

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **ACCUNEB**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **ACETYLCYSTEINE**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Actiq, Fentanyl Citrate Oral Transmucosal**

Diagnosis /Use(s): Breakthrough cancer pain

If authorized, Approval Duration: 6 months

Requirement(s): Documentation of the following: breakthrough cancer pain AND other generic or preferred brand formulary short acting strong narcotic analgesic alternatives (other than fentanyl) have been ineffective, not tolerated or contraindicated AND patient is opioid tolerant

Prior Authorization Requirements

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Drug Name(s): **Actos, Actoplus Met, Duetact, Avandia, Avandaryl, Avandamet**

Diagnosis /Use(s): Type II diabetes mellitus, nonalcoholic steatohepatitis, polycystic ovary syndrome

If authorized, Approval Duration: 1 year

Requirement(s): Type II diabetes mellitus: documentation that the patient's hemoglobin A1C is over 7% AND treatment with metformin is contraindicated, not tolerated or has been inadequate in reducing hemoglobin A1C to goal after 90 days of therapy. Nonalcoholic steatohepatitis-metformin was ineffective, contraindicated or not tolerated. Polycystic Ovary Syndrome-metformin was ineffective, contraindicated or not tolerated

Drug Name(s): **ALBUTEROL SULFATE**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **ALKERAN**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Amevive**

Diagnosis /Use(s): Chronic plaque psoriasis

Must be prescribed by: Dermatologist

If authorized, Approval Duration: 12 weeks

Requirement(s): Documented diagnosis of chronic plaque psoriasis involving a minimum of 10% of body surface area (or documentation of significant functional impairment) AND treatment with phototherapy or photochemotherapy was ineffective, not tolerated or contraindicated AND treatment with at least one oral systemic agent for psoriasis was ineffective or not tolerated, unless all are contraindicated

Drug Name(s): **AMINESS**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **AMINOSYN**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **AMINOSYN 7%/ELECTROLYTES**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **AMINOSYN 8.5%/ELECTROLYTES**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **AMINOSYN II**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **AMINOSYN II 3.5%/DEXTROSE5%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **AMINOSYN II 3.5/DEXTROSE 25%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **AMINOSYN II 4.25/DEXTROSE10%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **AMINOSYN II 4.25/DEXTROSE20%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **AMINOSYN II 4.25/DEXTROSE25%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **AMINOSYN II 5/DEXTROSE 25**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **AMINOSYN II 8.5%/ELECTROLYTES**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **AMINOSYN II M 3.5%/DEXTROSE 5%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **AMINOSYN II M 4.25%/DEXTROSE 10%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **AMINOSYN M**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **AMINOSYN-HBC**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **AMINOSYN-HF**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **AMINOSYN-PF**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **AMINOSYN-PF 7%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **ANZEMET**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Aranesp Albumin Free, Aranesp Albumin Free Sureclick**

Diagnosis /Use(s): All FDA-approved indications not otherwise excluded for Part D.

Must be prescribed by: Anemia-oncologist, hematologist, nephrologist

If authorized, Approval Duration: Duration requested by physician or up to 6 months per approval, whichever is less.

Requirement(s): Hematocrit less than 30% in AZT-treated HIV infected patients when the dose is less than or equal to 4,200mg per week OR anemia of chronic disease characterized by hematocrit less than or equal to 24% and hemoglobin less than 9mg/dL if the patient's erythropoietin levels are 500mU/ml or less AND patient's transferrin saturation is at least 20% and ferritin at least 100ng/mL

Drug Name(s): **Arcalyst**

Diagnosis /Use(s): Cryopyrin-associated periodic syndromes (CAPS)

If authorized, Approval Duration: Initial-1 month then annually with documentation of disease stability or improvement.

Requirement(s): There is laboratory evidence of a genetic mutation in CIAS1, also known as NLRP-3 AND there is clinical documentation that the patient is experiencing the classic symptoms of CAPS in either: Familial Cold Auto-Inflammatory Syndrome (FCAS) including recurrent intermittent episodes of fever and rash that primarily followed natural, artificial or both types of generalized cold exposure OR Muckle-Wells Syndrome (MWS), a syndrome of chronic fever and fever that may wax and wane in intensity resulting in significant impairment.

Prior Authorization Requirements

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Drug Name(s): **ATGAM**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **ATROPINE SULFATE**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **AZASAN**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **AZATHIOPRINE**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **AZATHIOPRINE SODIUM**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Betaseron**

Diagnosis /Use(s): Multiple Sclerosis

If authorized, Approval Duration: 1 year

Requirement(s): Treatment with interferon beta-1a OR interferon beta-1a OR glatiramer acetate is ineffective or not tolerated

Drug Name(s): **BONIVA**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Botox**

Diagnosis /Use(s): All FDA-approved indications not otherwise excluded for Part D.

If authorized, Approval Duration: 4 injections in 12mths or 2 injections in 6mths then 4 injections in 12mths depending on diagnosis

Requirement(s): Documentation of functional impairment. Anal fissures-patients will be assessed for success of other therapeutic alternatives such as nitroglycerin ointment. Achalasia/cardiospasm-patients who have not responded to dilation therapy or who are considered poor surgical candidates. Hyperhidrosis, including gustatory hyperhidrosis-hyperhidrosis is persistent and severe and has resulted in significant medical complications

Drug Name(s): **BROVANA**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **BUSULFEX**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Byetta**

Diagnosis /Use(s): Type 2 Diabetes

If authorized, Approval Duration: 1 year

Requirement(s): Hemoglobin A1C greater than 7% AND a 90 day treatment course with the following did not adequately reduce the hemoglobin A1c to a goal of 7% or less or was not tolerated or is contraindicated: metformin and one other preferred or generic medication for the treatment of Type 2 diabetes [examples include insulin, glyburide, glipizide, rosiglitazone (Avandia®) and pioglitazone (Actos®)]

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Carimune NF, Flebogamma, Iveegam, Gamimune N, Gammagard Liquid, Gammagard S/D, Gammar PIV, Gammar IV, Gamunex, Iveegam EN, Octagam, Panglobulin, Panglobuin NF, Polygam S/D, Sandoglobulin, Venoglobulin, Vivaglobin**

Diagnosis /Use(s): Primary humoral immunodeficiency diseases, HIV infected children , allogeneic bone marrow transplant recipients, acquired hypogammaglobulinemia, acute idiopathic thrombocytopenia purpura, chronic idiopathic thrombocytopenia purpura, idiopathic thrombocytopenia purpura in pregnancy, Kawasaki syndrome, dermatomyositis, post-transfusion purpura, relapsing remitting multiple sclerosis, fetal alloimmune thrombocytopenia, autoimmune hemolytic anemia, pure red cell aplasia, multiple myeloma, infectious disease prophylaxis in hypogammaglobulinemic neonates, pediatric intractable epilepsy, myasthenia gravis, polymyositis, acute inflammatory demyelinating polyneuropathy including Guillian-Barre syndrome, chronic inflammatory demyelinating polyneuropathy, multifocal motor neuropathy, acquired Factor VIII inhibitor, systemic lupus erythematosus, Lambert-Eaton myasthenic syndrome, Stiff-Person syndrome, refractory pemphigus foliaceus

If authorized, Approval Duration: 3 months to 1 year depending on diagnosis

Requirement(s): Primary humoral immunodeficiency diseases-documented with laboratory findings, HIV infected children-less than 13 years of age and T4 cell count greater than 200/mm³, Allogeneic bone marrow transplantation-20 years of age or older, Acquired hypogammaglobulinemia-documented with laboratory findings, Chronic ITP-dangerously low platelet count-not for maintenance therapy, ITP of pregnancy-refractory to steroids with platelets less than 10,000/mm³ OR platelets less than 30,000/mm³ before delivery OR woman who has previously delivered infant with autoimmune thrombocytopenia OR platelet count less than 75,000/mm³ OR past history of splenectomy, Kawasaki syndrome-during first 10 days of diagnosis, Dermatomyositis-severe disability complicated by sensitivity or resistance to steroid therapy, Multiple sclerosis-standard therapies have failed, become intolerable or contraindicated, Autoimmune hemolytic anemia-warm type non-responsive to other therapies, Pure red cell aplasia-documented parvovirus B19 infection and severe anemia, Multiple myeloma-stable disease and high risk of recurrent infections, poor IgG response to pneumococcal vaccine, low normal IgG levels during acute septic episode, Infectious disease prophylaxis in hypogammaglobulinemic neonates-low birth weight is less than 1500g or in setting with high baseline infection rate or morbidity, Pediatric intractable epilepsy-candidates being considered for surgical resection or other interventions have failed, Myasthenia gravis-severe MG to treat acute, severe decompensation where other treatment have been unsuccessful or are contraindicated or thymectomy candidate, Polymyositis-severe active illness where other

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

interventions have failed or not tolerated, Acute inflammatory demyelinating polyneuropathy-deteriorating pulmonary function tests OR rapid deterioration with symptoms for less than 2 weeks OR rapidly deteriorating ability to ambulate OR frank inability to ambulate for 10 meters

Other Requirements: CIDP-significant functional disability AND documentation of slowing nerve conduction velocity on EMG/NCS AND documentation of elevated spinal fluid protein on lumbar puncture OR nerve biopsy confirming diagnosis, Multifocal motor neuropathy-anti GM-1 anti

Drug Name(s): **Celebrex**

Diagnosis /Use(s): All FDA-approved indications not otherwise excluded for Part D.

If authorized, Approval Duration: 1 year

Requirement(s): Used in the treatment of chronic pain and/or inflammation when treatment with at least two generically available prescription nonsteroidal anti-inflammatory drugs (NSAIDs) were ineffective or not tolerated where one of the previously used NSAIDs must be diclofenac, etodolac, nabumetone or salsalate OR used to reduce the number of adenomatous colorectal polyps in familial adenomatous polyposis (FAP) as an adjunct to usual care

Drug Name(s): **CELLCEPT**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **CELLCEPT INTRAVENOUS**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Cerezyme**

Diagnosis /Use(s): Type 1 Gaucher's Disease

If authorized, Approval Duration: 6 months

Requirement(s): Biochemical assay of glucocerebrosidase activity in WBCs or skin fibroblasts is less than or equal to 30% of normal activity OR genotype mutation of two alleles of the glucocerebrosidase gene AND symptomatic manifestations of the disease are present

Drug Name(s): **Cimzia**

Diagnosis /Use(s): Moderate to severe Crohn's disease

If authorized, Approval Duration: Initial -1 month and if effective annually

Requirement(s): Treatment with an adequate course of systemic corticosteroids has been ineffective or is contraindicated OR the patient has been unable to taper off an adequate course of systemic corticosteroids without experiencing worsening of disease OR the patient is experiencing breakthrough disease while stabilized for at least 2 months on an immunomodulatory medication AND either adalimumab(Humira®) or infliximab (Remicade®) was not effective after at least an adequate treatment course except if not tolerated due to documented clinical side effects.

Drug Name(s): **CLINIMIX 2.75%/DEXTROSE 5%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **CLINIMIX 4.25%/DEXTROSE 10%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **CLINIMIX 4.25%/DEXTROSE 20%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **CLINIMIX 4.25%/DEXTROSE 25%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **CLINIMIX 4.25%/DEXTROSE 5%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **CLINIMIX 5%/DEXTROSE 15%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **CLINIMIX 5%/DEXTROSE 20%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **CLINIMIX 5%/DEXTROSE 25%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **CLINIMIX E 2.75%/DEXTROSE 10%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **CLINIMIX E 2.75%/DEXTROSE 5%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **CLINIMIX E 4.25%/DEXTROSE 25%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **CLINIMIX E 4.25%/DEXTROSE 5%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **CLINIMIX E 5%/DEXTROSE 15%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **CLINIMIX E 5%/DEXTROSE 20%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **CLINIMIX E 5%/DEXTROSE 25%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **CLINIMIX E 5%/DEXTROSE 35%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **CLINISOL SF 15%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **COMVAX**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Crestor, Vytorin**

Diagnosis /Use(s): All FDA-approved indications not otherwise excluded for Part D.

If authorized, Approval Duration: 1 year

Requirement(s): Greater than 40% reduction in LDL is needed OR simvastatin or pravastatin or lovastatin has not achieved the LDL-C target after at least two months of treatment or is not tolerated

Drug Name(s): **CYCLOPHOSPHAMIDE**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **CYCLOSPORINE**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **CYCLOSPORINE MODIFIED**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Cymbalta, Lexapro, Pristiq**

Diagnosis /Use(s): Major depressive disorder, social anxiety disorder, panic disorder, premenstrual dysphoric disorder, obsessive compulsive disorder, bulimia nervosa, generalized anxiety disorder, neuropathic pain conditions, post traumatic stress disorder, fibromyalgia(Cymbalta®)

If authorized, Approval Duration: 1 year

Requirement(s): At least two generic or preferred brand name medications have been ineffective, not tolerated or contraindicated

Drug Name(s): **CYTOXAN**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **DUONEB**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Effexor XR**

Diagnosis /Use(s): Major depressive disorder, social anxiety disorder, panic disorder, generalized anxiety disorder, post traumatic stress disorder, bulimia nervosa, premenstrual dysphoric disorder, obsessive-compulsive disorder

If authorized, Approval Duration: 1 year

Requirement(s): One generic medication has been ineffective, not tolerated or contraindicated

Drug Name(s): **EMEND**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Enbrel, Enbrel Sureclick**

Diagnosis /Use(s): Psoriatic arthritis, ankylosing spondylitis, rheumatoid arthritis, juvenile arthritis, chronic plaque psoriasis

Must be prescribed by: Chronic Plaque Psoriasis-dermatologist or rheumatologist

If authorized, Approval Duration: 1 year

Requirement(s): Psoriatic arthritis-diagnosis established by or in consultation with a rheumatologist or dermatologist. Ankylosing spondylitis-diagnosis established by or in consultation with a rheumatologist. Rheumatoid arthritis(RA) or juvenile rheumatoid arthritis: diagnosis established by or in consultation with a rheumatologist or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND methotrexate is ineffective after a minimum 6 to 12 week treatment course based on documentation of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis except where methotrexate is contraindicated or not tolerated based on clinical documentation. Chronic plaque psoriasis: Documented diagnosis of chronic plaque psoriasis involving a minimum of 10% of body surface area (or documentation of significant functional impairment) AND treatment with phototherapy or photochemotherapy was ineffective, not tolerated or contraindicated AND treatment with at least one oral systemic agent for psoriasis was ineffective or not tolerated, unless all are contraindicated

Drug Name(s): **ENGERIX-B**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **ETOPOPHOS**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **ETOPOSIDE**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Fentora**

Diagnosis /Use(s): Breakthrough cancer pain

If authorized, Approval Duration: 6 months

Requirement(s): Documentation of breakthrough cancer pain AND other generic for preferred brand formulary short acting strong narcotic analgesic alternatives (other than fentanyl) have been ineffective, not tolerated or contraindicated AND patient is opioid tolerant

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Forteo**

Diagnosis /Use(s): Osteoporosis, postmenopausal, primary or hypogonadism

If authorized, Approval Duration: One time two year authorization then annually

Requirement(s): Bone mineral density that is 2.5 or more standard deviations below that of a young, normal adult or have osteopenia with T-score between -1 and -2.5 and a history of previous fractures or glucocorticoid use for at least 3 months at a dose of 5mg per day of prednisone or equivalent AND at least one bisphosphonate is not effective after minimum 24 month treatment period based on objective documentation unless there is documented bisphosphonate contraindication based on current medical literature or bisphosphonates are not tolerated due to documented clinical side effects

Drug Name(s): **FREAMINE HBC 6.9%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **FREAMINE III**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **FREAMINE III 3%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **GENGRAF**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Gleevec**

Diagnosis /Use(s): Chronic myelogenous leukemia with the presence of the Philadelphia (Ph-1) chromosome, gastrointestinal stromal tumor, relapsed or refractory Philadelphia chromosome positive acute lymphoblastic leukemia, myelodysplastic /myeloproliferative diseases associated with platelet derived growth factor receptor gene arrangements, aggressive systemic mastocytosis without the D816V c-Kit mutation or with c-Kit mutational status unknown, hypereosinophilic syndrome and/or chronic eosinophilic leukemia who have the FIP1L1-PDGFR alpha fusion kinase and for patients with hypereosinophilic and/or chronic eosinophilic leukemia who are FIP1L1-PDGFR alpha fusion kinase negative or unknown, unresectable recurrent and/or metastatic dermatofibrosarcoma protuberans.

If authorized, Approval Duration: 1 year

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **GRANISETRON HCL**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **GRANISOL**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **HEPATAMINE**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **HEPATASOL**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Humatrope, Humatrope Combo Pack, Genotropin, Genotropin Miniquick, Norditropin Nordiflex Pen, Norditropin Cartridge, Zorbitive, Serostim, Tev-Tropin, Omnitrope**

Diagnosis /Use(s): All FDA-approved indications not otherwise excluded for Part D.

If authorized, Approval Duration: Short bowel syndrome-up to 4 weeks. All other indications-1 year.

Requirement(s): Adult and Pediatric-Saizen and Nutropin products have not been tolerated AND Documented GHD defined as two GH stimulation tests below 10ng/ml OR at least one GH stimulation test less than 15ng/ml and IGF-1 and IGF-BP3 levels below normal for bone age and sex OR one GH stimulation test below 10ng/ml for those with defined CNS pathology, history of irradiation, or genetic condition associated with GHD OR growth stimulation hormone tests, IGF-1 or IGF-3 levels are not needed for GHD if multiple pituitary hormone deficiencies exist or for congenital GHD. Open growth plates-an initial bone age, demonstration of open growth plates. Short Stature/Growth failure-Height is less than the minimum percentile specified for age/sex OR when the height is below the minimum percentile specified for age/sex and untreated growth velocity with a minimum of 1 year of growth data is below the 25th percentile OR if GHD defined as GH stimulation tests, IGF-1 or IGF-BP3 levels not needed for congenital GHD, growth failure/short stature is not needed. Chronic Renal Insufficiency-requires weekly dialysis OR chronic renal insufficiency defined as glomerular filtration rate (GFR) less than 75ml/min/1.73m². Documented decrease muscle tone by exam. Pediatric burns-burns over at least 40% of total body surface area. Adults-Two pituitary hormone deficiencies other than growth hormone requiring hormone replacement AND at least one known cause for pituitary disease or condition affecting pituitary function is documented AND one provocative stimulation test less than 5ng/ml OR three pituitary hormone deficiencies other than growth hormone requiring hormone replacement AND an IGF-1 below 80ng/ml.SBS-ability to ingest solid food AND dependent on parenteral nutrition at least five days per week to provide at least 3000kcal/week AND chart notes indicate dietary needs and goals have been addressed

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Humira, Humira Pen, Humira Pen-Crohn's Disease Starter**

Diagnosis /Use(s): All FDA-approved indications not otherwise excluded for Part D.

Must be prescribed by: Chronic Plaque Psoriasis-dermatologist or rheumatologist

If authorized, Approval Duration: Rheumatologic conditions, chronic plaque psoriasis-annually, Crohn's Disease-3 months then annually

Requirement(s): Psoriatic arthritis-diagnosis established by or in consultation with a rheumatologist or dermatologist. Ankylosing spondylitis-diagnosis established by or in consultation with a rheumatologist. Rheumatoid arthritis(RA) or juvenile idiopathic arthritis (JIA)-diagnosis established by or in consultation with a rheumatologist or for RA meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND 6-12 week course of methotrexate was ineffective based on documentation which includes one or more of the American College of Rheumatology Assessment Components for improvement in Rheumatoid Arthritis unless methotrexate is contraindicated or not tolerated based on clinical documentation. Crohn's Disease-Fistulizing Crohn's Disease OR acute treatment of an exacerbation when at least one of the three the following criteria is met: treatment with an adequate course of systemic corticosteroids has been ineffective or is contraindicated, patient has been unable to taper off an adequate course of systemic corticosteroids without experiencing worsening of disease, patient is experiencing breakthrough disease while stabilized for at least 2 months on an immunomodulatory medication OR acute and/or maintenance of Crohn's Disease when infliximab has been ineffective or not tolerated. Chronic plaque psoriasis - Documented diagnosis of chronic plaque psoriasis involving a minimum of 10% of body surface area (or documentation of significant functional impairment) AND treatment with phototherapy or photochemotherapy was ineffective, not tolerated or contraindicated AND treatment with at least one oral systemic agent for psoriasis was ineffective or not tolerated, unless all are contraindicated

Drug Name(s): **IMURAN**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Increlex**

Diagnosis /Use(s): Primary IGF-1 deficiency, growth hormone gene deletion, genetic mutation of growth hormone receptor

Must be prescribed by: Pediatric endocrinologist

If authorized, Approval Duration: 1 year

Requirement(s): Current high measurement at less than 3rd percentile for age and sex AND IGF-1 level greater than or equal to 3 standard deviations below normal AND normal or elevated growth hormone levels based upon at least one growth hormone stimulation test AND open growth plates

Drug Name(s): **INTRALIPID**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **INTRALIPID 20%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **IPRATROPIUM BROMIDE**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **IPRATROPIUM BROMIDE/ALBUTEROL SULFATE**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **IRINOTECAN**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **IXEMPRA KIT**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Januvia, Janumet**

Diagnosis /Use(s): Diabetes mellitus, type 2

If authorized, Approval Duration: 1 year

Requirement(s): Hemoglobin A1C greater than 7% AND treatment with metformin is contraindicated, not tolerated or ineffective in reducing hemoglobin A1C to goal after 90 days of therapy

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Kapidex**

Diagnosis /Use(s): Erosive esophagitis, healing of all grades and maintenance of healing and gastroesophageal reflux disease, symptomatic, non-erosive

If authorized, Approval Duration: 1 year

Requirement(s): Generic prescription proton pump inhibitor (omeprazole or pantoprazole) AND lansoprazole (Prevacid®) ineffective or not tolerated after an adequate treatment course or are contraindicated

Drug Name(s): **Kineret**

Diagnosis /Use(s): Rheumatoid Arthritis

If authorized, Approval Duration: 1 year

Requirement(s): Rheumatoid arthritis(RA)-diagnosis established by or in consultation with a rheumatologist or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND methotrexate alone is ineffective after a minimum 6 to 12 week treatment course based on documentation of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis except where methotrexate is contraindicated or not tolerated based on clinical documentation AND etanercept or adalimumab was not effective after a minimum 12 week treatment course unless not tolerated due to documented clinical side effects AND therapy does not exceed administration of anakinra 100mg subcutaneously once daily

Drug Name(s): **Kuvan**

Diagnosis /Use(s): Phenylketonuria, responsive to tetrahydrobiopterin

If authorized, Approval Duration: Initially 2 months then annually

Requirement(s): Diagnosis of phenylketonuria established by or in consultation with a metabolic specialist AND phenylalanine levels cannot be maintained within the recommended maintenance range with dietary intervention alone AND documentation of an average baseline blood phenylalanine level is provided prior to initiating therapy

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **KYTRIL**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Lipitor**

Diagnosis /Use(s): All FDA-approved indications not otherwise excluded for Part D.

If authorized, Approval Duration: 1 year

Requirement(s): Ezetimibe/simvastatin is ineffective at achieving the LDL-C target after at least two months of treatment or is not tolerated AND rosuvastatin is ineffective at achieving the LDL-C target after at least two months of treatment or is not tolerated AND either the need for greater than 40% LDL-C reduction is documented OR simvastatin or pravastatin or lovastatin has not achieved the LDL-C target after at least two months of treatment or is not tolerated

Drug Name(s): **Luvox CR**

Diagnosis /Use(s): Social anxiety disorder, obsessive compulsive disorder, major depression

If authorized, Approval Duration: 1 year

Requirement(s): Documentation of previous fluvoxamine therapy

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Lyrica**

Diagnosis /Use(s): Partial seizures, diabetic peripheral neuropathy, post herpetic neuralgia, fibromyalgia

If authorized, Approval Duration: 1 year

Requirement(s): Neuropathic pain- when a previous history of adequate treatment courses of at least 30 days with gabapentin and one tricyclic antidepressant are ineffective unless contraindicated or not tolerated.
Fibromyalgia-when a previous history of adequate treatment course of at least 30 days with gabapentin and either cyclobenzaprine or a tricyclic antidepressant are ineffective unless contraindicated or not tolerated

Drug Name(s): **METAPROTERENOL SULFATE**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **MIACALCIN**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **MYFORTIC**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **MYFORTIC**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Myobloc**

Diagnosis /Use(s): Functional impairment originating from spasticity or dystonia of cervical dystonia or spasmodic torticollis OR sialorrhea associated with Parkinson's disease

If authorized, Approval Duration: 1 year

Requirement(s): Documentation of diagnosis and functional impairment

Drug Name(s): **NEBUPENT**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **NEORAL**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **NEPHRAMINE**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Nexavar**

Diagnosis /Use(s): Advanced renal cell carcinoma, unresectable liver carcinoma

Must be prescribed by: Oncologist

If authorized, Approval Duration: 1 year

Requirement(s): Documentation of diagnosis

Drug Name(s): **Nexium, Aciphex**

Diagnosis /Use(s): Duodenal ulcer disease, erosive esophagitis gastroesophageal reflux disease, gastric ulcer, Zollinger-Ellison syndrome

If authorized, Approval Duration: 1 year

Requirement(s): Prescription omeprazole, pantoprazole or Prevacid ineffective or not tolerated after an adequate treatment course or are contraindicated

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **NOVAMINE**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **ONDANSETRON ODT**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Orencia**

Diagnosis /Use(s): All FDA-approved indications not otherwise excluded for Part D.

If authorized, Approval Duration: 6 months initially then 1 year

Requirement(s): Rheumatoid arthritis(RA)-diagnosis established by or in consultation with a rheumatologist or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND treatment with methotrexate has been ineffective after 6-12 weeks based on documentation of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis or not tolerated based on clinical documentation

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **ORTHOCLONE OKT3**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **PEDIARIX**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **PEDVAX HIB**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Pegasys**

Diagnosis /Use(s): Active type B viral hepatitis, chronic. Hepatitis C, chronic

If authorized, Approval Duration: Genotype 2,3-24 weeks, not 2,3 -12wks then 36wks, ribavirin contraindicated/HIV+-48wks, hep B-48wks

Requirement(s): Chronic hepatitis C in combination with ribavirin-hepatitis C viral RNA levels are greater than 50IU/ml AND has not received previous treatment with peginterferon. Chronic hepatitis C-ribavirin contraindicated AND detectable hepatitis C RNA levels are greater than 50IU/ml AND has not received previous treatment with peginterferon. Chronic hepatitis B-confirmed diagnosis of compensated hepatitis B AND has not received previous treatment with peginterferon

Drug Name(s): **PEG-Intron, Peg-Intron Redipen Pak 4, Peg-Intron Redipen,**

Diagnosis /Use(s): Hepatitis C, chronic

If authorized, Approval Duration: Genotype 2,3-24 weeks,genotype not 2,3-12 weeks then 36 wks,ribavirin contraindicated/HIV+-48 wks

Requirement(s): Chronic hepatitis C in combination with ribavirin-hepatitis C viral RNA levels are greater than 50IU/ml AND has not received previous treatment with peginterferon. Chronic hepatitis C-ribavirin contraindicated AND detectable hepatitis C RNA levels are greater than 50IU/ml AND has not received previous treatment with peginterferon

Drug Name(s): **PERFOROMIST**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **PREMASOL**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Prevacid, Prevacid Naprapac, Prevacid Solutab, Protonix**

Diagnosis /Use(s): Duodenal ulcer disease, erosive esophagitis gastroesophageal reflux disease, gastric ulcer, Zollinger-Ellison syndrome

If authorized, Approval Duration: 1 year

Requirement(s): Prescription omeprazole or pantoprazole ineffective or not tolerated after an adequate treatment course or are contraindicated

Drug Name(s): **PROCALAMINE**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Procrit, Epogen**

Diagnosis /Use(s): All FDA-approved indications not otherwise excluded for Part D.

Must be prescribed by: Anemia-oncologist, hematologist, nephrologist

If authorized, Approval Duration: Duration requested by physician or up to 6 months per approval, whichever is less.

Requirement(s): Anemia in AZT treated patients-hematocrit less than 30% and AZT dose is less than or equal to 4200mg/week. Anemia in hepatitis C-hemoglobin less than 12g/dL in patients receiving combination therapy with interferon alfa and ribavirin. Anemia in low birth weight infants: hematocrit less than 32%. Limited acute severe anemia conditions: hematocrit less than or equal to 24%. Anemic patients at high risk for perioperative transfusions with significant, anticipated blood loss-surgery is preplanned, non-cardiac and non-vascular AND hemoglobin less than or equal to 13g/dL AND not a candidate for autologous blood transfusion. Anemia of chronic disease: hematocrit less than or equal to 24% and hemoglobin less than 9g/dL if erythropoietin levels are 1500mU/ml or less AND transferrin saturation is at least 20% and ferritin at least 100ng/mL. Anemia associated with myelodysplastic syndrome-hematocrit 30% or less or hemoglobin less than 10g/dL

Drug Name(s): **PROGRAF**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **PROSOL**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Provigil**

Diagnosis /Use(s): All FDA-approved indications not otherwise excluded for Part D.

If authorized, Approval Duration: Narcolepsy-1 year, obstructive sleep apnea/hypoapnea-6 months

Requirement(s): Excessive sleepiness associated with narcolepsy when at least one generic or preferred brand medication has been ineffective or not tolerated OR documentation of residual excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome and documented compliance with CPAP or BiPAP for at least 2 months for 4 hours per night

Drug Name(s): **PULMICORT**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **PULMOZYME**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **RAPAMUNE**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Raptiva**

Diagnosis /Use(s): All FDA-approved indications not otherwise excluded for Part D.

Must be prescribed by: Dermatologist

If authorized, Approval Duration: 1 year

Requirement(s): Documented diagnosis of chronic plaque psoriasis involving a minimum of 10% of body surface area (or documentation of significant functional impairment) AND treatment with phototherapy or photochemotherapy was ineffective, not tolerated or contraindicated AND treatment with at least one oral systemic agent for psoriasis was ineffective or not tolerated, unless all are contraindicated

Drug Name(s): **RECOMBIVAX HB**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Relistor**

Diagnosis /Use(s): Opioid-induced constipation in patients with advanced illness receiving palliative care after failing laxative therapy

If authorized, Approval Duration: Up to 4 months

Requirement(s): Diagnosis of opioid-induced constipation where an adequate trial of a prescribed bowel regimen has been ineffective AND patient has an advanced medical illness with a life expectancy of less than 6 months and is enrolled in a hospice program or meets hospice criteria AND patient is receiving chronic opioid therapy

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Remicade**

Diagnosis /Use(s): All FDA-approved indications not otherwise excluded for Part D.

Must be prescribed by: Plaque psoriasis-dermatologist or rheumatologist

If authorized, Approval Duration: Initial authorization-6 months then continued authorization 1 year

Requirement(s): RA-diagnosed by or in consultation with a rheumatologist, 6-12 week course of methotrexate ineffective, infliximab administered w/MTX. Psoriatic arthritis-diagnosed by rheumatologist or dermatologist. Ankylosing spondylitis-diagnosed by or in consultation with a rheumatologist. Crohn's Disease-adequate course of systemic corticosteroids ineffective or contraindicated OR unable to taper off an adequate course of systemic corticosteroids without worsening or symptoms or breakthrough disease while stabilized for at least 2 months on an immunomodulatory medication Documented diagnosis of chronic plaque psoriasis involving a minimum of 10% of body surface area (or documentation of significant functional impairment) AND treatment with phototherapy or photochemotherapy was ineffective, not tolerated or contraindicated AND treatment with at least one oral systemic agent for psoriasis was ineffective or not tolerated, unless all are contraindicated

Drug Name(s): **RENAMIN**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Revatio**

Diagnosis /Use(s): Pulmonary arterial hypertension

If authorized, Approval Duration: 1 year

Requirement(s): Diagnosis of pulmonary arterial hypertension

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Revlimid**

Diagnosis /Use(s): All FDA-approved indications not otherwise excluded for Part D.

If authorized, Approval Duration: MDS-Initially 3 months then yearly. MM-1 year

Requirement(s): Myelodysplastic syndrome-patient is transfusion dependent AND has an absolute neutrophil count of at least 500/mm³ AND has a platelet count of at least 50,000/mm³. Multiple Myeloma-at least one prior therapy for multiple myeloma was ineffective or not tolerated AND lenalidomide is used in combination with dexamethasone AND patient has an absolute neutrophil count of at least 1,000/mm³ AND patient has a platelet count of at least 30,000/mm³

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Saizen, Saizen Click.Easy, Nutropin, Nutropin AQ Pen, Nutropin AQ**

Diagnosis /Use(s): Pediatric-Growth hormone deficiency, Prader-Willi syndrome, Turner's syndrome, chronic renal insufficiency, pediatric burn patients. Adults-Growth hormone deficiency with panhypopituitarism, short bowel syndrome

Must be prescribed by: Pediatrics-pediatric endocrinologist, pediatric nephrologist, trauma/burn surgeon

If authorized, Approval Duration: Short bowel syndrome-up to 4 weeks. All other indications-1 year

Requirement(s): Pediatric-Documented GHD defined as two GH stimulation tests below 10ng/ml OR at least one GH stimulation test less than 15ng/ml and IGF-1 and IGF-BP3 levels below normal for bone age and sex OR one GH stimulation test below 10ng/ml for those with defined CNS pathology, history of irradiation, or genetic condition associated with GHD OR growth stimulation hormone tests, IGF-1 or IGF-3 levels are not needed for GHD if multiple pituitary hormone deficiencies exist or for congenital GHD. Open growth plates-an initial bone age, demonstration of open growth plates. Short Stature/Growth failure-Height is less than the minimum percentile specified for age/sex OR when the height is below the minimum percentile specified for age/sex and untreated growth velocity with a minimum of 1 year of growth data is below the 25th percentile OR if GHD defined as GH stimulation tests, IGF-1 or IGF-BP3 levels not needed for congenital GHD, growth failure/short stature is not needed. Chronic Renal Insufficiency-requires weekly dialysis OR chronic renal insufficiency defined as glomerular filtration rate (GFR) less than 75ml/min/1.73m². Documented decrease muscle tone by exam. Pediatric burns-burns over at least 40% of total body surface area. Adults-Two pituitary hormone deficiencies other than growth hormone requiring hormone replacement AND at least one known cause for pituitary disease or condition affecting pituitary function is documented AND one provocative stimulation test less than 5ng/ml OR three pituitary hormone deficiencies other than growth hormone requiring hormone replacement AND an IGF-1 below 80ng/ml. SBS-ability to ingest solid food AND dependent on parenteral nutrition at least five days per week to provide at least 3000kcal/week AND chart notes indicate dietary needs and goals have been addressed

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Sancuso**

Diagnosis /Use(s): Chemotherapy induced nausea/vomiting, moderately and highly emetogenic, prophylaxis

If authorized, Approval Duration: 6 months

Requirement(s): Use is for the prevention of nausea/vomiting associated with chemotherapy AND treatment with at least one generic 5-HT3 antagonist (ondansetron or oral granisetron) is not effective or not tolerated

Drug Name(s): **SANDIMMUNE**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Sprycel**

Diagnosis /Use(s): Chronic myelogenous leukemia, Philadelphia chromosome positive acute lymphoblastic leukemia

Must be prescribed by: Hematologist or oncologist

If authorized, Approval Duration: 1 year

Requirement(s): Resistant or intolerant to treatment with imatinib

Drug Name(s): **Sutent**

Diagnosis /Use(s): Gastrointestinal stromal tumor, renal cell carcinoma

Must be prescribed by: Hematologist or oncologist

If authorized, Approval Duration: 1 year

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Symlin, Symlin 60, Symlin 120**

Diagnosis /Use(s): Type 1 diabetes mellitus, Type 2 diabetes mellitus

Must be prescribed by: Endocrinologist or physician in consultation with an endocrinologist

If authorized, Approval Duration: 1 year

Requirement(s): Documentation that the patient's hemoglobin A1C is greater than 7% AND effective glycemic control as defined by a hemoglobin A1C less than or equal to 7% has not been achieved with insulin

Drug Name(s): **Synagis**

Diagnosis /Use(s): Respiratory syncytial virus prophylaxis

Must be prescribed by:

If authorized, Approval Duration: 1 year

Requirement(s): Infants with bronchopulmonary dysplasia who are less than 2 years of age at the start of RSV season and who have required medical therapy for bronchopulmonary dysplasia within 6 months or during the RSV season and infants that required treatment with supplemental oxygen as neonates for at least 28 days OR infants less than or equal to 6 months of chronological age at the onset of RSV season and history of premature birth between 32 1/7 weeks to 35 0/7 weeks gestation who have two or more of the following risk factors: childcare attendance, school aged siblings, exposure to environmental air pollutants, congenital abnormalities of the airways, severe neuromuscular disease OR infants less than or equal to 6 months chronological age at the onset of RSV season with a history of premature birth between 29 0/7 to 32 0/7 weeks with or without the presence of additional risk factors OR infants less than or equal to 12 months chronological age at the onset of RSV season and born at 28 6/7 weeks of gestation or earlier OR infants or children at the onset of RSV season are younger than 24 months of age with hemodynamically significant congenital heart disease or an infant younger than 12 months of age with congenital heart disease who: receive medication to control congestive heart failure or have moderate to severe pulmonary hypertension or have cyanotic heart disease

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Tarceva**

Diagnosis /Use(s): Locally advanced or metastatic non-small cell lung cancer, locally advanced, unresectable or metastatic pancreatic cancer in combination with gemcitabine.

If authorized, Approval Duration: 1 year

Requirement(s): Locally advanced or metastatic non-small cell lung cancer where at least one prior chemotherapy regimen prescribed for non-small cell lung cancer was not effective. Palliative treatment for non-small cell lung cancer in terminally ill patient at end of life

Drug Name(s): **Tasigna**

Diagnosis /Use(s): Chronic or accelerated phase Philadelphia chromosome positive chronic myelogenous leukemia

Must be prescribed by: Hematologist or oncologist

If authorized, Approval Duration: 1 year

Requirement(s): Resistant or intolerant to treatment with imatinib

Drug Name(s): **THYMOGLOBULIN**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **TOBI**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **TOPOSAR**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **TPN ELECTROLYTES FTV**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **TRAVASOL**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **TRAVASOL 2.75%/DEXTROSE 10%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **TRAVASOL 2.75%/DEXTROSE 5%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **TRAVASOL 3.5%/ELECTROLYTES**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **TRAVASOL 4.25%/DEXTROSE 10%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **TRAVASOL 4.25%/DEXTROSE 25%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **TRAVASOL 5.5%/DEXTROSE 10%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **TRAVASOL 5.5%/DEXTROSE 20%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **TRAVASOL 5.5%/ELECTROLYTES**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **TRAVASOL 8.5%/DEXTROSE 10%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **TRAVASOL 8.5%/DEXTROSE 20%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **TRAVASOL 8.5%/DEXTROSE 50%**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **TRAVASOL 8.5%/ELECTROLYTES**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **TREANDA**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Tretinoin cream, tretinoin gel, Retin-A cream, Retin-A gel, Retin-A Micro, Avita**

Diagnosis /Use(s): Precancerous and following pathologic conditions: acne vulgaris, bullous congenital ichthyosiform, cutaneous horn, diabetic foot ulcers, hyperpigmented lesions in blacks, ichthyosis vulgaris, keratoacanthoma, keratosis follicularis, lamellar ichthyosis, mollusca contagiosa, pityriasis rubra pilaris, porokeratosis, solar keratosis, verrucae planus, verrucae planae juvenilis, acute promyelocytic leukemia

If authorized, Approval Duration: 1 year

Drug Name(s): **TROPHAMINE**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Tykerb**

Diagnosis /Use(s): HER2 positive breast cancer

If authorized, Approval Duration: 1 year

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **Tysabri**

Diagnosis /Use(s): Relapsing form of multiple sclerosis, Crohn's Disease

Must be prescribed by: Multiple Sclerosis-Prescribed by or in consultation with a neurologist or multiple sclerosis physician specialist

If authorized, Approval Duration: MS-1 year, Crohn's-initially 12 weeks then every 6 months

Requirement(s): MS-Definitive diagnosis of relapsing form of multiple sclerosis that has been established by or in consultation with a neurologist or multiple sclerosis physician specialist AND interferon beta product or glatiramer acetate documented in clinical notes to be ineffective, contraindicated or not tolerated with ineffectiveness defined as meeting two of the following criteria: patient continues to have clinical relapses(at least two clinical relapses within the past 12 months) or patient continues to have CNS lesion progression as measured by MRI or patient continues to have worsening disability . Crohn's Disease-Diagnosis when one of the following criteria are met: treatment with an adequate course of corticosteroids has been ineffective or is contraindicated OR patient has been unable to taper off an adequate course of systemic corticosteroids without experiencing worsening of disease OR patient is experiencing breakthrough disease while stabilized for at least two months on an immunomodulatory medication AND infliximab is not effective after at least an initial induction period (5mg/kg on weeks 0,2,6) except if not tolerated due to documented clinical side effects AND adalimumab is not effective after at least an initial 3-dose induction period except if not tolerated due to documented clinical side effects AND patients have an elevated (greater than 6mg/dl) baseline C-reactive protein level

Drug Name(s): **VENTAVIS**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **VIRAZOLE**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Xolair**

Diagnosis /Use(s): Allergic asthma

If authorized, Approval Duration: 6 months

Requirement(s): Patient is followed by an asthma specialist (allergist, immunologist or pulmonologist) AND positive skin prick test or in-vitro specific IgE test to one or more allergens supporting the patient's clinical history AND total serum IgE level is greater than or equal to 30IU/ml and less than or equal to 700IU/ml AND clinical documentation of poor asthma control or recurrent exacerbation requiring additional medical treatment with recurrent exacerbation defined as 2 or more acute exacerbations in a 12 month period AND clinical documentation that the patient is compliant with high dose inhaled corticosteroids and long-acting beta-2 agonists and use of oral corticosteroids for exacerbation unless contraindicated AND underlying conditions or triggers for asthma or pulmonary disease are being maximally managed

Drug Name(s): **XOPENEX**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **XOPENEX CONCENTRATE**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Xyrem**

Diagnosis /Use(s): Cataplexy, excessive daytime sleepiness, narcolepsy

If authorized, Approval Duration: 1 year

Requirement(s): Excessive daytime sleepiness when modafinil in doses up to 400mg daily has been ineffective, not tolerated or contraindicated AND at least one other generic or preferred brand drug has been ineffective, not tolerated or contraindicated

Drug Name(s): **Zavesca**

Diagnosis /Use(s): Type 1 Gaucher's Disease

If authorized, Approval Duration: 1 year

Drug Name(s): **ZENAPAX**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

Drug Name(s): **ZOFRAN**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **ZOFRAN ODT**

Diagnosis /Use(s): B versus D Determination

Requirement(s): This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Drug Name(s): **Zolinza**

Diagnosis /Use(s): Chronic T-cell lymphoma

If authorized, Approval Duration: 1 year

Requirement(s): Progressive, persistent or recurrent disease on or following two systemic therapies

Prior Authorization Requirements

Listed below are prior authorization requirements. To be considered for coverage the following conditions must be met:

How to Get an Exception

Please contact us for an initial coverage decision about an exception. Submit a statement from your physician supporting your request. Generally, we must make our decision within 72 hours of your request.

Exceptions you can request are:

Covering your drug even if it is not on our formulary.

Waiving coverage restrictions or limits on your drug. For example, if your drug has a quantity limit, you can ask us to waive the limit and cover more.

Providing a higher level of coverage for your drug. For example if your drug is a tier 3 or tier 4 you can ask us to cover it at a lower tier (tier 2 or tier 3), to lower what you pay.

For more information about exceptions, please refer to the Evidence of Coverage booklet.

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