

# Medicare Part D - Medication Coverage Requirements

The medications in this document have requirements that must be met for coverage on our Medicare plans to be considered. Included in this listing are prior authorization, quantity level limitations and/or step therapy requirements.

Drug	Covered Uses	Requirements	Age Restriction	Who Can Prescribe	Approval Duration	Quantity and/or Days Supply Restriction
<b>ACTIQ, FENTANYL CITRATE ORAL TRANSMUCOSAL, FENTORA</b>	All FDA-approved indications not otherwise excluded from Part D.	Documentation of 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, taking at least the equivalent of 60mg oral morphine sulfate			6 months	Actiq and Fentanyl 96 LPOP per 30 days. Fentora: 84 tabs per 30 day(s)
<b>ACTONEL, ACTONEL WITH CALCIUM</b>	All FDA-approved indications not otherwise excluded from Part D.	Generic oral bisphosphonate (such as alendronate) has not been tolerated or is contraindicated.			1 year	
<b>ACTOS, ACTOPLUS MET, DUETACT, AVANDIA, AVANDARYL, AVANDAMET</b>	All FDA-approved indications not otherwise excluded from Part D.	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 of 7% or less after 90 days of therapy. Nonalcoholic steatohepatitis- metformin was ineffective, contraindicated or not tolerated. Polycystic Ovary Syndrome- metformin was ineffective, contraindicated or not tolerated			1 year	

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<b>ADCIRCA</b>	All FDA-approved indications not otherwise excluded from Part D.	Documented diagnosis of pulmonary arterial hypertension (PAH).			1 year	60 tabs per 30 day(s)
<b>AFINITOR</b>	All FDA-approved indications not otherwise excluded from Part D.	Documentation of renal cell carcinoma where sorafenib(Nexavar® ) and sunitinib(Sutent®) have not been effective		Oncologist	12 months	30 tabs per 30 day(s)
<b>AMEVIVE</b>	All FDA-approved indications not otherwise excluded from Part D.	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		Dermatologist	12 weeks	
<b>ANZEMET</b>	All FDA-approved indications not otherwise excluded from Part D.	Documentation of diagnosis and treatment with at least one generic 5-HT3 antagonist (ondansetron or granisetron) is not effective or not tolerated.			6 months	4 tabs/patches per 30 day(s)
<b>ARCALYST</b>	All FDA-approved indications not otherwise excluded from Part D.	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			Initial-1 month then annually with documentat ion of	9.2ml per 30 day(s)

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		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 AND there is clinical documentation of significant functional impairment leading resulting in significant impairment or limitation of activities of daily living(ADLs).			disease stability or improvement.	
<b>BETASERON</b>	All FDA-approved indications not otherwise excluded from Part D.	Documentation that treatment with interferon beta-1a(Avonex®) OR interferon beta-1a(Rebif®) OR glatiramer acetate(Copaxone®) is ineffective or not tolerated			1 year	18ml per 30 day(s)
<b>BONIVA</b>	All FDA-approved indications not otherwise excluded from Part D.	Generic oral bisphosphonate (such as alendronate) has not been tolerated or is contraindicated AND risedronate(Actonel®) has not been tolerated or is contraindicated.			1 year	
<b>BONVIA IV</b>	All FDA-approved indications not otherwise excluded from Part D.	Oral bisphosphonate [such as alendronate, ibandronate(Boniva®) or risedronate(Actonel®)] has not been tolerated or is contraindicated.			1 year	
<b>BOTOX</b>	All FDA-approved indications not otherwise excluded from Part D, central demyelinating of	Documentation of functional impairment originating from spasticity or dystonia from condition with cervical dystonia and spasmodic torticollis requiring documentation of			6 months	

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	<p>corus callosum, cerebral palsy, demyelinating disease of CNS, seventh cranial nerve disorders, other facial nerve disorders (facial myokymia, Melkersson's syndrome, facial/hemifacial spasms), hereditary spastic paraplegia, laryngeal spasm, laryngeal adductor spastic dysphonia or stridulus, leukodystrophy, multiple sclerosis, neuromyelitis optica, organic writer's cramp, orofacial dyskinesia, Schilder's disease, sialorrhea in patients with Parkinson's Disease, spasmodic dysphonia, spastic hemiplegia(spasticity related to stroke, spasticity related to</p>	<p>involuntary contractions of the neck muscles resulting in twisting and repetitive movements and/or abnormal postures. 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. Incontinence due to detrusor overactivity, either idiopathic or due to neurogenic causes, when therapy with anticholinergic agents is not effective or not tolerated.</p>				

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	spinal cord injury), torsion dystonia(idiopathic and symptomatic), anal fissures, achalasia/cardiospasm and incontinence due to detrusor overactivity.					
<b>BYETTA</b>	All FDA-approved indications not otherwise excluded from Part D.	Documented 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®), pioglitazone (Actos®), pioglitazone/metformin (ACTOplus MET®) and pioglitazone/glimepiride (Duetact®)]			1 year	2.4ml per 30 day(s)
<b>CARIMUNE NF, FLEBOGAMMA, IVEEGAM, GAMINUM N, GAMMAGARD LIQUID, GAMMAGARD S/D, GAMMAR PIV, GAMMAR IV,</b>	All FDA-approved indications not otherwise excluded from Part D.	Acquired Factor VIII inhibitor-cyclophosphamide, corticosteroids or azathioprine is ineffective or not tolerated. Autoimmune hemolytic anemia-patient is diagnosed with warm type AIHA that does not respond to corticosteroids, immunosuppressive agents, plasmapheresis, or splenectomy.	Allogeneic bone marrow transplant recipients-20 years of age or older. HIV infected		2 weeks to 1 year depending on diagnosis	

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<b>GAMUNEX, IVEEGAMEN, OCTAGAM, PANGLOBULIN, PANGLOBUIN NF, POLYGAM S/D, SANDOGLOBULIN, VENOGLOBULIN, VIVAGLOBIN</b>		<p>Dermatomyositis-documented EMG abnormalities and/or increased CPK levels with associated severe disability when corticosteroid therapy is ineffective or not tolerated. Fetal alloimmune thrombocytopenia-documented diagnosis. HIV infected children(less than 13 years of age) when T4 cell count is greater than 200/mm<sup>3</sup>.</p> <p>Hypogammaglobulinemia(acquired) associated with either chronic B-cell lymphocytic leukemia or post allogeneic bone marrow transplant and documented with laboratory findings. Hypogammaglobulinemic neonates-low birth weight(less than 1500g) or in a setting with high baseline infection rate. Inflammatory demyelinating polyneuropathy(acute) including Guillain-Barre' syndrome with deteriorating pulmonary function tests OR rapid deterioration with symptoms for less than 2 weeks OR rapidly deteriorating ability to ambulate OR inability to walk independently for 10 meters. Inflammatory demyelinating polyneuropathy(chronic, CIDP) with significant functional disability AND documentation of slowing of nerve conduction velocity on EMG/NCS AND documentation of elevated spinal fluid protein on lumbar puncture or a nerve biopsy</p>	children-less than 13 years of age			

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		confirming diagnosis. Acute ITP-when rapid increase in platelet count is necessary such as acute bleeding episode or prior to surgery. Chronic ITP-platelet count is less than 30,000 cells/mm <sup>3</sup> in children or less than 20,000 cells/mm <sup>3</sup> in adults. □ ITP in pregnancy-refractory to steroids with platelet counts less than 10,000cells/mm <sup>3</sup> in the third trimester OR platelet counts less than 30,000/mm <sup>3</sup> associated with bleeding before vaginal delivery of C-section OR history of autoimmune thrombocytopenia d				
<b>CEREZYME</b>	All FDA-approved indications not otherwise excluded from Part D.	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			6 months	
<b>CIMZIA</b>	All FDA-approved indications not otherwise excluded from Part D.	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®)			Initial -1 month and if effective annually	2ml per 30 day(s)

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		or infliximab (Remicade®) was not effective after at least an adequate treatment course except if not tolerated due to documented clinical side effects				
<b>CRESTOR</b>	All FDA-approved indications not otherwise excluded from Part D.	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			1 year	
<b>CYMBALTA, PRISTIQ</b>	All FDA-approved indications not otherwise excluded from Part D.	Two generic alternatives have been ineffective, not tolerated or contraindicated.			1 year	
<b>EMEND 125MG CAPS</b>		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. This medication has a quantity level limit applied.				2 caps per 30 day(s)
<b>EMEND 80 MG CAPS</b>		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. This medication has a quantity level limit applied				4 caps per 30 day(s)
<b>EMEND PAK</b>		This drug may be covered under Medicare Part B or D depending on the circumstances. Information may				6 caps per 30 day(s)

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<b>ENBREL, ENBREL SURECLICK</b>	All FDA-approved indications not otherwise excluded from Part D.	<p>need to be submitted describing the use and setting of the drug to make the determination. This medication has a quantity level limit applied.</p> <p>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 polyarticular juvenile idiopathic 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</p>		Chronic Plaque Psoriasis-dermatologist or rheumatologist	1 year	4ml per 30 day(s)

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		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				
<b>EXTAVIA</b>	All FDA-approved indications not otherwise excluded from Part D.	Treatment with interferon beta-1a OR interferon beta-1a OR glatiramer acetate is ineffective or not tolerated			1 year	15ml per 30 day(s)
<b>FORTEO</b>	All FDA-approved indications not otherwise excluded from Part D.	Bone mineral density that is 2.5 or more standard deviations below that of a young, normal adult(T score at or below -2.5) 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			One time two year authorization then annually	2.4ml per 30 day(s)
<b>GLEEVEC</b>	All FDA-approved indications not otherwise excluded from Part D.	Documentation of chronic myelogenous leukemia with the presence of the Philadelphia (Ph-1) chromosome, gastrointestinal stromal tumor, relapsed or refractory Philadelphia chromosome positive			1 year	

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		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				
<b>GRANISETRON HCL</b>	B versus D Determination	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. This medication has a quantity level limit applied.				30 tabs per 30 day(s)
<b>GRANISOL</b>	B versus D Determination	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. This medication has a quantity level limit applied.				150ml per 30 day(s)

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<b>HUMATROPE, HUMATROPE COMBO PACK, GENOTROPIN, GENOTROPIN MINIQUICK, NORDITROPIN NORDIFLEX PEN, NORDITROPIN CARTRIDGE, ZORBTIVE, SEROSTIM, TEV-TROPIN, OMNITROPE</b>	All FDA-approved indications not otherwise excluded from Part D.	Adult and Pediatric-Saizen and Nutropin products have not been tolerated AND documented Pediatric-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 congenial 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 cogential 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		Children-pediatric endocrinologist, pediatric nephrologist or trauma/burn surgeon	Short bowel syndrome-up to 4 weeks. All other indications-up to 1 year.	

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		<p>than 75ml/min/1.73m<sup>2</sup>. 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</p>				
<p><b>HUMIRA 40MG/0.8ML KIT</b></p>	<p>All FDA-approved indications not otherwise excluded from Part D.</p>	<p>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 polyarticular 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</p>		<p>Chronic Plaque Psoriasis-dermatologist or rheumatologist</p>	<p>Rheumatologic conditions, chronic plaque psoriasis-annually, Crohn's Disease-3 months then annually</p>	<p>1.6ml per 30 day(s)</p>

Drug	Covered Uses	Requirements	Age Restriction	Who Can Prescribe	Approval Duration	Quantity and/or Days Supply Restriction
		<p>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.</p> <p>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</p>				

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		<p>treatment with at least one oral systemic agent for psoriasis was ineffective or not tolerated, unless all are contraindicated AND prescribing physician is a dermatologist or rheumatologist.</p> <p>This medication has a quantity level limit applied</p>				
<b>HUMIRA PEN-CROHNS DISEASESTARTER</b>	All FDA-approved indications not otherwise excluded from Part D.	<p>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 polyarticular 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</p>		Chronic Plaque Psoriasis-dermatologist or rheumatologist	Rheumatologic conditions, chronic plaque psoriasis-annually, Crohn's Disease-3 months then annually	4.8ml per 30 day(s)

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		<p>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.</p> <p>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 AND prescribing physician is a dermatologist or rheumatologist.</p>				
<b>INCRELEX</b>	All FDA-approved indications not otherwise excluded from Part D.	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		Pediatric endocrinologist	1 year	

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		growth hormone levels based upon at least one growth hormone stimulation test AND open growth plates				
<b>INFERGEN 9MCG/0.3ML INJ</b>		This medication has a quantity level limit applied				6ml per 30 day(s)
<b>JANUVIA, JANUMET</b>	All FDA-approved indications not otherwise excluded from Part D.	Documented hemoglobin A1C greater than 7% AND treatment with metformin is contraindicated, not tolerated or ineffective in reducing hemoglobin A1C to goal of 7% or less after 90 days of therapy			1 year	Januvia: 30 tabs per 30 days. Janumet: 60 tabs per 30 day(s)
<b>KINERET</b>	All FDA-approved indications not otherwise excluded from Part D.	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			1 year	20.1ml per 30 day(s)

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		side effects AND therapy does not exceed administration of anakinra 100mg subcutaneously once daily				
<b>KUVAN</b>	All FDA-approved indications not otherwise excluded from Part D.	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			Initially 2 months then annually	420 tabs per 30 day(s)
<b>KYTRIL</b>	B versus D Determination	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. This medication has a quantity level limit applied.				30 tabs per 30 day(s)
<b>LIPITOR</b>	All FDA-approved indications not otherwise excluded from Part D.	Rosuvastatin (Crestor®) 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			1 year	
<b>LYRICA</b>	All FDA-approved indications not otherwise excluded	Documentation of diagnosis Neuropathic pain - when a previous history of adequate treatment courses			1 year	300mg 60 caps per 30 days. All other

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	from Part D.	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.				strengths 90 caps per 30 day(s)
<b>MAXALT, MAXALT MLT</b>	All FDA-approved indications not otherwise excluded from Part D.	One generic triptan has been ineffective or not tolerated			1 year	12 tabs per 30 day(s)
<b>MICARDIS, MICARDIS HCT, BENICAR, BENICAR HCT, DIOVAN, DIOVAN HCT, VALTURNA</b>	All FDA-approved indications not otherwise excluded from Part D.	Angiotensin converting enzyme inhibitor (ACE inhibitor) ineffective, not tolerated or contraindicated.			1 year	
<b>MYOBLOC</b>	All FDA-approved indications not otherwise excluded from Part D, excessive salivation associated with Parkinson's disease	Spasmodic torticollis-Documentation of diagnosis and functional impairment originating from spasticity or dystonia with documentation of involuntary contractions of the neck muscles resulting in twisting and repetitive movements, and/or abnormal postures. Sialorrhea-documented functional impairment resulting from excessive saliva associated with Parkinson's disease.			1 year	

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<b>NASACORT AQ</b>	All FDA-approved indications not otherwise excluded from Part D.	Treatment with at least one generic nasal corticosteroid has been ineffective or not tolerated			1 year	
<b>NASONEX, RHINOCORT AQ, BECONASE AQ, OMNARIS, VERAMYST</b>	All FDA-approved indications not otherwise excluded from Part D.	Treatment with one generic nasal corticosteroid AND Nasacort AQ has been ineffective or not tolerated			1 year	
<b>NEXAVAR</b>	All FDA-approved indications not otherwise excluded from Part D.	Documentation of advanced renal cell carcinoma, unresectable hepatocellular carcinoma		Oncologist	1 year	120 tabs per 30 day(s)
<b>ONDANSETRON HCL</b>	B versus D Determination	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. This medication has a quantity level limit applied.				4mg 90 tabs per 30 days. 8mg 90 tabs per 30 days. 24mg 30 tabs per 30 day(s)
<b>ONDANSETRON HCL 4MG/5ML SOLN</b>	B versus D Determination	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. This medication has a quantity level limit applied.				450ml per 30 day(s)
<b>ONDANSETRON ODT</b>	B versus D Determination	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. This medication				4mg 90 tabs per 30 days. 8mg 90 tabs per 30 day(s)

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<b>OPANA ER TB12</b>		has a quantity level limit applied.  This medication has a quantity level limit applied				5mg 480 tabs per 30 days. 7.5mg 320 tabs per 30 days. 10mg 240 tabs per 30 days. 15mg 160 tabs per 30 days. 20mg 120 tabs per 30 days. 30mg 80 tabs per 30 days. 40mg 60 tabs per 30 day(s)
<b>ORENCIA</b>	All FDA-approved indications not otherwise excluded from Part D.	Polyarticular juvenile idiopathic arthritis (JIA) or 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 for RA 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 or contraindicated based on clinical documentation			6 months initially then 1 year	

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<b>OXYCODONE HCL ER TB12</b>		This medication has a quantity level limit applied				10mg 150 tabs per 30 days. 20mg 150 tabs per 30 days. 40mg 150 tabs per 30 days. 80mg 60 tabs per 30 day(s)
<b>OXYCONTIN 10MG TB12</b>		This medication has a quantity level limit applied				10mg 150 tabs per 30 days. 15mg 150 tabs per 30 days. 20mg 150 tabs per 30 days. 30mg 150 tabs per 30 days. 40mg 150 tabs per 30 days. 60mg 90 tabs per 30 days. 80mg 60 tabs per 30 day(s)
<b>PEGASYS</b>	All FDA-approved indications not otherwise excluded from Part D.	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			Genotype 2,3-24 weeks, not 2,3 -12wks then 36wks, ribavirin contraindicated/HIV+-48wks, hep B-48wks	2ml per 30 day(s)

Drug	Covered Uses	Requirements	Age Restriction	Who Can Prescribe	Approval Duration	Quantity and/or Days Supply Restriction
<b>PEG-INTRON, PEG-INTRON REDIPEN PAK 4, PEG-INTRON REDIPEN,</b>	All FDA-approved indications not otherwise excluded from Part D.	previous treatment with peginterferon  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 viral RNA levels are greater than 50IU/ml AND has not received previous treatment with peginterferon.			Genotype 2,3-24 weeks,genotype not 2,3-12 weeks then 36 wks,ribavirin contraindicated/HIV+-48 wks	2ml per 30 day(s)
<b>PREGNYL, NOVAREL, CHORIONIC GONADOTROPIN</b>	All FDA-approved indications not otherwise excluded from Part D.	Documentation of diagnosis			1 year	
<b>PREVACID, PREVACID SOLUTAB</b>	All FDA-approved indications not otherwise excluded from Part D.	Treatment with prescription omeprazole has been ineffective, not tolerated or is contraindicated.			1 year	
<b>PROMACTA</b>	All FDA-approved indications not otherwise excluded from Part D.	Diagnosis of chronic ITP made by or in consultation with a hematologist AND patient is at risk of spontaneous bleeding as demonstrated in chart notes by either platelet count less than 20,000mm <sup>3</sup> or platelet count less than 30,000/mm <sup>3</sup> accompanied by symptoms of bleeding AND treatment with at least one of the following ITP treatments was ineffective or not tolerated: adequate course of systemic corticosteroids or			Initial-3 months then every 6 months	

Drug	Covered Uses	Requirements	Age Restriction	Who Can Prescribe	Approval Duration	Quantity and/or Days Supply Restriction
<b>PROVIGIL</b>	All FDA-approved indications not otherwise excluded from Part D.	immunoglobulin replacement therapy or splenectomy.  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 OR excessive sleepiness associated with shift-work disorder when diagnosis is made using the criteria from International Classification of Sleep Disorders AND sleep disturbance causes measurable functional impairment in social, occupational or other important areas of functioning that has persisted for at least three months AND sleep disturbance is not due to otherwise reversible conditions AND non-pharmacologic therapies have been inadequate in improving functional impairments.			Narcolepsy and shift work disorder-1 year. Obstructive sleep apnea/hypopnea-6 months then annually	60 tabs per 30 day(s)
<b>QUALAQUIN</b>	All FDA-approved indications not otherwise excluded from Part D.	Documented diagnosis of uncomplicated malaria due to Plasmodium falciparum			7 days	
<b>RELISTOR</b>	All FDA-approved indications not otherwise excluded from Part D.	Diagnosis of opioid-induced constipation where an adequate trial of a prescribed bowel regimen has been ineffective AND patient has an			Up to 4 months	8.4ml per 30 day(s)

Drug	Covered Uses	Requirements	Age Restriction	Who Can Prescribe	Approval Duration	Quantity and/or Days Supply Restriction
<b>RELPA</b>	All FDA-approved indications not otherwise excluded from Part D.	One generic triptan has been ineffective or not tolerated			1 year	12 tabs per 30 day(s)
<b>REMICADE</b>	All FDA-approved indications not otherwise excluded from Part D.	RA-diagnosed by or in consultation with a rheumatologist AND 6-12 week course of methotrexate ineffective alone AND infliximab administered with methotrexate(MTX). Psoriatic arthritis-diagnosed by or in consultation with a rheumatologist or dermatologist. Ankylosing spondylitis-diagnosed by or in consultation with a rheumatologist. Crohn's Disease and ulcerative colitis-fistulizing Crohn's disease OR acute treatment of an exacerbation of Crohn's disease or ulcerative colitis where 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. Plaque psoriasis- Documented diagnosis of chronic		Plaque psoriasis-dermatologist or rheumatologist	Initial authorization-6 months then continued authorization 1 year	

Drug	Covered Uses	Requirements	Age Restriction	Who Can Prescribe	Approval Duration	Quantity and/or Days Supply Restriction
		<p>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</p>				
<b>REVATIO</b>	<p>All FDA-approved indications not otherwise excluded from Part D.</p>	<p>Documentation of diagnosis</p>			<p>1 year</p>	<p>90 tabs per 30 day(s)</p>
<b>REVLIMID</b>	<p>All FDA-approved indications not otherwise excluded from Part D.</p>	<p>Myelodysplastic syndrome-patient is transfusion dependent AND has an absolute neutrophil count of at least 500/mm<sup>3</sup> AND has a platelet count of at least 50,000/mm<sup>3</sup>. 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/mm<sup>3</sup> AND patient has a platelet count of at least 30,000/mm<sup>3</sup></p>			<p>MDS-Initially 3 months then yearly. MM-1 year</p>	<p>30 caps per 30 day(s)</p>
<p><b>SAIZEN, SAIZEN CLICK.EASY, NUTROPIN, NUTROPIN AQ PEN, NUTROPIN AQ</b></p>	<p>All FDA-approved indications not otherwise excluded from Part D.</p>	<p>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</p>		<p>Pediatrics-pediatric endocrinologist, pediatric nephrologist, trauma/burn</p>	<p>Short bowel syndrome-up to 4 weeks. All other</p>	

Drug	Covered Uses	Requirements	Age Restriction	Who Can Prescribe	Approval Duration	Quantity and/or Days Supply Restriction
		<p>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-BP3 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/1.73m<sup>2</sup>. 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</p>		surgeon	indications-up to 1 year	

Drug	Covered Uses	Requirements	Age Restriction	Who Can Prescribe	Approval Duration	Quantity and/or Days Supply Restriction
		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				
<b>SANCUSO 3.1MG/24HR PTCH</b>	All FDA-approved indications not otherwise excluded from Part D.	Documentation of diagnosis and treatment with at least one generic 5-HT3 antagonist (ondansetron or granisetron) is not effective or not tolerated. This medication has a quantity level limit applied				2 patches per 30 day(s)
<b>SIMPONI</b>	All FDA-approved indications not otherwise excluded from Part D.	Psoriatic arthritis-diagnosis has been established by a rheumatologist or a dermatologist AND etanercept(Enbrel®) and adalimumab(Humira®) are not effective after at least a 12 week treatment course of each drug except if not tolerated due to documented clinical side effects. Ankylosing spondylitis-diagnosis has been established by a rheumatologist AND etanercept(Enbrel®) and adalimumab(Humira®) are not effective after at least a 12 week treatment course of each drug except			1 year	0.5ml per 30 day(s)

Drug	Covered Uses	Requirements	Age Restriction	Who Can Prescribe	Approval Duration	Quantity and/or Days Supply Restriction
		if not tolerated due to documented clinical side effects. Rheumatoid Arthritis-diagnosis has been established by a rheumatologist or meets 4 of 7 diagnostic criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND etanercept(Enbrel®) and adalimumab(Humira®) are not effective after a minimum 12 week treatment course unless not tolerated due to documented clinical side effects AND golimumab (Simponi®) is administered with an oral disease modifying antirheumatic drug (DMARD) unless etanercept(Enbrel®), adalimumab(Humira®) and abatacept(Orencia®) each have been ineffective, contraindicated or not tolerated as these medications have been proven to be effective when given without the concomitant administration of an oral DMARD.				
<b>SPRYCEL</b>	All FDA-approved indications not otherwise excluded from Part D.	Documentation of chronic myelogenous leukemia, Philadelphia chromosome positive acute lymphoblastic leukemia resistant or intolerant to treatment with imatinib		Hematologist or oncologist	1 year	
<b>SUMATRIPTAN SUCCINATE 4MG/0.5ML SOLN</b>		This medication has a quantity level limit applied				4ml per 30 day(s)

<b>Drug</b>	<b>Covered Uses</b>	<b>Requirements</b>	<b>Age Restriction</b>	<b>Who Can Prescribe</b>	<b>Approval Duration</b>	<b>Quantity and/or Days Supply Restriction</b>
<b>SUMATRIPTAN SUCCINATE 6MG/0.5ML SOLN</b>		This medication has a quantity level limit applied				3ml per 30 day(s)
<b>SUMATRIPTAN SUCCINATE TABS (ALL STRENGTHS)</b>		This medication has a quantity level limit applied				12 tabs per 30 day(s)
<b>SUTENT</b>	All FDA-approved indications not otherwise excluded from Part D.	Documentation of gastrointestinal stromal tumor or renal cell carcinoma		Hematologist or oncologist	1 year	12.5mg 60 caps per 30 days. 25mg 30 caps per 30 days. 50mg 30 caps per day(s)
<b>SYMLIN, SYMLIN 60, SYMLIN 120</b>	All FDA-approved indications not otherwise excluded from Part D.	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 and insulin therapy is administered concomitantly with Symlin®.		Endocrinologist or physician in consultation with an endocrinologist	1 year	Symlin 20ml per 30 days. Symlin 60 10.5ml per 30 days. Symlin 120 10.8ml per 30 day(s)
<b>SYMLINPEN 60 1000MCG/ML SOLN</b>		This medication has a quantity level limit applied				10.5ml per 30 day(s)
<b>SYNAGIS</b>	All FDA-approved indications not otherwise excluded from Part D.	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			1 year	

Drug	Covered Uses	Requirements	Age Restriction	Who Can Prescribe	Approval Duration	Quantity and/or Days Supply Restriction
		<p>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</p>				
<b>TARCEVA</b>	All FDA-approved indications not otherwise excluded from Part D.	Locally advanced or metastatic non-small cell lung cancer where at least one prior chemotherapy regimen prescribed for non-small cell lung			1 year	25mg 180 tabs per 30 days. 100mg 45 tabs per 30 days.

Drug	Covered Uses	Requirements	Age Restriction	Who Can Prescribe	Approval Duration	Quantity and/or Days Supply Restriction
		cancer was not effective OR palliative treatment for non-small cell lung cancer in terminally ill patient at end of life OR diagnosis of locally advanced, unresectable or metastatic pancreatic cancer when given in combination with gemcitabine.				150mg 30 tabs per day(s)
<b>TASIGNA</b>	All FDA-approved indications not otherwise excluded from Part D.	Chronic or accelerated phase Philadelphia chromosome positive chronic myelogenous leukemia resistant or intolerant to treatment with imatinib		Hematologist or oncologist	1 year	120 caps per 30 day(s)
<b>TRETINOIN CREAM, TRETINOIN GEL, RETIN-A CREAM, RETIN-A GEL, RETIN-A MICRO, AVITA</b>	All FDA-approved indications not otherwise excluded from Part D.	Documentation of diagnosis			1 year	
<b>TYKERB</b>	All FDA-approved indications not otherwise excluded from Part D.	Documentation of diagnosis			1 year	150 tabs per 30 day(s)
<b>TYSABRI</b>	All FDA-approved indications not otherwise excluded from Part D.	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		Multiple Sclerosis- Prescribed by or in consultation with a neurologist or multiple sclerosis physician specialist	MS-1 year, Crohn's- initially 12 weeks then every 6 months	

Drug	Covered Uses	Requirements	Age Restriction	Who Can Prescribe	Approval Duration	Quantity and/or Days Supply Restriction
		<p>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 critieria 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</p>				
<b>XENAZINE</b>	All FDA-approved indications not otherwise excluded from Part D.	Diagnosis of Huntington's disease with presence of chorea symptoms as confirmed by a neurologist AND documentation of screening for			Initially 3 months then every 6 months	60 tabs per 30 day(s)

Drug	Covered Uses	Requirements	Age Restriction	Who Can Prescribe	Approval Duration	Quantity and/or Days Supply Restriction
<b>XOLAIR</b>	All FDA-approved indications not otherwise excluded from Part D.	depression and if depression present that treatment is being addressed.  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			6 months	
<b>XYREM</b>	All FDA-approved indications not otherwise excluded from Part D.	Narcolepsy with cataplexy OR narcolepsy with 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 (stimulant) drug has been ineffective,			1 year	540ml per 30 day(s)

<b>Drug</b>	<b>Covered Uses</b>	<b>Requirements</b>	<b>Age Restriction</b>	<b>Who Can Prescribe</b>	<b>Approval Duration</b>	<b>Quantity and/or Days Supply Restriction</b>
		not tolerated or contraindicated				
<b>ZALEPLON CAPS (ALL STRENGTHS)</b>		This medication has a quantity level limit applied				30 caps per 30 day(s)
<b>ZAVESCA</b>	All FDA-approved indications not otherwise excluded from Part D.	Documentation of diagnosis			1 year	
<b>ZOFRAN 4MG/5ML SOLN</b>	B versus D Determination	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. This medication has a quantity level limit applied. This medication has a quantity level limit applied				450ml per 30 day(s)
<b>ZOFRAN ODT</b>	B versus D Determination	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. This medication has a quantity level limit applied.				90 tabs per 30 day(s)
<b>ZOFRAN TABS</b>	B versus D Determination	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. This medication has a quantity level limit applied.				90 tabs per 30 day(s)

<b>Drug</b>	<b>Covered Uses</b>	<b>Requirements</b>	<b>Age Restriction</b>	<b>Who Can Prescribe</b>	<b>Approval Duration</b>	<b>Quantity and/or Days Supply Restriction</b>
<b>ZOLINZA</b>	All FDA-approved indications not otherwise excluded from Part D.	Progressive, persistent or recurrent disease on or following two systemic therapies including, but not limited to, bexarotene (Targretin®), denileukin diftitox (Ontak®), doxorubicin (Doxil®), and gemcitabine (Gemzar®).			1 year	120 caps per 30 day(s)
<b>ZOLPIDEM TARTRATE TABS</b>		This medication has a quantity level limit applied				30 tabs per 30 day(s)
<b>ZOMIG NASAL SOLUTION</b>	All FDA-approved indications not otherwise excluded from Part D.	Generic sumatriptan nasal spray has been ineffective or not tolerated.			1 year	6 units per 30 day(s)
<b>ZOMIG, ZOMIG-ZMT</b>	All FDA-approved indications not otherwise excluded from Part D.	One generic triptan has been ineffective or not tolerated			1 year	Tabs: 12 tabs per 30 days. ZMT: 12 tabs per 30 days. Soln: 6ml per 30 day(s)

Drug	Covered Uses	Requirements	Age Restriction	Who Can Prescribe	Approval Duration	Quantity and/or Days Supply Restriction
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**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.

Drug	Covered Uses	Requirements	Age Restriction	Who Can Prescribe	Approval Duration	Quantity and/or Days Supply Restriction
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**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 preferred tier, to lower what you pay.

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

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