year	Approve for continuation of prior therapy.
Rituxan	All FDA-approved indications not otherwise excluded from		Non-Hodgkin's Lymphoma: As first-line treatment of diffuse large B-cell, CD20-positive, non-Hodgkin's lymphoma in combination with CHOP or other anthracycline-based chemotherapy regimens, or as first-line	RA: 18 years and older.	RA: Prescribed by a rheumatologist.	All uses except RA: 1 year. RA: One month	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D. Chronic Lymphocytic Leukemia, Immune or idiopathic thrombocytopenic purpura, Waldenstrom's macroglobulinemia		treatment of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma in combination with CVP chemotherapy, or 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, or confirmed diagnosis of relapsed or refractory, low grade or follicular CD20-positive, B-cell non-Hodgkin's lymphoma. RA (Initial): Diagnosis of moderate-to-severe active RA. Used in combination with methotrexate. Failure to a TNF antagonist. RA (Reauthorization): Documented positive clinical response. At least 24 weeks since last Rituxan tx.				
Sabril	All FDA approved indications not otherwise excluded from Part D		<b>Complex Partial Seizures (CPS):</b> For use as adjunctive therapy in patients who have failed two formulary anticonvulsants.  <b>Infantile Spasms (IS):</b> Diagnosis of IS.			12 months	Approve for continuation of prior therapy.
Samsca Effective 3/1/2010	All FDA-approved indications not otherwise excluded from Part D		Initial: Diagnosis of significant hyponatremia (euvolemic or hypovolemic). Treatment has been initiated or re-initiated in a hospital setting prior to discharge. Reauth: documentation of clinical benefit, 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	Initial: 1 month. Reauth: 3 months	
Saphris	All FDA-approved indications not otherwise excluded from		Failure on one tier 1 or tier 2 atypical antipsychotic	Patient is 18 years of age or older	Psychiatrist	12 months	Approve for continuation of prior therapy.

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Soltamox	Part D. All FDA-approved indications not otherwise excluded from Part D					1 year	Approve for continuation of prior therapy.
Somatuline	All FDA-approved indications not otherwise excluded from Part D.		Acromegaly: Patients who require long-term treatment due to inadequate response to surgery and/or radiotherapy, or who are not a surgical and/or radiotherapy candidate. Diagnosis of acromegaly by one of the following: serum GH level greater than 1 ng/mL after a 2-hour oral glucose tolerance test, or elevated serum IGF-1 levels as compared to normal reference values by age and gender.			Indefinite, long term therapy (open-ended)	
Somavert	All FDA-approved indications not otherwise excluded from Part D.		Acromegaly (Initial): Inadequate response to surgery and/or radiation therapy or not a candidate for surgery or radiation. Inadequate response or intolerance to octreotide, or lanreotide, or IGF-1 value greater than 900 ng/mL. Acromegaly (Reauth): Serum IGF-1 level within the age-adjusted normal range.			Acromegaly (Initial): 12 weeks. Acromegaly (Reauth): indefinite	
Sotret	All FDA-approved indications not otherwise excluded from Part D. Isotretinoin is indicated for the treatment of severe nodular acne	Contraindicated if Pregnant. Non-FDA approved or not medically accepted uses.	Because of safety concerns, Isotretinoin is not recommended as a first line agent for the treatment of acne and is used for a short duration. Patient must have a diagnosis of severe (recalcitrant) nodular acne. Documentation that previous treatment attempts with incomplete success must be reported. Patient must have documented failures to a minimum of two of the following formulary medications: Topical antibiotics, Topical retinoids, Tetracycline, Minocycline,			Initial: 5 months Renewal: 5 months (not to exceed 10 months of therapy total)	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	that is unresponsive to conventional therapy.		Doxycycline, Erythromycin or Cephalexin Requests for Renewal: Documentation that the patient has been off of therapy for at least 8 weeks after a 20 week treatment course with isotretinoin. Confirmation that the patient's acne improved while on isotretinoin is required. The patient must have received less than 10 months of therapy previously.				
Sporanox (solution)	All FDA-approved indications not otherwise excluded from Part D		Fungal Infection: Diagnosis of blastomycosis, histoplasmosis, aspergillosis, or onychomycosis in patients unable to swallow tablets, or diagnosis of febrile neutropenia with suspected fungal infection, or oropharyngeal or esophageal candidiasis.			Fungal Infection: Length of therapy.	
Sprycel	All FDA-approved indications not otherwise excluded from Part D.		CML: Diagnosis of Philadelphia chromosome positive or BCR-ABL positive chronic, accelerated, or myeloid or lymphoid blast phase chronic myeloid leukemia. Failure to Gleevec. ALL: Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia. Failure to Gleevec.			CML, ALL: Length of therapy.	Approve for continuation of prior therapy.
Stelara Effective 5/1/2010	All FDA approved indications not otherwise excluded from Part D		<b>Plaque Psoriasis</b> 1. Diagnosis moderate-to-severe plaque psoriasis. 2. Failed phototherapy and 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.  <b>Reauthorization:</b>	Age greater than or equal to 18 years.	Prescribed or recommended by a dermatologist.	12 months	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

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Demonstration of clinical response to therapy.				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.
Strattera	All FDA-approved indications not otherwise excluded from Part D					1 year	
Suboxone	All FDA-approved indications not otherwise excluded from Part D	Suboxone will not be reauthorized for patients that are not compliant with therapy as illustrated by concurrent utilization of prescription opioid products. Non-FDA approved or not medically accepted uses.		Patients should be at least 16 years old.		Initial: 8 weeks Renewal: 6 months	
Subutex	All FDA-approved indications not	Subutex will not be reauthorized for patients that		Patients should be at least 16		Initial: 8 weeks Renewal: 6 months	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D	are not compliant with therapy as illustrated by concurrent utilization of prescription opioid products. Non-FDA approved or not medically accepted uses.		years old.			
Sucraid	All FDA-approved indications not otherwise excluded from Part D.				Prescribed by an Endocrinologist	Requests will be approved as requested by prescriber up to 1 year	
Sutent	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.		If drug requested is limited as a second line agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent.		Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.
Symlin	All FDA-approved indications not otherwise		DM: Type 1 or type 2 diabetes. Concurrent use of insulin therapy.	DM: 18 years and older.		DM: Length of therapy.	

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	excluded from Part D						
Synarel	All FDA-approved indications not otherwise excluded from Part D	NON COVERAGE Synarel is NOT covered for members who meet the following criteria: The patient is pregnant (category X)			Prescribed by an OBGYN and Endocrinologist	All uses: 6 months	
Tarceva	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.		If drug requested is limited as a second line agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent.		Prescribed by an Oncologist	Length of therapy.	Approve for continuation of prior therapy.
Targetin	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS				Prescribed by an Oncologist	Length of therapy.	Approve for continuation of prior therapy.

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	SUPPORTED BY THE STATUTORY PART D COMPENDIA.						
Tasigna	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.		Chronic Myelogenous Leukemia: Diagnosis of Philadelphia chromosome positive chronic or accelerated phase chronic myeloid leukemia and failure to Gleevec.		Prescribed by an Oncologist	Chronic Myelogenous Leukemia: Length of therapy.	Approve for continuation of prior therapy.
Taxotere	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.		If drug requested is limited as a second line agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent.		Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.
Tazorac	All FDA-approved	NON COVERAGE	ACNE: Patient must have had an inadequate response or intolerance to both an oral			Requests will be approved as	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded from Part D	Tazorac is NOT covered for members for treatment of the following indications: facial wrinkles, photo aging, melasma or other cosmetic uses	antibiotic formulary agent ( ex. doxycycline, minocycline) AND a topical formulary agent (ex. erythromycin, benzoyl peroxide/erythromycin, sulfacetamide sulfur, clindamycin.)			requested by prescriber up to 1 year	
Testosterone	All FDA-approved indications not otherwise excluded from Part D.	NON COVERAGE Testosterone is NOT covered for members for treatment of erectile dysfunction.	Hypogonadism: Diagnosis of hypogonadism in men with a pre-treatment testosterone level below normal physiological value of 280 ng/dL or below normal reference level provided by the physician laboratory.			Hypogonadism: Length of therapy	
Thalomid	All FDA-approved indications not otherwise excluded from Part D. Waldenstrom's Macroglobulin emia (WM), Apthous stomatitis or ulcers (AS), Crohn's Disease, Graft-versus-Host Disease, Primary Brain		Erythema nodosum leprosum: Confirmed diagnosis of moderate to severe ENL. Multiple Myeloma: For newly diagnosed multiple myeloma in combination with dexamethasone or conventional dose chemotherapy, or in combination with high dose chemotherapy with stem cell rescue, or salvage therapy in refractory or relapsed multiple myeloma after primary therapy, or in combination with dexamethasone, doxorubicin, cyclophosphamide, and etoposide as part of induction regimen prior to autologous transplant. Waldenstrom's Macroglobulinemia: Disease progression on an alkylating agent, nucleoside analog, or rituximab. Aphthous stomatitis or ulcers: Diagnosis of HIV-associated aphthous ulcers, or recurrent			Length of therapy.	Approve for continuation of prior therapy.

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Tumors, AIDS-related cachexia or wasting, Renal Cell Carcinoma.		<p>aphthous stomatitis in immunocompromised patients. Refractory to alternative therapies. Crohn's Disease: Patient is refractory to all of the following standard treatment regimens: corticosteroids, 5-aminosalicylic acid, immunomodulators, Remicade. GVHD: Diagnosis of chronic or refractory GVHD in patient unresponsive to all of the following: corticosteroids, azathioprine, tacrolimus, cyclosporine, antithymocyte globulin. Primary Brain Tumors: As adjuvant therapy to current cytotoxic therapies, or previous failure to cytotoxic therapies and/or tumor resection. AIDS-related wasting (Initial): Diagnosis of AIDS wasting or cachexia defined as chronic unremitting weight loss of more than 10% body weight in the previous 4 months. Nutritional evaluation since onset of wasting first occurred. Screened for hypogonadism. Failure to respond to hormone replacement therapy in patients with hypogonadism. Failure, contraindication or intolerance to standard treatments. AIDS-related wasting (Reauthorization): Weight has stabilized or improved but not at goal weight. Advanced Renal Cell Carcinoma: Confirmed diagnosis of metastatic renal cell carcinoma. Patient is refractory to, or an unsuitable of the following: interferon-alfa-2b, interleukin-2, sorafenib, sunitanib.</p>				
Topical Retinoids	All FDA-approved indications not otherwise excluded from	NON COVERAGE Tretinoin are NOT covered for members for				12 months	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D.	treatment of the following indications: facial wrinkles, photo aging, melasma or other cosmetic uses					
Torisel	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.		If drug requested is limited as a second line agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent.		Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.
Tracleer	All FDA-approved indications not otherwise excluded from Part D.		PAH: Patients with a confirmed diagnosis of pulmonary arterial hypertension (modified WHO Group I) which is symptomatic.			PAH: Length of therapy.	
Treanda	All FDA-approved indications not otherwise excluded from Part D		NHL: Diagnosis of indolent B-cell NHL. Progression of NHL during or within 6 months of tx with rituximab or a rituximab-containing regimen.			6 months	
Trisenox	FDA-		If drug requested is limited as a second line		Prescribed by an	Length of	Approve for

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.		agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent.		Oncologist	therapy	continuation of prior therapy.
Tykerb	All FDA-approved indications not otherwise excluded from Part D.		Breast Cancer: Diagnosis of HER2-positive advanced or metastatic breast cancer. Confirmation of normal left ventricular ejection fraction.			Breast Cancer: Length of therapy.	Approve for continuation of prior therapy.
Vancocin	All FDA-approved indications not otherwise excluded from Part D.		Pseudomembranous Colitis: Diagnosis of pseudomembranous colitis due to Clostridium difficile. Failure to oral Flagyl.			Pseudomembranous Colitis: Length of therapy.	
Vectibix	All FDA-approved indications not otherwise excluded from Part D.		Colorectal Cancer: Diagnosis of metastatic colorectal cancer. Relapsed, refractory, or disease progression on one standard chemotherapy regimen containing a fluoropyrimidine, oxaliplatin, or irinotecan.			Colorectal Cancer: 6 months	Approve for continuation of prior therapy.
Velcade	FDA-APPROVED INDICATIONS		If drug requested is limited as a second line agent by the compendia of current literature described in CMS regulations and by FDA		Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.

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Unison Advantage® Plus Integrated Care (HMO)

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.		indication, the beneficiary must demonstrate failure or intolerance to a first line agent.				
Ventavis	All FDA-approved indications not otherwise excluded from Part D.		PAH: Patients with a confirmed diagnosis of pulmonary arterial hypertension (modified WHO Group I) which is symptomatic.			PAH: Length of therapy	Subject to Part B vs. Part D review.
Vfend	FDA-APPROVED INDICATIONS Vfend is indicated: A. For the treatment of infection with invasive aspergillosis, candidiasis, furariosis, Scedosporium apiospermum		Infections: A. The patient is diagnosed with invasive aspergillosis B. AND the patient has had previous trial and failure or contraindication to itraconazole *If aspergillosis infection is extrapulmonary no previous trial is required C. AND chart notes documenting trial and failure or contraindication to itraconazole are received D. OR the patient is diagnosed with candidiasis E. AND the patient has previous trial and failure or contraindication to BOTH fluconazole and itraconazole F. AND chart notes documenting trial and failure or contraindication to itraconazole are received G. OR the patient is diagnosed with furariosis or Scedosporium sp. H. AND Vfend is being used as salvage therapy due to failure of other therapies I. AND chart notes documenting previous treatment failures is received		Prescribed by an infectious disease specialist	1 month	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Vfend IV	FDA-APPROVED INDICATIONS Vfend is indicated: A. For the treatment of infection with invasive aspergillosis, candidiasis, furariosis, Scedosporium apiospermum		Infections: A. The patient is diagnosed with invasive aspergillosis B. AND the patient has had previous trial and failure or contraindication to itraconazole *If aspergillosis infection is extrapulmonary no previous trial is required C. AND chart notes documenting trial and failure or contraindication to itraconazole are received D. OR the patient is diagnosed with candidiasis E. AND the patient has previous trial and failure or contraindication to BOTH fluconazole and itraconazole F. AND chart notes documenting trial and failure or contraindication to itraconazole are received G. OR the patient is diagnosed with furariosis or Scedosporium sp. H. AND Vfend is being used as salvage therapy due to failure of other therapies I. AND chart notes documenting previous treatment failures is received		Prescribed by an infectious disease specialist	1 month	
Vidaza	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY PART D COMPENDIA.					Length of therapy	Approve for continuation of prior therapy.
Vimpat	All FDA-approved indications not					1 year	Approve for continuation of prior therapy.

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	otherwise excluded from Part D						
Votrient Effective 3/1/2010	All FDA-approved indications not otherwise excluded from Part D		Diagnosis of advanced renal cell cancer.			1 year	Prior authorization applies to new starts only
Vpriv Effective 7/1/2010	All FDA-approved indications not otherwise excluded from Part D.		Gaucher's disease: Confirmed diagnosis of Type 1 Gaucher's disease. Symptomatic disease defined by one of the following: moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly.			12 months	
Xenazine	All FDA-approved indications not otherwise excluded from Part D. Tardive dyskinesia. Tourette's syndrome.		Huntington's Disease: Initial Therapy: Diagnosis of chorea in patients with Huntington's disease. Reauth: documented clinical response and benefit from therapy. Tardive dyskinesia and Tourette's syndrome: Stereotypies associated with tardive dyskinesia, or tics associated with Tourette's and failure to haloperidol.		Prescribed by a neurologist.	Initial: 3 months. Reauth: 12 months.	
Xolair	All FDA-approved indications not otherwise excluded from Part D.		Asthma (Initial): Diagnosis of moderate-to-severe persistent allergic asthma, defined by daily asthmatic symptoms, daily use of inhaled short-acting beta agonists, exacerbations affect/limit activity, exacerbations 2 or more times per week, nocturnal symptoms once a week or more, forced expiratory volume in one second or peak expiratory flow less than or equal to 80% of predicted, or PEF variability	Asthma (Initial): 6 years and older.	Asthma (Initial): Prescribed by a pulmonologist or allergist/immunologist.	Asthma (Initial): 16 weeks. Asthma (Reauthorization): 1 year.	

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			greater than 30%. Baseline IgE level greater than or equal to 30 IU/mL. Documented failure to combination therapy with an inhaled corticosteroid at the maximum dosage and a long-acting beta-agonist. Asthma (Reauthorization): Documented reduction in the frequency of asthma exacerbations while treated with Xolair. Documented reduction in the use of rescue medications or inhaled corticosteroids while treated with Xolair.				
Zavesca	FDA-APPROVED INDICATIONS Zavesca is indicated: A. For the treatment of adult patients with mild-to-moderate type-1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option.		Zavesca is covered for members who meet the following criteria: A. Diagnosis has been confirmed by bone marrow histology, DNA testing or measurement of b-glucocerebrosidase enzyme activity less than 30%. B. AND the patient has a hemoglobin concentration above 9 g/dL or a platelet count above 50 x10 <sup>9</sup> /L or active bone disease. (Zavesca has not been evaluated in patients with severe disease). C. AND the patient has tried and failed enzyme replacement therapy (e.g. Ceredase, Cerezyme) or is not a therapeutic option (e.g. allergy, hypersensitivity). D. AND if the patient is female and of childbearing years, she is NOT pregnant, has NO plans for pregnancy, is on a form of contraception or has NO ability to conceive and has been educated on the potential dangers of Zavesca therapy. E. AND if the patient has previously received 24 months of Zavesca therapy, they must show a decrease in liver and spleen volume and/or increases in platelet count and/or increases in hemoglobin concentration.		Prescribed by an Endocrinologist	Requests will be approved as requested by prescriber up to 1 year	
Zemaira	All FDA-					1 year	Approve for

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	approved indications not otherwise excluded from Part D						continuation of prior therapy.
Zetia	FDA-APPROVED INDICATIONS Zetia is indicated: A. For the treatment of hypercholesterolemia B. For the treatment of hyperlipoproteinemia. Or all FDA approved indications not otherwise excluded from Part D.		The patient has had an adequate trial (60 days) and failed to reach their lipid lowering goals or is unable to tolerate one drug from each of the following drug classes: 1.statin 2.fenofibrate	Patients should be 10 years of age or older.		1 year	
Zolinza	FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D OR OTHER USES AS SUPPORTED BY THE STATUTORY		If drug requested is limited as a second line agent by the compendia of current literature described in CMS regulations and by FDA indication, the beneficiary must demonstrate failure or intolerance to a first line agent (systemic therapy with interferons or bexarotene).		Prescribed by an Oncologist	Length of therapy	Approve for continuation of prior therapy.

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	PART D COMPENDIA.						
Zortress Effective 11/1/2010	All FDA-approved indications not otherwise excluded from Part D. Cardiac Transplant.		<b>Transplant:</b> 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.
Zymar	All FDA-approved indications not otherwise excluded from Part D		Infections: A. The patient has a diagnosis of bacterial conjunctivitis B. AND the patient has failed at least one first line formulary agent such as tobramycin, gentamicin, bacitracin/neomycin/polymixin C. OR the patient is undergoing ophthalmic surgery and is prescribed Zymar for use during the ophthalmic perioperative period.			14 days	
Zyprexa injection	All FDA-approved indications not otherwise excluded from Part D		Patients must have a chart documented compliance issue (ex: cheeking traditional dosage forms) OR chart documentation of difficulty or inability to swallow traditional dosage forms.			All uses: 1 year	Approve for continuation of prior therapy.
Zyprexa Zydisk	All FDA-approved indications not otherwise excluded from Part D		Patients must have a chart documented compliance issue (ex: cheeking traditional dosage forms) OR chart documentation of difficulty or inability to swallow traditional dosage forms.			All uses: 1 year	Approve for continuation of prior therapy.
Zyvox	All FDA-approved indications not		Infections: One of the following: Infections caused by vancomycin-resistant enterococci (VRE) documented by culture and sensitivity			Infections: 28 days.	

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Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D		report. Nosocomial pneumonia caused by methicillin-resistant Staphylococcus aureus (MRSA) documented by culture and sensitivity report. Complicated skin and skin structure infections (including diabetic foot infections) without osteomyelitis caused by methicillin-resistant Staphylococcus aureus (MRSA) documented by culture and sensitivity report. Empirical treatment of patients with community-acquired complicated skin and skin structure infections without osteomyelitis where MRSA infection is likely, in patients who have failed one of the following: trimethoprim-sulfamethoxazole, tetracycline, doxycycline, minocycline. As continuation of therapy when transitioning from intravenous daptomycin, intravenous vancomycin, or intravenous Zyvox therapy.				
Zyvox solution	All FDA-approved indications not otherwise excluded from Part D		Infections: One of the following: Infections caused by vancomycin-resistant enterococci (VRE) documented by culture and sensitivity report. Nosocomial pneumonia caused by methicillin-resistant Staphylococcus aureus (MRSA) documented by culture and sensitivity report. Complicated skin and skin structure infections (including diabetic foot infections) without osteomyelitis caused by methicillin-resistant Staphylococcus aureus (MRSA) documented by culture and sensitivity report. Empirical treatment of patients with community-acquired complicated skin and skin structure infections without osteomyelitis where MRSA infection is likely, in patients who have failed one of the following: trimethoprim-sulfamethoxazole, tetracycline, doxycycline,			Infections: 28 days.	

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			minocycline. As continuation of therapy when transitioning from intravenous daptomycin, intravenous vancomycin, or intravenous Zyvox therapy.				

**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:**

• Acetylcysteine	• Engerix-B	• Premasol
• Albuterol	• Freamine HBC	• Procalamine
• Aminosyn	• Freamine III	• Prograf
• Aminosyn in D5W	• Gengraf	• Prosol
• Azathioprine	• Hepatamine	• Pulmicort
• Cellcept	• Hepatasol	• Pulmozyme
• Clinimix	• Intralipid	• Rapamune
• Clinimix E	• Ipratropium bromide	• Recombivax HB
• Clinisol SF	• Liposyn III	• Renamin
• Cromolyn Sodium	• Mycophenolate	• Tobi
• Cyclophosphamide	• Myfortic	• Travasol
• Cyclosporine	• Nephramine	• Trophamine
• Cyclosporine Modified	• Novamine	

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