

**Prior Authorization (PA) requests should be directed to the PA Department**

- Prior Authorization Requests (PAR) may be faxed to 1-800-527-0531
- Prior Authorization phone lines provide quicker decisions: 1-800-711-4555 (Physician) or 1-877-897-3390 (Member)

**PRIOR AUTHORIZATION CRITERIA – Fidelis GOLD Formulary**

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Adcirca	All FDA-approved indications not otherwise excluded from Part D.	Patients using organic nitrates.	<b>Pulmonary Arterial Hypertension:</b> Patients with a confirmed diagnosis of pulmonary arterial hypertension (modified WHO Group I) which is symptomatic.			Length of therapy	
Afinitor	All FDA-approved indications not otherwise excluded from Part D.					Length of the therapy	Failure of treatment with sunitinib or sorafenib.
Alimta	All FDA-approved indications not otherwise excluded from Part D.		<b>Malignant Pleural Mesothelioma</b> 1. Disease is unresectable or patient is not a candidate for curative surgery; AND 2. Used in combination with cisplatin.  <b>Non-Small Cell Lung Cancer:</b> 1. Confirmed diagnosis of locally advanced or metastatic (Stage III or IV) NSCLC; AND 2. Prior history of first-line chemotherapy treatment for NSCLC or used in combination with cisplatin.			Length of the therapy	Alimta will be approved for continuation of prior therapy.
Amitiza	All FDA approved indications not otherwise excluded from Part D		<b>Chronic Idiopathic Constipation:</b> Failure to polyethylene glycol or lactulose.  <b>Irritable Bowel Syndrome with Constipation in women:</b> Failure to polyethylene glycol or lactulose.	≥ 18 years and older.		12 months	

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Anadrol-50	All FDA approved indications not otherwise excluded from Part D		<p><b>Acquired Aplastic Anemia:</b></p> <ol style="list-style-type: none"> <li>History of failure; OR</li> <li>Used in combination with, antilymphocyte globulin or both antilymphocyte globulin and corticosteroid treatment.</li> </ol> <p><b>Hypoplastic Anemia:</b></p> <ol style="list-style-type: none"> <li>Diagnosis of hypoplastic anemia due to myelotoxic drugs; AND</li> <li>Failure to an erythropoietic stimulating agent.</li> </ol> <p><b>Pure Red Cell Aplasia:</b> Failure to immunosuppressive therapy.</p> <p><b>Chronic Renal Failure:</b> Failure to an erythropoietic stimulating agent.</p>			Length of the therapy for hypoplastic anemia. For other uses, authorization will be granted for 12 months.	
Apokyn	All FDA approved indications not otherwise excluded from Part D		<p><b>Advanced Parkinson's Disease:</b></p> <ol style="list-style-type: none"> <li>Confirmed diagnosis of advanced Parkinson's disease; AND</li> <li>Unable to control "off" symptoms with adequate combinations of conventional oral therapy; AND</li> <li>Used in combination with a non-5-HT3 antagonist antiemetic for initial therapy; AND</li> <li>Not used in combination with 5-HT3 antagonists.</li> </ol>			1 year	Apokyn will only be approved for intermittent subcutaneous injection.
Aranesp	All FDA approved indications not otherwise excluded from Part D	<p><b>Anemia Due to Chronic Renal Failure:</b> Patient is on dialysis (covered under Part B).</p> <p><b>Anemia in cancer patients on chemotherapy:</b> Patient is</p>	<p><b>Initial Therapy for Chronic Renal Failure:</b></p> <ol style="list-style-type: none"> <li>Hct &lt; 33% OR Hgb &lt; 11 gm/dl; AND</li> <li>Verification of iron evaluation for adequate iron stores.</li> </ol> <p><b>Reauthorization for Chronic Renal Failure:</b></p> <ol style="list-style-type: none"> <li>Verification that average Hct was below 36% over a 3-month period; AND</li> <li>Verification of iron evaluation for adequate iron stores; AND</li> <li>One of the following: <ol style="list-style-type: none"> <li>Hct reached target range (30% to 36%); OR</li> <li>Decrease in blood transfusion; OR</li> <li>Hgb is ≥ 1 g/dL from pre-treatment level.</li> </ol> </li> </ol> <p><b>Initial Therapy for Chemotherapy:</b></p> <ol style="list-style-type: none"> <li>Verification that other causes of anemia have been ruled out; AND</li> </ol>			<p><b>Initial Therapy:</b> Three months for chemotherapy and MDS. Six months for CRF.</p> <p><b>Reauthorization:</b> 12 months for CRF and MDS</p>	<p>Aranesp is subject to Part B vs. Part D review.</p> <p><b>Chemotherapy-Induced Anemia:</b> Hgb/Hct levels must be collected within prior two weeks of request.</p> <p><b>All other uses:</b></p>

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		<p>not receiving cancer chemotherapy or patient has malignancy for which therapy with Aranesp is contraindicated.</p> <p><b>Other off-label requests:</b> Hgb greater than 10 gm/dL or Hct greater than 30%</p>	<p>2. Verification of iron evaluation for adequate iron stores with one of the following: a. Hct &lt; 36%; OR b. Hgb &lt; 12 gm/dl;</p> <p>3. Verification that the cancer is a non-myeloid malignancy.</p> <p>4. AND one of the following: a. Verification that the patient is concurrently on chemotherapy; OR b. Will be on concomitant chemotherapy for 2 months; OR c. The anemia is caused by cancer chemotherapy.</p> <p><b>Reauthorization for Chemotherapy:</b> 1. Hct &lt; 36% OR Hgb &lt; 12 gm/dl; AND 2. Hct reached target range (30% to 36%); AND 3. One of the following: a. Decrease in blood transfusion; OR b. Hgb is 1 g/dL; OR c. greater from pre-treatment level. 4. One of the following: a. Verification that the patient is concurrently on chemotherapy; OR b. Will be on concomitant chemotherapy for 2 months; OR c. The anemia is caused by cancer chemotherapy.</p> <p><b>Initial Therapy for Myelodysplastic Syndrome:</b> 1. Hct &lt; 33%; OR Hgb &lt; 11 g/dL; AND 2. One of the following: a. Serum erythropoietin of ≤ 500 mU/mL; OR b. Diagnosis of transfusion-dependent MDS. 3. Verification of adequate iron stores.</p> <p><b>Reauthorization of Myelodysplastic Syndrome:</b> 1. Verification that average Hct was below 36% over a 3 month period; AND 2. One of the following: a. Verification that Hct reached target (30% to 36%); OR b. Decrease in blood transfusion; OR c. Hgb increase ≥ 1 g/dL from pre-treatment</p>				Hgb/Hct levels must be collected within prior 30 days of request.

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			level.				
Arcalyst	All FDA approved indications not otherwise excluded from Part D			12 years and older		Indefinite, long-term therapy (open-ended)	
Avastin	All FDA approved indications not otherwise excluded from Part D	<b>NSCLC:</b> 1. Squamous cell histology 2. History of hemoptysis. 3. CNS metastases. 4. On-going therapeutic anticoagulation	<b>Colorectal Cancer:</b> 1. Diagnosis of metastatic colorectal cancer; AND 2. Used in combination with: a. 5-FU; OR b. oxaliplatin plus capecitabine; OR c. capecitabine.  <b>Non-Small Cell Lung Cancer:</b> 1. Diagnosis of unresectable locally advanced recurrent or metastatic NSCLC; AND 2. Used in combination with paclitaxel and carboplatin.  <b>Renal Cell Cancer:</b> 1. Diagnosis of metastatic renal cell cancer; AND 2. Used in combination with interferon-alpha or refractory to either interferon alpha or interleukin-2.  <b>Breast Cancer:</b> 1. Diagnosis of metastatic breast cancer; AND 2. Used in combination with paclitaxel.  <b>Age-related Macular Degeneration::</b> 1. Failure to FDA-approved therapies or likely to have greater benefit from the use of intravitreal bevacizumab.		<b>Renal Cell Cancer, Breast Cancer:</b> Prescribed by or in consultation with an oncologist.  <b>ARMD:</b> Prescribed or recommended by retina specialist	<b>Colorectal Cancer, NSCLC, RCC, Breast Cancer, ARMD:</b> Length of therapy	Avastin will be approved for continuation of prior therapy.
Cellcept Intravenous	All FDA approved indications not otherwise excluded from Part D		<b>Transplant</b> 1. Patient received a renal (kidney), cardiac (heart), or hepatic (liver) transplant; AND 2. Patient is unable to take oral formulations of mycophenolate.  <b>Lupus Nephritis:</b>			Length of therapy	Cellcept is subject to Part B vs. Part D review (not limited to new starts only).

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			1, Diagnosis of lupus nephritis; AND 2. Failure to combination therapy with corticosteroids and cyclophosphamide. 3. Patient is unable to take oral formulations of mycophenolate.				Cellcept will be approved for continuation of prior therapy if Part D.
Cellcept	All FDA approved indications not otherwise excluded from Part D		<b>Transplant:</b> 1. Patient received a renal (kidney), cardiac (heart), or hepatic (liver) transplant. 2. Patient received a bone marrow/stem cell transplant.  <b>Lupus Nephritis:</b> 1. Diagnosis of lupus nephritis; AND 2. Failure to combination therapy with corticosteroids and cyclophosphamide.  <b>Obliterative Bronchiolitis:</b> Diagnosis of obliterative bronchiolitis following lung transplantation.			Length of therapy	Cellcept is subject to Part B vs. Part D review (not limited to new starts only).  Cellcept will be approved for continuation of prior therapy if Part D.
Chorionic Gonadotropin, Novarel, Pregnyl	All FDA approved indications not otherwise excluded from Part D					6 months	
Degarelix	All FDA-approved indications not otherwise excluded from Part D.		Failure to an LHRH agonist			12 months	
Emend	All FDA-approved indications not otherwise excluded from Part D.		<b>Acute Chemotherapy-Induced Nausea and Vomiting:</b> 1. Patient is currently receiving moderately or highly emetogenic chemotherapy; AND 2. Patient is concurrently on both a corticosteroid and a 5-HT3 receptor antagonist.			<b>Acute CINV, Delayed CINV, PONV:</b> 6 months	Emend is subject to Part B vs. Part D review.

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			<p><b>Delayed Chemotherapy-Induced Nausea and Vomiting:</b></p> <ol style="list-style-type: none"> <li>1. Patient is currently receiving highly emetogenic chemotherapy and a steroid; OR</li> <li>2. Patient is on an anthracycline and cyclophosphamide.</li> </ol> <p><b>Prevention of Postoperative Nausea and Vomiting:</b></p> <p>For the prevention of postoperative nausea and vomiting when administered prior to the induction of anesthesia.</p>				

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Enbrel, Enbrel Sureclick	All FDA-approved indications not otherwise excluded from Part D.	Con-current use of anakinra.	<p><b>Rheumatoid Arthritis (RA):</b> 1. Diagnosis of moderate-to-severe RA; AND 2. Failed methotrexate or 2 DMARDs for 3 months.</p> <p><b>Juvenile Idiopathic Arthritis (JIA):</b> 1. Diagnosis of moderate-to-severe poly-articular course JIA; AND 2. Failed NSAID or steroid and methotrexate for three months</p> <p><b>Psoriatic Arthritis (PsA):</b> 1. Diagnosis of active PsA. 2. Failed methotrexate or 2 DMARDs for 3 months.</p> <p><b>Ankylosing Spondylitis (AS):</b> 1. Diagnosis of AS. 2. Failed 2 NSAIDs for 3 months.</p> <p><b>Plaque Psoriasis (PPs):</b> 1. Diagnosis moderate-to-severe chronic (greater than 6 months) plaque psoriasis. 2. Failed phototherapy and systemic therapy with one of the following: methotrexate, cyclosporine, acitretin, hydroxyurea, sulfasalazine, 6-thioguanine, or mycophenolate.</p> <p><b>Reauthorization:</b> Demonstration of clinical response to therapy.</p>	<p><b>RA, PsA, AS, PPs:</b> ≥ 18 years</p> <p><b>JIA:</b> ≥ 2 years</p>	<p><b>Initial Therapy for RA, JIA, PsA, AS:</b> Prescribed or recommended by a rheumatologist.</p> <p><b>Initial Therapy for PPs:</b> Prescribed or recommended by a dermatologist.</p>	<p><b>Initial Therapy:</b> 3 months for plaque psoriasis; 12 months for other uses</p> <p><b>Reauthorization:</b> 12 months for all uses</p>	<p>All diagnoses require verification that the patient has been evaluated for tuberculosis and has been treated accordingly</p> <p>Reauthorization of Enbrel for PPs requires a dosage of 50 mg or less per week or less.</p>
Procrit	All FDA-approved indications not otherwise excluded from Part D.	<b>Anemia in cancer patients on chemotherapy:</b> Patient is not receiving cancer chemotherapy; OR Patient has malignancy for which	<p><b>Anemia due to Chronic Renal Failure:</b> 1. Hematocrit (Hct) less than 33%; OR 2. Hemoglobin (Hgb) less than 11 gm/dl.</p> <p><b>Reauthorization of CRF:</b> 1. Average Hct was below 36% over 3-months: AND 2. One of the following: a. Hct reached target (30% to 36%); OR b. Decrease in blood transfusion; OR c. Hgb is 1 g/dL or greater from pre-treatment level.</p> <p><b>Anemia in HIV-infected patients:</b> 1. Anemia is due to zidovudine treatment or due to</p>			<p><b>Initial Therapy Pre-Op:</b> 1 month</p> <p><b>Chemo, HCV, and MDS:</b> 3 months.</p> <p><b>CRF, HIV:</b> 6 months</p> <p><b>Reauthorization CRF, HIV:</b> 6 months</p>	<p>Epoetin will be subject to Part B vs. Part D review.</p> <p>For Chemotherapy-Induced Anemia, Hgb/Hct levels must be collected within prior two weeks of request.</p>

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		<p>therapy with epoetin is contra-indicated.</p> <p><b>Chronic Renal Failure:</b> Patient is on dialysis (covered under Part B).</p> <p><b>Other off-label requests:</b> Hgb greater than 10 gm/dL or Hct greater than 30%</p>	<p>HIV infection; AND 2. Hgb less than 12 g/dL or Hct less than 36%.</p> <p><b>Reauthorization in HIV:</b> 1, Hct was below 36% over 3 months; AND 2. One of the following: a. Hct reached target (30% to 36%); OR b. Decrease in blood transfusion; OR c. Hgb is 1 g/dL or greater from pre-treatment level.</p> <p><b>Anemia in cancer patients on Chemotherapy:</b> 1. Verify other causes of anemia have been ruled out; AND 2. Hct less than 36% or Hgb less than 12 gm/dl. 3. Cancer is a non-myeloid malignancy; AND 4. Concurrently on chemo, will be on concomitant chemo for 2 months OR anemia is caused by cancer chemotherapy.</p> <p><b>Reauthorization in Chemo:</b> 1. Hct less than 36% or Hgb less than 12 gm/dl; AND 2. One of the following; AND: a. Hct reached target (30% to 36%) b. Decrease in blood transfusion c. Hgb is 1 g/dL or greater from pre-treatment level. 3. Concurrently on chemotherapy for 2 months or anemia is caused by cancer chemo.</p> <p><b>Preoperative use in patients undergoing surgery for reduction of allogeneic blood transfusion (Pre-op):</b> 1. Hgb greater than 10 to less than 13 g/dL scheduled to undergo elective, non-cardiac/vascular surgery to reduce blood transfusions; OR 2. Patient at high risk for perioperative transfusions with expected blood loss of 2 units or greater.</p> <p><b>Refractory anemia in Myelodysplastic Syndrome:</b> 1. Hct less than 33% or Hgb less than 11 g/dL;</p>			<p><b>HCV:</b> 3 months.</p> <p><b>Other uses:</b> 12 months</p>	<p>For all other indications, Hgb/Hct levels must be collected within prior 30 days of request.</p>

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			<p>AND</p> <p>2. One of the following:</p> <p>a. Serum erythropoietin of 500 mU/mL or less</p> <p>b. Diagnosis of transfusion-dependent MDS.</p> <p><b>Reauthorization for MDS:</b></p> <p>1. Average Hct was below 36% over a 3 months;</p> <p>AND</p> <p>2. One of the following:</p> <p>a. Hct reached target (30% to 36%)</p> <p>b. Decrease in blood transfusion</p> <p>c. Hgb increase of 1 g/dL or more from pre-treatment level.</p> <p><b>Treatment of anemia in HCV-infected patients due to ribavirin in combination with interferon or peg-interferon:</b></p> <p>1. Hgb less than 12 g/dL or Hct less than 36%;</p> <p>AND</p> <p>2. Is concurrently on ribavirin and interferon or peg-interferon alfa for the treatment of HCV and the anemia is due to treatment.</p> <p><b>Reauthorization of HCV:</b></p> <p>1. Average Hct was below 36% over a 3 months;</p> <p>And</p> <p>2. One of the following:</p> <p>a. Hct reached target (30% to 36%)</p> <p>b. Decrease in blood transfusion</p> <p>c. Hgb is 1 g/dL or greater from pre-treatment level.</p> <p><b>All uses:</b></p> <p>Verify iron evaluation for adequate Fe stores.</p>				
Erbix	All FDA-approved indications not otherwise excluded from Part D.		<p><b>Head and Neck Cancer:</b></p> <p>1. One of the following:</p> <p>a. Confirmed diagnosis of locally or regionally advanced squamous cell carcinoma of the head and neck</p> <p>b. Recurrent or metastatic squamous cell head and neck cancer; AND</p> <p>2. One of the following:</p> <p>a. Used in combination with radiation therapy</p>			Length of therapy	Erbix will be approved for continuation of prior therapy.

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			<p>b. After failure of platinum-based chemotherapy.</p> <p><b>Colorectal Cancer:</b></p> <ol style="list-style-type: none"> <li>1. Confirmed diagnosis of metastatic carcinoma of the colon or rectum; AND</li> <li>2. One of the following:               <ol style="list-style-type: none"> <li>a. Used in combination with irinotecan-based chemotherapy</li> <li>b. Intolerance to irinotecan-based chemotherapy</li> <li>c. Failure of irinotecan or oxaliplatin-based chemotherapy regimens; AND</li> </ol> </li> <li>3. Tumor expresses wild-type KRAS gene.</li> </ol>				
fentanyl citrate oral transmucosal	All FDA-approved indications not otherwise excluded from Part D.		<p><b>Cancer Pain:</b></p> <ol style="list-style-type: none"> <li>1. Confirmed diagnosis of malignant pain; AND</li> <li>2. Failure or contraindication to an immediate-release opioid; AND</li> <li>3. Demonstrated tolerance to opioids.</li> </ol>			Length of therapy	
Foradil	All FDA-approved indications not otherwise excluded from Part D.		Diagnosis of moderate or severe persistent asthma when used concurrently with an inhaled corticosteroid, or for the prevention of exercise-induced bronchospasm, or for COPD.			Long-term approval	
Forteo	All FDA-approved indications not otherwise excluded from Part D.	<ol style="list-style-type: none"> <li>1. Paget's disease history</li> <li>2. Bone metastases of skeletal malignancies</li> <li>3. Radiation therapy</li> <li>4. Bone disease other</li> </ol>	<p><b>Osteoporosis:</b></p> <ol style="list-style-type: none"> <li>1. Failure to a formulary bisphosphonate AND history of fracture resulting from minimal trauma (or BMD T score of -2.5 or less); OR</li> <li>2. Both of the following:               <ol style="list-style-type: none"> <li>a. Failure to a formulary alternative</li> <li>b. BMD T score of -3.0 or less and a previous fracture resulting from minimal trauma.</li> </ol> </li> </ol>			2 years	Forteo is subject to Part B vs. Part D review.

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		<p>than osteoporosis</p> <p>5. Concurrent use of bisphosphonate.</p>					
Gamastan S/D	All FDA approved indications not otherwise excluded from Part D		<p><b>Hepatitis A:</b> For use before or soon after exposure.</p> <p><b>Measles:</b> For use in susceptible individuals exposed fewer than 6 days previously.</p> <p><b>Varicella:</b> For use in immunocompromised patients.</p> <p><b>Rubella:</b> For pregnant women who will not consider a therapeutic abortion.</p>			Length of therapy	
Gleevec	All FDA approved indications not otherwise excluded from Part D		<p><b>Chronic Myeloid Leukemia (Adults):</b> Diagnosis of Philadelphia chromosome positive CML.</p> <p><b>Chronic Myeloid Leukemia (Children):</b> 1. Diagnosis of Philadelphia chromosome positive (Ph+) chronic phase CML; AND 2. One of the following: a. Not candidates for stem cell transplantation b. Disease has recurred after stem cell transplant c. Patients who are resistant to interferon-alfa therapy.</p> <p><b>Acute Lymphoblastic Leukemia:</b> Adult patients with Philadelphia chromosome positive ALL.</p> <p><b>Myelodysplastic/Myeloproliferative disease:</b> Adults diagnosed with MDS/MPD diseases associated with platelet-derived growth factor</p>			Length of therapy	Gleevec will be approved for continuation of prior therapy.

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			<p>receptor gene rearrangements.</p> <p><b>Aggressive systemic mastocytosis:</b>  1. Adults diagnosed with aggressive systemic mastocytosis; AND  2. One of the following:  a. Patient is without the D816V c-Kit mutation  b. c-Kit mutation status unknown.</p> <p><b>Hyper eosinophilic syndrome and chronic eosinophilic leukemia :</b>  Adults diagnosed with HES or CEL.</p> <p><b>Dermatofibrosarcoma protuberans:</b>  Adults with unresectable, recurrent and/or metastatic DFSP.</p> <p><b>Gastrointestinal Stromal Tumors:</b>  Patients with a confirmed diagnosis of unresectable and/or metastatic GIST.</p>				
<p><b>Growth Hormones:</b>  Genotropin, Genotropin Miniquick, Humatrope, Humatrope Combo Pack, Norditropin Cartridge, Norditropin Nordiflex Pen, Nutropin, Nutropin Aq, Nutropin Aq Pen, Omnitrope, Saizen, Saizen Click Easy, Tev-Tropin</p>	<p>All FDA approved indications not otherwise excluded from Part D:</p> <p>Growth Hormone Deficiency (GHD) in Children</p> <p>Prader-Willi Syndrome (PWS)</p> <p>Small for Gestational Age (SGA)</p> <p>Turner Syndrome</p>	<p><b>Childhood Onset Growth Hormone Deficiency in Adults:</b></p> <ol style="list-style-type: none"> <li>Males with bone age greater than 17 yrs or females with bone age greater than 15 years</li> <li>Closed bone epi-</li> </ol>	<p><b>GHD Children:</b></p> <ol style="list-style-type: none"> <li>Diagnosis of GH deficiency based on two GH stimulation tests or low Insulin-like growth factor 1 (IGF-1) levels; AND</li> <li>Demonstrate growth failure based on growth velocity or height shorter than 2 standard deviations (SD) below the mean height for age.</li> </ol> <p><b>Prader-Willi Syndrome or Small for Gestational Age:</b></p> <ol style="list-style-type: none"> <li>Diagnosis of PWS confirmed by genetic testing; OR</li> <li>Diagnosis of SGA confirmed by birth wt of less than 2500g at gestation of more than 37 wks or at birth weight or length below the 3rd percentile for gestational age who failed to catch up by 2 years of age.</li> </ol> <p><b>Turner Syndrome, Noonan Syndrome:</b></p> <ol style="list-style-type: none"> <li>Treatment of short stature in females w/bone age less than 15 years associated w/TS or NS; OR</li> <li>Treatment of short stature in males w/bone age</li> </ol>		<p><b>GHD (Child), AOGH, COGHDA, IGHDA, Initial Therapy for TS or NS, GRCRF, and ISS:</b>  Prescribed by an endocrinologist.</p>	<p>Length of therapy for GHD in adults. One year for all other uses.</p>	

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	<p>(TS)</p> <p>Noonan Syndrome (NS)</p> <p>Growth Retardation associated with Chronic Renal Insufficiency (GRCRF)</p> <p>Idiopathic Short Stature (ISS)</p> <p>Adult Onset Growth Hormone Deficiency (AOGHD),</p> <p>Childhood Onset GH Deficiency in Adults (COGHDA)</p> <p>Isolated GH Deficiency in Adults (IGHDA)</p>	<p>physes on radiograph</p> <p>3. Growth velocity less than 2 cm/year during previous year of treatment unless COGHD criteria are met.</p>	<p>less than 17 years associated w/NS.</p> <p><b>Growth Retardation associated with Chronic Renal Insufficiency:</b></p> <p>1. Diagnosis of chronic renal insufficiency; AND</p> <p>2. Height shorter than or equal to 2 SD below the median age for children or where growth velocity falls to below 4.5 cm/year.</p> <p><b>Reauthorization for GHD in Children, PWS, SGA, TS, NS, GRCRF:</b></p> <p>1. Increase in growth velocity of at least 2 cm/year during previous year of treatment; AND</p> <p>2. Males with bone age less than 17 yrs or females with bone age less than 15 years.</p> <p><b>Idiopathic Short Stature:</b></p> <p>1. Height less than or equal to 2.25 SD below the mean height for age. Growth velocity less than the 25th percentile for bone age; AND</p> <p>2. Verify open epiphyses on last bone age radiograph; AND</p> <p>3. Absence of comorbid conditions that should be observed or treated by other means.</p> <p><b>Reauthorization of ISS:</b></p> <p>1. Increase in growth velocity of at least 4.5 cm/year during previous year of treatment; AND</p> <p>2. Males w/bone age less than 17 years or females w/bone age less than 15 years.</p> <p><b>Adult Onset Growth Hormone Deficiency:</b></p> <p>1. Pts who have GHD alone or multiple hormone deficiencies because of pituitary disease/insult, hypothalamic disease, surgery, or radiation treatment; AND</p> <p>2. IGF-1 level less than 77 mcg/L or 2 SD below the mean value, matched by age and gender.</p> <p><b>Childhood Onset GH Deficiency in Adults:</b></p> <p>1. Childhood onset in patients who were GH deficient during childhood who have GH deficiency confirmed as an adult before replacement treatment with GH is started; AND</p>				

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			<p>2. Persistent deficiency of GH documented by GH stimulation tests.</p> <p><b>Isolated GH Deficiency in Adults:</b> Documented deficiency of GH documented by 2 GH stimulation tests.</p>				
Hexalen	All FDA approved indications not otherwise excluded from Part D.		<p>1. Diagnosis of ovarian cancer</p> <p>2. Cancer has progressed or recurred following first-line treatment with a cisplatin or alkylating agent-based combination</p>		Prescribed by an oncologist	12 months	Hexalen will be approved for continuation of prior therapy.
Humira, Humira Pen-Crohns Disease	All FDA approved indications not otherwise excluded from Part D.	Concurrent use of anakinra	<p><b>Rheumatoid Arthritis:</b></p> <p>1. Diagnosis of moderate-to-severe RA; AND</p> <p>2. Failed methotrexate or 2 DMARDs for 3 months.</p> <p><b>Juvenile Rheumatoid Arthritis / Juvenile Idiopathic Arthritis:</b> Diagnosis of moderate-to-severe poly-articular course</p> <p><b>Juvenile Rheumatoid Arthritis:</b> Failed NSAID or steroid and DMARD for three months.</p> <p><b>Psoriatic Arthritis:</b></p> <p>1. Diagnosis of active PsA.</p> <p>2. Failed methotrexate or 2 DMARDs for 3 months.</p> <p><b>Ankylosing Spondylitis:</b></p> <p>1. Diagnosis of AS.</p> <p>2. Failed 2 NSAIDs for 3 months.</p> <p><b>Plaque Psoriasis:</b></p> <p>1. Diagnosis moderate-to-severe plaque psoriasis.</p> <p>2. Failed phototherapy and systemic therapy.</p> <p><b>Crohn's disease:</b></p> <p>1. Diagnosis of moderate to severe CD; AND</p> <p>2. Failed conventional therapies.</p> <p><b>Reauthorization:</b></p>	<p><b>RA, PsA, CD, AS, Plaque Psoriasis:</b> 18 years and older.</p> <p><b>JIA:</b> 4 years and older.</p>	<p><b>RA, PsA, AS, JIA:</b> Prescribed or recommended by a rheumatologist.</p> <p><b>Plaque Psoriasis:</b> Prescribed or recommended by a dermatologist.</p> <p><b>CD:</b> Prescribed or recommended by gastroenterologist.</p>	<p><b>Initial Authorization:</b> 4 months for Plaque Psoriasis; 12 months for other uses.</p> <p><b>Reauthorization</b> 12 months</p>	<p><b>RA:</b> Authorization is for 40 mg every other week unless documented treatment failure to Humira every other week dosing. Then Humira may be approved for every week dosing if other criteria met.</p> <p><b>Plaque Psoriasis:</b> Humira dosage is 40 mg every other week.</p> <p><b>All diagnoses:</b> Verification that the patient has</p>

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Demonstration of clinical response to therapy.				been evaluated for TB and treated accordingly.
<b>Immune Globulin:</b> Carimune Nanofiltered, Flebogamma, Gammagard Liquid, Gamunex, Octagam, Polygam S/D	All FDA approved indications not otherwise excluded from Part D		<p><b>Idiopathic Thrombocytopenic Purpura (ITP):</b> For patients with ITP who require a rapid temporary increase in platelet count or to control excessive bleeding</p> <p><b>Kawasaki Disease (KD):</b> Confirmed diagnosis of KD.</p> <p><b>B-cell Chronic Lymphocytic Leukemia (CLL):</b> 1. Documented hypogammaglobulinemia (IgG less than 600mg/dL); OR 2. History of bacterial infections associated with B-cell CLL.</p> <p><b>Bone Marrow Transplantation (BMT):</b> 1. Confirmed allogeneic BMT within the last 100 days; AND 2. Documented severe hypogammaglobulinemia (IgG less than 400 mg/dL)</p> <p><b>Dermatomyositis:</b> Failure or intolerance to one of the following: corticosteroid therapy, methotrexate, azathioprine, or cyclophosphamide.</p> <p><b>HIV:</b> Documented hypogammaglobulinemia (IgG less than 400 mg/dL).</p> <p><b>Guillane-Barre Syndrome (GBS):</b> 1. Confirmed diagnosis of severe GBS; AND 2. Patients with severe disease requiring aid to walk; AND 3. Onset of muscle weakness within the last 4 weeks.</p> <p><b>Lambert-Eaton Myasthenic Syndrome (LEMS):</b> 1. Confirmed diagnosis of LEMS.</p>		<b>MG:</b> Prescribed by a neurologist.	<b>BMT:</b> 100 days after transplant  <b>KD:</b> 1 month  <b>MG, GBS:</b> 1 treatment course  <b>ITP, LEMS:</b> 6 months  <b>Other Uses:</b> 1year	Immune Globulin is subject to Part B vs. Part D review.  For Part D: For patients in which immune globulin is administered in the patient's home.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p><b>Acute Myasthenia Gravis (MG) Exacerbation :</b>  1. Confirmed diagnosis of myasthenia gravis with myasthenic exacerbation, defined by one of the following:  a. Difficulty swallowing  b. Acute respiratory failure  c. Major functional disability responsible for the discontinuation of physical activity.</p> <p><b>Relapsing-Remitting Multiple Sclerosis (MS) :</b>  1. Confirmed diagnosis of relapsing remitting form of MS AND  2. Failure to two of the following: Betaseron, Avonex, Rebif, Copaxone, Tysabri.</p> <p><b>Stiff Person Syndrome :</b>  Chart documentation confirming a diagnosis of stiff-person syndrome.</p>				
Infergen	All FDA approved indications not otherwise excluded from Part D		<p><b>Hepatitis C - Treatment Naive Patients:</b>  For patients with Chronic Hepatitis C with compensated liver disease with positive HCV antibody and HCV RNA.</p> <p><b>Hepatitis C - Continuation of Therapy:</b>  For genotypes 2, 3, 5, or 6: Loss of detectable HCV RNA from serum or 100 fold drop or more in HCV RNA level.</p>	<b>Hepatitis C in Treatment Naive patients:</b> 18 years and older.		<p><b>Treatment-Naive: genotypes 2, 3, 5, 6:</b> 6 months</p> <p><b>Genotypes 1, 4 or HIV/HCV:</b> 12 months</p> <p><b>Continuation of treatment in genotypes 2, 3, 5, 6:</b> 6 months</p>	
Intron-A, Intron-A W/Diluent	All FDA approved indications not otherwise excluded from Part D		<p><b>Hepatitis B - HBeAg positive:</b>  1. HBsAg positive for at least 6 months; AND  2. HBV DNA level greater than 100,000 copies/mL; AND.  3. Compensated liver disease; AND  4. One of the following: persistent ALT 2 times ULN or moderate to severe hepatitis or fibrosis on biopsy.</p>	<b>Hep B - HBeAg positive, Hep B - HBeAg negative:</b> 1 year of age or older.		<p><b>HepB+:</b> 6 months</p> <p><b>HepB-:</b> 1 year</p> <p><b>HepC: genotypes 2, 3, 5, 6:</b> 6 months</p>	Intron A will be approved for continuation of prior therapy for neoplastic diseases.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p><b>Hepatitis B - HBeAg negative:</b></p> <ol style="list-style-type: none"> <li>1. HBsAg positive for at least 6 months; AND</li> <li>2. HBV DNA level of 2000 IU/mL or more or 11,200 copies/mL; AND</li> <li>3. Compensated liver disease; AND</li> <li>4. One of the following: persistent ALT 2 times ULN or moderate to severe hepatitis or fibrosis on biopsy.</li> </ol> <p><b>Hepatitis C - Treatment Naive Patients:</b> For patients with Chronic Hepatitis C with compensated liver disease with positive HCV antibody and HCV RNA.</p> <p><b>Hepatitis C - Continuation of Therapy:</b> For genotypes 2, 3, 5, or 6: loss of detectable HCV RNA from serum or 100 fold drop or more in HCV RNA level.</p> <p><b>Non-Hepatitis Diagnoses</b> Diagnosis of one of the following:</p> <ol style="list-style-type: none"> <li>1. Malignant Melanoma</li> <li>2. Hairy cell leukemia (HCL)</li> <li>3. Stage III or IV follicular Non-Hodgkin's Lymphoma</li> <li>4. Condylomata acuminata</li> <li>5. AIDS-related Kaposi's sarcoma</li> <li>6. Multiple Myeloma.</li> </ol> <p><b>Acute Hepatitis C:</b> Patients with acute hepatitis C.</p>	<p><b>Hep C - Treatment Naive Patients, Non-Hepatitis Diagnoses, Acute Hep C:</b> 18 years old and older.</p> <p><b>Hep C - Treatment Naive Patients (in combination with ribavirin):</b> 3 years of age and older.</p>		<p><b>HepC: genotypes 1, 4, HIV/HCV:</b> 12 months</p> <p><b>Acute HepC, HCL, Kaposi:</b> 6 months.</p> <p><b>Warts:</b> 3 weeks.</p> <p><b>Other uses:</b> 1 year</p>	
Ketek	All FDA approved indications not otherwise excluded from Part D		<p><b>Community-Acquired Pneumonia:</b></p> <ol style="list-style-type: none"> <li>1. Diagnosis of CAP in an adult outpatient; AND</li> <li>2. Resistance or failure to either azithromycin or clarithromycin.</li> </ol>			Ketek will be approved for the length of therapy.	
Kineret	All FDA approved indications not otherwise excluded from	Concurrent use of TNF-blockers or Orencia	<p><b>Initial Therapy for Rheumatoid Arthritis (RA):</b></p> <ol style="list-style-type: none"> <li>1. Moderate to severe active RA; AND</li> <li>2. Failure with a TNF-alpha-blocker; AND</li> <li>3. Failure on either methotrexate or at least 1 DMARD for at least 3 months.</li> </ol>	<b>RA:</b> 18 years and older	<b>RA:</b> Prescribed or recommended by a rheumatolo-	<b>Initial Therapy for RA:</b> Kineret will be approved for 12 months.	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D		<p><b>Reauthorization for RA:</b> Submission of chart documentation demonstrating positive clinical response.</p>		gist.	<p><b>Reauthorization for RA:</b> Kineret will be approved for 1 year.</p>	
Letairis	All FDA approved indications not otherwise excluded from Part D		<p><b>Pulmonary Arterial Hypertension:</b> Patients with a confirmed diagnosis of pulmonary arterial hypertension (modified WHO Group I) which is symptomatic.</p>			Length of therapy	
Leukine	All FDA approved indications not otherwise excluded from Part D		<p><b>Bone Marrow/Stem Cell Transplant (BMSCT):</b> 1. Patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous/allogeneic BMT; OR 2. Mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis; OR 3. Peripheral stem cell transplant patients who have received myeloablative chemotherapy.</p> <p><b>Acute Myeloid Leukemia (AML) Induction or Consolidation Therapy:</b> For patients with AML following induction or consolidation chemotherapy.</p> <p><b>Neutropenia associated with dose dense chemotherapy (NDDC):</b> 1. Patient is receiving the National Comprehensive Cancer Network's (NCCN's) Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer; OR 2. A dose-dense regimen for which the incidence of febrile neutropenia is unknown.</p> <p><b>Chemotherapy with risk of febrile neutropenia (CFN):</b> 1. Patient is receiving a chemotherapy regimen associated with more than 20% incidence of febrile neutropenia; OR 2. Patient is receiving chemotherapy regimen associated with 10-20% incidence of febrile</p>	<p><b>AML:</b> Greater than or equal to 55 years old.</p>		<p><b>BMSCT, AML, NDDC, CFN, FN:</b> 3 months</p> <p><b>HIVN:</b> 6 months</p>	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>neutropenia and has risk factors associated with chemotherapy-induced infection, febrile neutropenia or neutropenia.</p> <p><b>Febrile Neutropenia (FN):</b>  1. For patients receiving myelosuppressive anticancer drugs associated with neutropenia;  AND  2. Patient either has febrile neutropenia or has a history of febrile neutropenia during a previous course of chemotherapy.</p> <p><b>HIV-related neutropenia (HIVN):</b>  HIV-infected patients with an Absolute Neutrophil Count (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.</p>				
Lotronex	All FDA approved indications not otherwise excluded from Part D	Initial therapy for Irritable Bowel Syndrome (IBS) in the male gender.	<p><b>Initial Therapy for Irritable Bowel Syndrome:</b>  1. Confirmed diagnosis of IBS with diarrhea predominant symptoms for at least 6 months;  AND  2. Failure to an antispasmodic and an anti-diarrhea agent.</p> <p><b>Reauthorization for IBS:</b>  1. Recurrence of diarrhea-predominant IBS; AND  2. Documentation of positive clinical response while on Lotronex.</p>	18 years and older.	Verification that physician has enrolled in the GlaxoSmith-Kline Prescribing Program.	<p><b>Initial Therapy:</b>  12 weeks</p> <p><b>Reauthorization:</b>  6 months</p>	
Lyrica	All FDA approved indications not otherwise excluded from Part D		<p><b>Seizure Disorder:</b>  1. History of failure to a formulary anticonvulsant;  AND  2. As add-on therapy for the diagnosis of partial seizure.</p> <p><b>Diabetic Neuropathy:</b>  1, Diagnosis of Diabetes Mellitus; AND  2. Diagnosis of peripheral neuropathy; AND  3. Failure to gabapentin.</p> <p><b>Post-herpetic Neuropathic Pain:</b>  Failure to gabapentin.</p>			Length of therapy	Lyrica will be approved for continuation of prior therapy.

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		<p><b>Nausea and Vomiting Associated with Cancer Chemotherapy (CINV):</b></p> <ol style="list-style-type: none"> <li>1. Patient is receiving cancer chemotherapy; AND</li> <li>2. Failure to 5HT-3 receptor antagonist; AND</li> <li>3. Failure to one of the following agents:               <ol style="list-style-type: none"> <li>a. Antihistamine</li> <li>b. Corticosteroid</li> <li>c. Prokinetic agent</li> <li>d. Antipsychotic.</li> </ol> </li> </ol> <p><b>AIDS Anorexia:</b> Diagnosis of anorexia with weight loss in patients with AIDS.</p>			<p><b>CINV:</b> 6 months</p> <p><b>AIDS anorexia:</b> Length of therapy</p>	<p>Marinol is subject to Part B vs. Part D review.</p> <p><b>CINV:</b> Marinol will be approved for continuation covered under Part B when patient is receiving chemotherapy</p>
Neulasta	All FDA approved indications not otherwise excluded from Part D		<p><b>Chemotherapy with risk of febrile neutropenia (CFN):</b></p> <ol style="list-style-type: none"> <li>1. Patient is receiving a chemotherapy regimen associated with more than 20% incidence of febrile neutropenia; OR</li> <li>2. a. Patients is receiving chemotherapy regimen associated with 10-20% incidence of febrile neutropenia; AND               <ol style="list-style-type: none"> <li>b. Has risk factors associated with chemotherapy-induced infection, febrile neutropenia or neutropenia.</li> </ol> </li> </ol> <p><b>Neutropenia associated with dose dense chemotherapy (NDDC):</b></p> <ol style="list-style-type: none"> <li>1. Patients is receiving NCCN's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer; OR</li> <li>2. A dose-dense regimen for which the incidence of febrile neutropenia is unknown.</li> </ol> <p><b>Febrile Neutropenia (FN):</b></p> <ol style="list-style-type: none"> <li>1. For patients receiving myelosuppressive anticancer drugs associated with neutropenia; AND</li> <li>2. Patient either has febrile neutropenia or has a history of febrile neutropenia during a previous course of chemotherapy.</li> </ol>			<p><b>CFN, NDDC, FN:</b> One month or duration of treatment.</p>	
Neumega	All FDA	Patients	<b>Thrombocytopenia following chemotherapy</b>			3 week intervals for	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	approved indications not otherwise excluded from Part D	with myeloablative chemotherapy.	<ol style="list-style-type: none"> <li>1. Verification that the cancer is a non-myeloid malignancy; AND</li> <li>2. Platelet count is less than 50,000 cells/microliter; AND</li> <li>3. Patients with one or more of the following risk factors:               <ol style="list-style-type: none"> <li>a. Extensive prior cytotoxic chemotherapy</li> <li>b. Prior severe chemotherapy-induced thrombocytopenia</li> <li>c. Receiving chemotherapy regimens associated with high risk for thrombocytopenia.</li> </ol> </li> </ol>			up to 6 cycles post-chemotherapy.	
Neupogen	All FDA approved indications not otherwise excluded from Part D		<p><b>Bone Marrow/Stem Cell Transplant (BMSCT):</b></p> <ol style="list-style-type: none"> <li>1. For patients with non-myeloid malignancies undergoing myelo-ablative chemotherapy followed by autologous or allogeneic BMT; OR</li> <li>2. For mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis; OR</li> <li>3. For peripheral stem cell transplant patients who have received myelo-ablative chemotherapy.</li> </ol> <p><b>Acute Myeloid Leukemia (AML) Induction or Consolidation Therapy:</b> For patients with AML following induction or consolidation chemotherapy.</p> <p><b>Neutropenia associated with dose dense chemotherapy (NDDC):</b></p> <ol style="list-style-type: none"> <li>1. Patient is receiving NCCN's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer; OR</li> <li>2. A dose-dense regimen for which the incidence of febrile neutropenia is unknown.</li> </ol> <p><b>Chemotherapy with risk of febrile neutropenia (CFN):</b></p> <ol style="list-style-type: none"> <li>1. Patient is receiving a chemotherapy regimen associated with more than 20% incidence of febrile neutropenia; OR</li> <li>2. Patient is receiving a chemotherapy regimen associated with 10-20% incidence of febrile neutropenia and has risk factors associated with chemotherapy-induced infection, febrile</li> </ol>			<p><b>BMSCT, AML, NDDC, CFN, FN:</b> 3 months</p> <p><b>SCN, HCN:</b> 12 months</p> <p><b>HIVN:</b> 6 months</p>	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>neutropenia or neutropenia.</p> <p><b>Febrile Neutropenia (FN):</b>  1. For patients receiving myelosuppressive anticancer drugs associated with neutropenia;  AND  2. Patient either has febrile neutropenia or has a history of febrile neutropenia during a previous course of chemotherapy.</p> <p><b>Severe Chronic Neutropenia (SCN):</b>  For patients with severe chronic neutropenia.</p> <p><b>Hepatitis-C Treatment of Related Neutropenia (HCN):</b>  1. Neutropenia in Hepatitis C virus infected patients undergoing treatment with Peg-Intron or Pegasys after dose reduction; OR  2. For patients 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.</p> <p><b>HIV-related neutropenia (HVN):</b>  HIV-infected patients 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.</p>				
Nexavar	All FDA approved indications not otherwise excluded from Part D		One of the following: 1. Diagnosis of renal cell carcinoma with relapse following surgical excision 2. Diagnosis of renal cell carcinoma with medically or surgically unresectable tumor 3. Diagnosis of Stage IV renal cell carcinoma 4. Diagnosis of unresectable hepatocellular carcinoma.		Prescribed by an oncologist.	6 months	Nexavar will be approved for continuation of prior therapy.
oxandrolone	All FDA approved indications not otherwise excluded from Part D		<p><b>Bone Pain:</b>  Diagnosis of bone pain due to osteoporosis.</p> <p><b>Initial Therapy for AIDS Wasting:</b>  Diagnosis of AIDS wasting/cachexia and failure to hormone replacement therapy in patients with</p>			<p><b>Initial therapy:</b>  3 months</p> <p><b>Reauthorization:</b>  Length of therapy</p>	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>hypogonadism.</p> <p><b>Reauthorization for AIDS Wasting:</b> Verification that the patient's weight has increased a minimum of 2% while taking Oxandrin</p>				
Pegasys	All FDA approved indications not otherwise excluded from Part D		<p><b>Hepatitis B - HBeAg positive patients:</b></p> <ol style="list-style-type: none"> <li>1. HBsAg positive for at least 6 months; AND</li> <li>2. HBV DNA level greater than 100,000 copies/mL; AND.</li> <li>3. Compensated liver disease; AND</li> <li>4. One of the following:               <ol style="list-style-type: none"> <li>a. ALT (liver enzyme) 2 times upper limits of normal (ULN)</li> <li>b. Moderate-to-severe hepatitis or fibrosis on biopsy.</li> </ol> </li> </ol> <p><b>Hepatitis - HBeAg negative patients:</b></p> <ol style="list-style-type: none"> <li>1. HBsAg positive for at least 6 months; AND</li> <li>2. HBV DNA level of 2000 IU/mL or more or 11,200 copies/mL; AND</li> <li>3. Compensated liver disease; AND</li> <li>4. One of the following:               <ol style="list-style-type: none"> <li>a. ALT 2 times ULN</li> <li>b. Moderate-to-severe hepatitis or fibrosis on biopsy.</li> </ol> </li> </ol> <p><b>Hepatitis C - Treatment Naive Patients:</b></p> <ol style="list-style-type: none"> <li>1. Chronic Hepatitis C with compensated liver disease; AND</li> <li>2. Positive HCV antibody HCV RNA; AND</li> <li>3. HCV RNA level measurement; AND</li> <li>4. Genotype test result; AND</li> <li>5. For patients who have not previously been treated with interferon.</li> </ol> <p><b>Continuation of Therapy:</b></p> <p><b>A. For genotypes 5 or 6:</b></p> <ol style="list-style-type: none"> <li>1. Loss of detectable HCV RNA from serum or 100 fold drop or more in HCV RNA level.</li> </ol> <p><b>B. For genotype 1:</b></p> <ol style="list-style-type: none"> <li>1. Undetectable HCV RNA after 24 weeks of therapy; AND</li> </ol>	For all covered uses: 18 years and older		<p><b>Hepatitis B:</b> 1year.</p> <p><b>Hepatitis C Genotypes 5, 6:</b> 12 weeks; <b>Genotypes 2, 3:</b> 24 weeks; <b>Genotypes 1, 4:</b> (HIV/HCV co-infected patients): 48wk.</p> <p><b>Hepatitis C Continuation therapy:</b> <b>Genotypes 1,3:</b> 24 weeks, <b>Genotypes 5, 6:</b> 36wk.</p> <p><b>Hepatitis C Retreatment:</b> 1year</p>	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>2. One of the following:</p> <ul style="list-style-type: none"> <li>a. HCV RNA more than 50 IU/mL at 4 weeks into treatment</li> <li>b. Less than 100 fold drop or detectable HCV RNA 12 weeks into therapy.</li> </ul> <p><b>C. For genotype 3:</b></p> <ul style="list-style-type: none"> <li>1. Baseline HCV RNA more than 600,000 IU/mL; AND</li> <li>2. Steatosis or advanced fibrosis on liver biopsy.</li> </ul> <p><b>Hepatitis C Retreatment:</b></p> <ul style="list-style-type: none"> <li>1. One of the following <ul style="list-style-type: none"> <li>a. Retreatment in patients who have failed or relapsed following standard or pegylated interferon monotherapy; OR</li> <li>b. For non-responders or relapsers who have significant fibrosis or cirrhosis who have undergone previous regimens of treatment using non-pegylated interferon. AND</li> </ul> </li> <li>2. Used in combination with ribavirin.</li> </ul>				
Peg-Intron, Peg-Intron Redipen	All FDA approved indications not otherwise excluded from Part D		<p><b>Hepatitis C - Treatment Naive Patients:</b></p> <ul style="list-style-type: none"> <li>1. Chronic Hepatitis C with compensated liver disease; AND</li> <li>2. Positive HCV antibody HCV RNA; AND</li> <li>3. HCV RNA level measurement; AND</li> <li>4. Genotype test result; AND</li> <li>5. For patients who have not previously been treated with interferon.</li> </ul> <p><b>Hepatitis C (Continuation):</b></p> <p><b>A. For genotypes 5 or 6:</b></p> <ul style="list-style-type: none"> <li>1. Loss of detectable serum HCV RNA; OR</li> <li>2. 100 fold drop or more in HCV RNA level.</li> </ul> <p><b>B. For genotype 1:</b></p> <ul style="list-style-type: none"> <li>1. Undetectable HCV RNA after 24 weeks of therapy; AND</li> <li>2. One of the following: <ul style="list-style-type: none"> <li>a. HCV RNA more than 50 IU/mL at 4 weeks into treatment</li> <li>b. Less than 100 fold drop or detectable HCV RNA 12 weeks into therapy.</li> </ul> </li> </ul>	<b>Treatment Naive Patients:</b> 3 years and older		<p><b>Genotypes 5, 6:</b> 12 weeks</p> <p><b>Genotypes 2, 3:</b> 24 weeks</p> <p><b>Genotypes 1, 4, co-infection with HIV/HCV:</b> 48 weeks.</p> <p><b>Hepatitis C Continuation:</b> <b>Genotypes 1, 3:</b> 24 weeks <b>Genotypes: 5, 6:</b> 36 weeks.</p> <p><b>Hepatitis C Retreatment:</b> 1 year</p>	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p><b>C. For genotype 3:</b></p> <ol style="list-style-type: none"> <li>1. Baseline HCV RNA more than 600,000 IU/mL; AND</li> <li>2. Steatosis or advanced fibrosis on liver biopsy.</li> </ol> <p><b>Hepatitis C (Retreatment):</b></p> <ol style="list-style-type: none"> <li>1. One of the following:               <ol style="list-style-type: none"> <li>a. Retreatment in patients who have failed or relapsed following standard or pegylated interferon monotherapy; OR</li> <li>b. For non-responders or relapsers who have significant fibrosis or cirrhosis who have undergone previous regimens of treatment using non-pegylated interferon. AND</li> </ol> </li> <li>2. Used in combination with ribavirin.</li> </ol>				
Prograf intravenous	All FDA approved indications not otherwise excluded from Part D		<p><b>Transplant:</b></p> <ol style="list-style-type: none"> <li>1. One of the following:               <ol style="list-style-type: none"> <li>a. Patient received a renal (kidney), cardiac (heart), lung, pancreas, small bowel, or hepatic (liver) transplant.</li> <li>b. Patient received a bone marrow/stem cell transplant. AND</li> </ol> </li> <li>2. Patient is unable to take oral tacrolimus.</li> </ol>			Length of therapy	<p>Prograf is subject to Part B vs. Part D review (not limited to new starts only).</p> <p>Prograf will be approved for continuation of prior therapy if Part D.</p>
Prograf	All FDA approved indications not otherwise excluded from Part D		<p><b>Severe Uveitis:</b> Failure to one corticosteroid.</p> <p><b>Transplant:</b></p> <ol style="list-style-type: none"> <li>1. Patient received a renal (kidney), cardiac (heart), lung, pancreas, small bowel, hepatic (liver) transplant, bone marrow/stem cell transplant; AND</li> <li>2. Diagnosis of graft vs. host disease in patients receiving bone marrow transplants.</li> </ol>			Length of therapy	<p>Prograf is subject to Part B vs. Part D review (not limited to new starts only)</p> <p>Prograf will be approved for continuation of prior therapy if Part D.</p>

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Proleukin	All FDA approved indications not otherwise excluded from Part D		<p><b>Metastatic Renal Cell Carcinoma or Metastatic Melanoma:</b></p> <ol style="list-style-type: none"> <li>1. Measurable, histologically confirmed metastatic renal cell carcinoma or metastatic melanoma; AND</li> <li>2. Good neurologic or ambulatory performance status; AND</li> <li>3. Adequate organ function determined by all of the following:               <ol style="list-style-type: none"> <li>a. Normal cardiac stress test results</li> <li>b. FEV1 greater than 2 L on pulmonary function tests</li> <li>c. Creatinine concentration 1.5 mg/dL or less or calculated creatinine clearance &gt; 60 ml/min</li> <li>d. Bilirubin concentration of 1.5 mg/dL or less</li> <li>f. SGOT/AST less than 150 IU or 4x upper limit of normal. AND</li> </ol> </li> <li>4. Platelet count greater than or equal to 100,000/ mL; AND</li> <li>5. Hemoglobin greater than or equal to 10 g/dL; AND</li> <li>6. WBC greater than or equal to 3,500 / mL; AND</li> <li>7. At least 7 weeks since prior therapy and complete recovery from therapy-related side effects.</li> </ol>	<b>All uses:</b> 18 years and older		3 months	<p><b>All uses:</b> Proleukin will be approved for continuation of prior therapy.</p> <p><b>Metastatic Renal Cell Carcinoma or Melanoma:</b> Administered in a hospital setting.</p> <p><b>Additional treatment</b> given only if there is some tumor shrinkage following the last course and if retreatment is not contra-indicated.</p>
Provigil	All FDA approved indications not otherwise excluded from Part D	<p><b>Initial Therapy for Shift Work Sleep Disorder (SWSD):</b> Symptoms do not meet criteria for any other sleep disorder</p>	<p><b>Narcolepsy:</b> Submission of sleep study confirming the diagnosis of narcolepsy, as defined by the International Classification of Sleep Disorders (1997).</p> <p><b>Initial Therapy for Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS):</b></p> <ol style="list-style-type: none"> <li>1. More than 5 obstructive apneas, each greater than 10 seconds in duration, per hour of sleep confirmed by a sleep study; AND</li> <li>2. One of the following:               <ol style="list-style-type: none"> <li>a. Frequent arousals from sleep associated with apneas</li> <li>b. Bradycardia</li> </ol> </li> </ol>			<p><b>OSAHS, SWSD:</b> 3 months</p> <p><b>Other uses</b> 12 months</p>	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		producing insomnia or excessive sleepiness.	<p>c. Arterial oxygen desaturation in association with apneas. AND</p> <p>3. Fully compliant and concurrently using continuous positive airway pressure (CPAP); AND</p> <p>4. Symptoms of excessive daytime sleepiness.</p> <p><b>Reauthorization for Obstructive Sleep Apnea/Hypopnea Syndrome:</b> Patient continues to be fully compliant on concurrent CPAP and is experiencing relief of symptomatic hypersomnolence with Provigil use.</p> <p><b>Shift Work Sleep Disorder:</b></p> <p>1. One of the following:</p> <ul style="list-style-type: none"> <li>a. Symptoms of excessive sleepiness or insomnia, for at least 3 months, which is temporally associated with a work period that occurs during the habitual sleep phase</li> <li>b. Sleep study demonstrating loss of a normal sleep-wake pattern. AND</li> </ul> <p>2. Sleep disturbance causes significant distress or significant impairment; AND</p> <p>3. No other disorder accounts for the symptoms.</p> <p><b>Reauthorization for Shift Work Sleep Disorder:</b></p> <p>1. Patient is experiencing relief with use of Provigil for excessive sleepiness; AND</p> <p>2. Sleep disturbance continues to cause clinically significant distress or significant impairment in occupational functioning.</p> <p><b>Idiopathic Hypersomnia:</b> Submission of sleep study confirming the diagnosis of Idiopathic Hypersomnia as defined by the International Classification of Sleep Disorders.</p>				

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Quaaliquin	All FDA approved indications not otherwise excluded from Part D	<ol style="list-style-type: none"> <li>1. Severe or complicated P. falciparum malaria.</li> <li>2. Prevention of Malaria</li> <li>3. For treatment or prevention of nocturnal leg cramps.</li> </ol>	<p><b>Chloroquine-sensitive malaria:</b></p> <ol style="list-style-type: none"> <li>1. Diagnosis of Malaria; AND</li> <li>2. History of failure, contraindication or intolerance to chloroquine.</li> </ol> <p><b>Chloroquine-resistant malaria:</b></p> <p>Diagnosis of malaria.</p>			7 days	
Regranex	All FDA approved indications not otherwise excluded from Part D		<p><b>Diabetic Neuropathic Ulcers</b></p> <ol style="list-style-type: none"> <li>1. Diabetic patient with ulcer wound.</li> <li>2. Debridement being performed as needed; AND</li> <li>2. At least two of the following are present:               <ol style="list-style-type: none"> <li>a. Stage III or IV wound</li> <li>b. Wound at least 1 cm x 1 cm</li> <li>c. Long-standing wound that does not heal with standard care</li> <li>d. Patients at high risk for amputation (peripheral neuropathy, peripheral vascular disease, skin or nail abnormalities, previous foot ulcer amputation).</li> </ol> </li> </ol>			Maximum: 6 months	
Remodulin	All FDA approved indications not otherwise excluded from Part D		<p><b>Pulmonary Arterial Hypertension</b></p> <p>Patients with a confirmed diagnosis of pulmonary arterial hypertension (modified WHO Group I) which is symptomatic.</p>			Length of therapy	Remodulin is subject to Part B vs. Part D review.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Revatio	All FDA approved indications not otherwise excluded from Part D	<b>Pulmonary Arterial Hypertension (PAH):</b> Patients using organic nitrates.	<b>Pulmonary Arterial Hypertension:</b> Patients with a confirmed diagnosis of pulmonary arterial hypertension (modified WHO Group I) which is symptomatic.			Length of therapy	
Revlimid	All FDA approved indications not otherwise excluded from Part D		<b>Myelodysplastic Syndrome (MDS):</b> 1. Diagnosis of myelodysplastic syndrome associated with a deletion 5q cytogenic abnormality; AND 2. Patient is transfusion dependent.  OR 1. Diagnosis of myelodysplastic syndrome without a deletion 5q cytogenic abnormality; AND 2. Failure of initial treatment with epoetin alfa or darbopoetin alfa, hypomethylating agents (e.g., Vidaza, Dacogen), or immunosuppressive therapy (e.g., antithymocyte globulin, cyclosporine).  <b>Multiple Myeloma:</b> Used in combination with dexamethasone.  <b>Chronic Lymphocytic Leukemia (CLL):</b> Relapsed or refractory to one prior therapy for CLL.		<b>MDS, Multiple Myeloma, CLL:</b> Prescribed by an oncologist or hematologist or by oncology or hematology consult.	<b>MDS, Multiple Myeloma:</b> 6 months	Revlimid will be approved for continuation of prior therapy.
Rebetol, Ribasphere, ribavirin	All FDA approved indications not otherwise excluded from Part D		<b>Hepatitis C:</b> Adults with a diagnosis of Hepatitis C with compensated liver disease, and verification of concurrent use with an alfa-interferon product.			Length of therapy	
Rituxan	All FDA approved indications not otherwise excluded from		<b>Non-Hodgkin's Lymphoma:</b> One of the following: 1. As first-line treatment of diffuse large B-cell, CD20-positive, non-Hodgkin's lymphoma in combination with CHOP (cyclophosphamide,	<b>RA:</b> 18 years and older.	<b>RA:</b> Prescribed by a rheumatologist.	All uses except RA: 1 year  RA: 1 month	

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		<p>doxorubicin, vincristine, prednisone) or other anthracycline-based chemotherapy regimens</p> <p>2. As first-line treatment of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma in combination with CVP (cyclophosphamide, vincristine, prednisolone/prednisone) chemotherapy</p> <p>3. 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</p> <p>4. Confirmed diagnosis of relapsed or refractory, low grade or follicular CD20-positive, B-cell non-Hodgkin's lymphoma.</p> <p><b>Initial Therapy for Rheumatoid Arthritis (RA):</b></p> <p>1. Diagnosis of moderate/severe RA; AND</p> <p>2. Used in combination with methotrexate; AND</p> <p>3. Failure to a TNF antagonist.</p> <p><b>Reauthorization for Rheumatoid Arthritis:</b></p> <p>1. Documented positive clinical response; AND</p> <p>2. At least 24 weeks since last Rituxan treatment.</p>				
octreotide acetate	All FDA approved indications not otherwise excluded from Part D		<p><b>Acromegaly:</b></p> <p>1. Inadequate response to surgery and/or radiotherapy or patients who are not a surgical and/or radiotherapy candidate</p> <p>2. Diagnosis of acromegaly by one of the following:</p> <p>a. Serum growth hormone (GH) level greater than 1 ng/mL after a 2-hour oral glucose tolerance test</p> <p>b. Elevated serum IGF-1 levels as compared to normal reference values by age and gender.</p> <p><b>Carcinoid Tumors:</b></p> <p>Diagnosis of metastatic carcinoid tumor for symptomatic treatment of severe diarrhea or flushing.</p> <p><b>Vasoactive Intestinal Peptide Tumors:</b></p> <p>Diagnosis of metastatic vasoactive peptide tumor, for symptomatic treatment of diarrhea associated with vasoactive peptide tumor.</p>			<p><b>Acromegaly:</b> Long term approval.</p> <p><b>Tumors:</b> 6 months</p> <p><b>Chemotherapy induced diarrhea, AIDS-related diarrhea:</b> 3 months</p>	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p><b>Cancer Chemotherapy Induced Diarrhea:</b></p> <ol style="list-style-type: none"> <li>1. Diagnosis of diarrhea due to concurrent cancer chemotherapy; OR</li> <li>2. Both of the following:               <ol style="list-style-type: none"> <li>a. Diagnosis of complicated diarrhea due to concurrent cancer chemotherapy</li> <li>b. History of failure to standard therapy.</li> </ol> </li> </ol> <p><b>AIDS-related Diarrhea:</b></p> <ol style="list-style-type: none"> <li>1. Diagnosis of AIDS-related diarrhea.</li> <li>2. History of failure to standard therapy</li> </ol>				
Sandostatin LAR Depot	All FDA approved indications not otherwise excluded from Part D		<p><b>Acromegaly:</b></p> <ol style="list-style-type: none"> <li>1. Inadequate response to surgery and/or radiotherapy or patients who are not a surgical and/or radiotherapy candidate.</li> <li>2. Patient has shown to respond to and tolerate octreotide injection for at least 2 weeks.</li> </ol> <p><b>Carcinoid Tumors:</b></p> <ol style="list-style-type: none"> <li>1. Diagnosis of metastatic carcinoid tumor, for symptomatic treatment of severe diarrhea or flushing; AND</li> <li>2. Patient has been shown to respond to and tolerate octreotide.</li> </ol> <p><b>Vasoactive Intestinal Peptide Tumors:</b></p> <ol style="list-style-type: none"> <li>1. Diagnosis of metastatic vasoactive peptide tumor, for symptomatic treatment of diarrhea associated with vasoactive peptide tumor; AND</li> <li>2. Patient has been shown to respond to and tolerate octreotide.</li> </ol>			<p><b>Acromegaly:</b> Long term approval.</p> <p><b>Tumors:</b> 6 months</p>	
Serevent	All medically accepted indications not otherwise excluded from Part D		Diagnosis of moderate or severe persistent asthma when used concurrently with an inhaled corticosteroid, or for the prevention of exercise-induced bronchospasm, or for COPD.			Long-term approval	
Somatuline Depot	All FDA-approved indications not		<p><b>Acromegaly:</b></p> <ol style="list-style-type: none"> <li>1. Patients who require long-term treatment due to:               <ol style="list-style-type: none"> <li>a. Inadequate response to surgery and/or</li> </ol> </li> </ol>			Indefinite, long-term therapy (open-ended)	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D		radiotherapy; OR b. Who are not surgical and/or radiotherapy candidates. AND 2. Diagnosis of acromegaly by one of the following: a. Serum growth hormone level greater than 1 ng/mL after a 2-hour oral glucose tolerance test; OR b. Elevated serum IGF-1 levels as compared to normal reference values by age and gender.				
Somavert	Acromegaly		<b>Initial Therapy for Acromegaly:</b> 1. One of the following: a. Inadequate response to surgery and/or radiation therapy b. Not a candidate for surgery or radiation. AND 2. Inadequate response or intolerance to octreotide, or lanreotide, or IGF-1 value greater than 900 ng/mL.  <b>Reauthorization for Acromegaly:</b> Serum IGF-1 level within the age-adjusted normal range.			12 weeks	
Sporanox solution	All FDA approved indications not otherwise excluded from Part D		<b>Fungal Infection:</b> 1. Diagnosis of one of the following: a. Blastomycosis b. Histoplasmosis c. Aspergillosis 2. Onychomycosis in patients unable to swallow tablets; OR 3. Diagnosis of febrile neutropenia with suspected fungal infection, or oropharyngeal or esophageal candidiasis.			Length of therapy	
Sprycel	All FDA approved indications not otherwise excluded from Part D		<b>Chronic Myeloid Leukemia (CML):</b> 1. Diagnosis of Philadelphia chromosome positive or BCR-ABL positive chronic, accelerated, or myeloid or lymphoid blast phase chronic myeloid leukemia; AND 2. Failure to Gleevec.  <b>Acute Lymphoblastic Leukemia (ALL):</b> 1. Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia; AND			Length of therapy	Sprycel will be approved for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			2. Failure to Gleevec.				
Striant	All FDA approved indications not otherwise excluded from Part D		<b>Hypogonadism:</b> Diagnosis of hypogonadism in men with a pre-treatment testosterone level of less than 280 ng/dL.			Length of therapy	
Sutent	All FDA approved indications not otherwise excluded from Part D		<b>Gastrointestinal Stromal Tumor (GIST):</b> Disease progression on or intolerance to Gleevec.  <b>Renal Cell Carcinoma:</b> One of the following: 1. Diagnosis of renal cell carcinoma with relapse following surgical excision 2. Diagnosis of renal cell carcinoma with medically or surgically unresectable tumor 3. Diagnosis of Stage IV renal cell carcinoma.		Prescribed by an oncologist.	12 months	Sutent will be approved for continuation of prior therapy.
Symlin, Symlinpen	All FDA approved indications not otherwise excluded from Part D		<b>Diabetes Mellitus:</b> 1. Type 1 or type 2 diabetes 2. Concurrent use of insulin therapy	18 years and older.		Length of therapy	
Tarceva	All FDA approved indications not otherwise excluded from Part D		<b>Non-Small Cell Lung Cancer (NSCLC):</b> Patients diagnosed with locally advanced or metastatic NSCLC after failure of at least one prior chemotherapy regimen.  <b>Pancreatic Cancer:</b> 1. Patient diagnosed with locally advanced, unresectable or metastatic pancreatic cancer. 2. Used in combination with gemcitabine.  <b>Reauthorization (all uses):</b> Patient has not experienced disease progression.		Prescribed by an oncologist.	6 months	Tarceva will be approved for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Targretin (oral)	All FDA approved indications not otherwise excluded from Part D		Definitive diagnosis of cutaneous T-cell lymphoma (CTCL)			12 months	Targretin will be approved for continuation of prior therapy.
Tasigna	All FDA approved indications not otherwise excluded from Part D		<b>Chronic Myelogenous Leukemia:</b> 1. Diagnosis of Philadelphia chromosome positive chronic or accelerated phase chronic myeloid leukemia; AND 2. Failure to Gleevec.			Length of therapy	Tasigna will be approved for continuation of prior therapy.
Testosterone injectable	All FDA-approved indications not otherwise excluded from Part D.		<b>Hypogonadism:</b> Diagnosis of male hypogonadism with a pre-treatment total testosterone level below normal physiological value (less than 280 ng/dl), or pre-treatment free testosterone below normal reference value.  <b>Delayed puberty:</b> Diagnosis of delayed puberty in males.			<b>Hypogonadism:</b> Long-term.  <b>Delayed puberty:</b> 6 months	
<b>Topical testosterone:</b> Androderm, Androgel, Testim	All FDA-approved indications not otherwise excluded from Part D.		<b>Hypogonadism:</b> 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.			Length of therapy	
Thalomid	All FDA-approved indications not otherwise excluded from Part D.  Waldenstrom's Macroglobulinemia (WM)  Aphthous		<b>Erythema Nodosum Leprosum (ENL):</b> Confirmed diagnosis of moderate to severe ENL.  <b>Multiple Myeloma (MM):</b> 1. For newly diagnosed multiple myeloma in combination with dexamethasone or conventional dose chemotherapy; OR 2. In combination with high dose chemotherapy with stem cell rescue; OR 3. Salvage therapy in refractory or relapsed multiple myeloma after primary therapy; OR 4. In combination with dexamethasone, doxorubicin, cyclophosphamide, and etoposide			<b>AS:</b> 1 month  <b>ENL, MM:</b> 1 year  <b>WM, GVHD, and Primary Brain Tumors:</b> 6 months  <b>Other Uses:</b> 3 months	Thalomid will be approved for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	stomatitis or ulcers (AS)  Crohn's Disease,  Graft-versus-Host Disease (GVHD)  Primary Brain Tumors  AIDS-related cachexia or wasting  Renal Cell Carcinoma		<p>as part of induction regimen prior to autologous transplant.</p> <p><b>Waldenstrom's Macro-globulinemia (WM):</b> Disease progression on an alkylating agent, nucleoside analog, or rituximab.</p> <p><b>Aphthous stomatitis (AS) or ulcers:</b></p> <ol style="list-style-type: none"> <li>1. One of the following:               <ol style="list-style-type: none"> <li>a. Diagnosis of HIV-associated aphthous ulcers</li> <li>b. Recurrent aphthous stomatitis in immunocompromised patients. AND</li> </ol> </li> <li>2. Refractory to alternative therapies.</li> </ol> <p><b>Crohn's Disease:</b> Patient is refractory to all of the following standard treatment regimens:</p> <ol style="list-style-type: none"> <li>1. Corticosteroids</li> <li>2. 5-aminodalicylic acid</li> <li>3. Immunomodulators</li> <li>4. Remicade.</li> </ol> <p><b>Graft-versus-Host Disease (GVHD):</b></p> <ol style="list-style-type: none"> <li>1. Diagnosis of chronic or refractory GVHD; AND</li> <li>2. In patient unresponsive to all of the following:               <ol style="list-style-type: none"> <li>a. Corticosteroids</li> <li>b. Azathioprine</li> <li>c. Tacrolimus</li> <li>d. Cyclosporine</li> <li>e. Antithymocyte globulin.</li> </ol> </li> </ol> <p><b>Primary Brain Tumors:</b></p> <ol style="list-style-type: none"> <li>1. As adjuvant therapy to current cytotoxic therapies; OR</li> <li>2. Previous failure to cytotoxic therapies and/or tumor resection.</li> </ol> <p><b>Initial Therapy for AIDS-related cachexia or wasting:</b></p> <ol style="list-style-type: none"> <li>1. Diagnosis of AIDS wasting or cachexia defined as chronic unremitting weight loss of more than 10% body weight in the previous 4 months; AND</li> <li>2. Nutritional evaluation since onset of wasting first occurred. Screened for hypogonadism; AND</li> </ol>				

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>3. Failure to respond to hormone replacement therapy in patients with hypogonadism; AND</p> <p>4. Failure, contraindication or intolerance to standard treatments.</p> <p><b>Reauthorization for AIDS-related cachexia or wasting:</b> Weight has stabilized or improved but not at goal weight.</p> <p><b>Advanced Renal Cell Carcinoma:</b></p> <p>1. Confirmed diagnosis of metastatic renal cell carcinoma; AND</p> <p>2. Patient is refractory to, or unsuitable of the following:</p> <p>a. Interferon-alfa-2b</p> <p>b. Interleukin-2</p> <p>c. Sorafenib</p> <p>d. Sunitanib.</p>				
<b>Topical Retinoids:</b> Avita, Retin A Micro, tretinoin	All FDA approved indications not otherwise excluded from Part D					12 months	
Tracleer	All FDA approved indications not otherwise excluded from Part D		<b>Pulmonary Arterial Hypertension:</b> Patients with a confirmed diagnosis of pulmonary arterial hypertension (modified WHO Group I) which is symptomatic.			Length of therapy	
Treanda	All FDA approved indications not otherwise excluded from Part D		<b>Non-Hodgkin's Lymphoma (NHL):</b>			6 months	
			<p>1. Diagnosis of indolent B-cell NHL.</p> <p>2. Progression of NHL during or within 6 months of treatment with rituximab or a rituximab-containing regimen.</p>				
Tykerb	All FDA approved indications not		<b>Breast Cancer:</b> 1, Diagnosis of HER2-positive advanced or metastatic breast cancer			Length of therapy	Tykerb will be approved for continuation

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D		2. Confirmation of normal left ventricular ejection fraction.				of prior therapy.
Tysabri	All FDA approved indications not otherwise excluded from Part D		<p><b>Relapsing forms of Multiple Sclerosis (MS):</b> Failure to one of the following: Avonex, Betaseron, Copaxone, Rebif.</p> <p><b>Initial Therapy for Crohn's Disease (CD):</b> 1. Moderate-to-severe Crohn's disease with evidence of inflammation; AND 2. History of conventional therapy. History of a TNF blocker. Patient is not receiving immuno-suppressants.</p> <p><b>Reauthorization for Crohn's Disease:</b> Demonstrated remission or significant clinical response to Tysabri.</p>	<b>Initial therapy for CD:</b> 18 years and older.	<p><b>Relapsing MS:</b> Prescribing physician is enrolled in the TOUCH Prescribing Program.</p> <p><b>Initial Therapy - CD:</b> Prescribing physician is enrolled in the CD TOUCH Prescribing Program.</p>	<p><b>Initial Therapy:</b> Tysabri will be authorized for 1 year for MS and 3 months for CD</p> <p><b>Reauthorization for CD:</b> Tysabri will be reauthorized for 6 months for patients on steroids. Otherwise, 3 months.</p>	<b>For Relapsing MS:</b> Tysabri will not be authorized in combination with Avonex, Betaseron, Copaxone, or Rebif.
Vancocin	All FDA approved indications not otherwise excluded from Part D		<p><b>Pseudo-membranous Colitis:</b> 1. Diagnosis of pseudo-membranous colitis due to Clostridium difficile; AND 2. Failure to oral Flagyl.</p>			Length of therapy	
Vectibix	All FDA approved indications not otherwise excluded from Part D		<p><b>Colorectal Cancer:</b> 1. Diagnosis of metastatic colorectal cancer. 2. Relapsed, refractory, or disease progression on one standard chemotherapy regimen containing a fluoropyrimidine, oxaliplatin, or irinotecan. 3. Tumor expresses wild-type KRAS gene.</p>			6 months	Vectibix will be approved for continuation of prior therapy.
Ventavis	All FDA approved indications not otherwise excluded from Part D		<p><b>Pulmonary Arterial Hypertension</b> Patients with a confirmed diagnosis of pulmonary arterial hypertension (modified WHO Group I) which is symptomatic.</p>			Length of therapy	Ventavis is subject to Part B vs. Part D review.
Xolair	All FDA		<b>Initial Therapy for Allergic Asthma:</b>	<b>Initial</b>	<b>Initial</b>	<b>Initial Therapy:</b>	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	approved indications not otherwise excluded from Part D		<p>1. Diagnosis of moderate-to-severe persistent allergic asthma, defined by one of the following:</p> <ul style="list-style-type: none"> <li>a. Daily asthmatic symptoms</li> <li>b. Daily use of inhaled short-acting beta agonists</li> <li>c. Exacerbations affect/limit activity</li> <li>d. Exacerbations 2 or more times per week</li> <li>e. Nocturnal symptoms once a week or more</li> <li>f. Forced expiratory volume in one second or peak expiratory flow less than or equal to 80% of predicted</li> <li>g. PEF variability greater than 30%. AND</li> </ul> <p>2. Baseline IgE level greater than or equal to 30 IU/mL; AND</p> <p>3. Documented failure to combination therapy with an inhaled corticosteroid at the maximum dosage and a long-acting beta-agonist.</p> <p><b>Reauthorization for Allergic Asthma:</b></p> <ul style="list-style-type: none"> <li>1. Documented reduction in the frequency of asthma exacerbations while treated with Xolair; AND</li> <li>2. Documented reduction in the use of rescue medications or inhaled corticosteroids while treated with Xolair.</li> </ul>	<p><b>treatment</b></p> <p>: 6 years and older.</p>	<p><b>Therapy:</b></p> <p>Prescribed by a pulmonologist or allergist/immunologist.</p>	<p>16 weeks</p> <p><b>Reauthorization:</b></p> <p>1 year</p>	
Zolinza	All FDA approved indications not otherwise excluded from Part D		Definitive diagnosis of cutaneous T-cell lymphoma (CTCL)			12 months	Zolinza will be approved for continuation of prior therapy.
Zyvox	All FDA approved indications not otherwise excluded from Part D		<p><b>Infections:</b></p> <p>One of the following:</p> <ul style="list-style-type: none"> <li>1. Infections caused by vancomycin-resistant enterococci (VRE) documented by culture and sensitivity report.</li> <li>2. Nosocomial pneumonia caused by methicillin-resistant Staphylococcus aureus (MRSA) documented by culture and sensitivity report</li> <li>3. Complicated skin and skin structure infections (including diabetic foot infections) without osteomyelitis caused by MRSA documented by culture and sensitivity report.</li> </ul>			28 days.	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			<p>4. 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:</p> <ul style="list-style-type: none"> <li>a. trimethoprim-sulfamethoxazole</li> <li>b. tetracycline</li> <li>c. doxycycline</li> <li>d. minocycline.</li> </ul> <p>5. As continuation of therapy when transitioning from intravenous daptomycin, intravenous vancomycin, or intravenous Zyvox therapy.</p>				

**The following drugs may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination:**

- Acetylcysteine
- Acyclovir
- Adriamycin (20 mg INJ only)
- Albuterol sulfate
- Albuterol/ipratropium
- Aminess
- Aminosyn (all except 15% INJ)
- Amphotericin
- Anzemet
- Clinimix
- Clinimix E
- Clinisol SF
- Cromolyn Sodium
- Cyclophosphamide
- Cyclosporine
- Cyclosporine Modified
- Doxil
- Doxorubicin
- Engerix-B
- Foscarnet
- Freamine HBC
- Freamine III
- Gengraf
- Granisetron
- Granisol
- Hepatamine
- Hepatasol
- Intralipid (all, except 30% INJ)
- Ipratropium bromide
- Metaproterenol
- Myfortic
- Nephramine
- Novamine
- Ondansetron
- Ondansetron ODT
- Premasol
- Procalamine
- Prosol
- Pulmicort
- Rapamune
- Recombivax HB
- Renamin
- Travasol
- Trophamine (10% INJ only)
- Xopenex