

Prior Authorization Group Description	Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SHT3 ANTI-NAUSEA AGENT BVD DETERMINATION	GRANISETRON HCL GRANISOL ONDANSETRON HCL ONDANSETRON ODT	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
ABIRATERONE	ZYTIGA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
APREPITANT BVD DETERMINATION	EMEND	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
BECAPLERMIN	REGRANEX	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NON-DIABETIC. KNOWN NEOPLASM AT APPLICATION SITE. PRESSURE OR VENOUS STASIS ULCERS. ULCER DOES NOT EXTEND THROUGH DERMIS.			VASCULAR SURGEON, PODIATRIST, ENDOCRINOLOGIST OR PHYSICIAN PRACTICING IN A SPECIALTY WOUND CLINIC ONLY	3 MONTHS	
BENZYL ALCOHOL	ULESFIA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			6 MONTHS AND OLDER		1 MONTH	
BOCEPREVIR	VICTRELIS	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	PATIENT HAS FAILED SHORT TRIAL OR HAS CONTRAINDICATION TO TELAPREVIR (INCIVEK). FAILURE OF FULL COURSE OF TRIPLE THERAPY WITH TELAPREVIR (INCIVEK) OR BOCEPREVIR (VICTRELIS). CURRENTLY TAKING CARBAMAZEPINE, PHENOBARBITAL, PHENYTOIN, OR RIFAMPIN. CO-INFECTION WITH HIV OR HEPATITIS B, OR HISTORY OF PREVIOUS SOLID ORGAN TRANSPLANT. DETECTABLE HCV RNA LEVEL/VIRAL LOAD OR HCV RNA LEVEL/VIRAL LOAD GREATER THAN OR EQUAL TO 100 IU/ML AFTER TRIPLE THERAPY TREATMENT LEVEL WEEK 8, 12, AND 24.	CHRONIC HEPATITIS C, GENOTYPE 1. NATIVE PATIENT. HCV RNA LEVEL/VIRAL LOAD AT TRIPLE THERAPY TREATMENT WEEK 4, 8, 12, AND 24 OF BOCEPREVIR THERAPY. PARTIAL RESPONDER, NULL RESPONDER, OR RELAPSER: HCV RNA LEVEL/VIRAL LOAD AT WEEK 8 AND 20 OF BOCEPREVIR THERAPY.	PATIENT 18 YEARS OF AGE OR OLDER.	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST) OR SPECIALLY TRAINED GROUP (E.G. EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES).	INITIAL: UP TO 12 WKS. RENEWAL: W/ CIRRHOSIS UP TO 32 WKS, W/O CIRRHOSIS UP TO 20 WKS.	CONCURRENT USE OF RIBAVIRIN AND PEGINTERFERON ALFA. APPROVAL CONSIDERATION GIVEN FOR PATIENTS WITH CIRRHOSIS, POOR INTERFERON RESPONSE AT TREATMENT WEEK 4, LESS THAN 2-LOG ₁₀ HCV RNA DECLINE BY TREATMENT WEEK 12 DURING PRIOR THERAPY WITH PEGINTERFERON/RIBAVIRIN DETECTABLE HCV RNA LEVEL AT TREATMENT WEEK 8 BUT UNDETECTABLE LEVEL AT WEEK 24. FAILURE (PARITAL RESPONDER, RELAPSER, OR NULL RESPONDER) OF PRIOR TRIAL OF RIBAVIRIN AND PEGINTERFERON THERAPY.
BOTULINUM NEUROTOXIN CI ESTERASE INHIBITOR	BOTOX XEOMIN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	COSMETIC DIAGNOSIS: WRINKLES				12 MONTHS	
CALCINEURIN INHIBITORS	CINRYZE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NOT TRIED/FAILED OR INTOLERABLE SIDE EFFECTS TO DANAZOL			HEMATOLOGIST, IMMUNOLOGIST	12 MONTHS	
	ELIDEL PROTOPIC	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NOT TRIED/FAILED OR INTOLERABLE ADVERSE EFFECTS TO TOPICAL CORTICOSTEROIDS		ELIDEL 1% AND PROTOPIC 0.03%: 2 YEARS OR OLDER. PROTOPIC 0.1%: OVER 14 YEARS		12 MONTHS	
DABIGATRAN	PRADAXA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
DALFAMPRIDINE	AMPYRA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.				NEUROLOGIST	12 MONTHS	
DARBEPOETIN	ARANESP	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CHEMOTHERAPY: PRE-TREATMENT HEMOGLOBIN GREATER THAN OR EQUAL TO 10G/DL.	CHRONIC RENAL FAILURE WITHOUT DIALYSIS: PRE-TREATMENT HEMOGLOBIN LESS THAN 10 G/DL.			RENAL FAILURE: 12 MONTHS. CANCER CHEMOTHERPY: COURSE OF TREATMENT BASED ON CHEMOTHERAPY CYCLE.	PART D MEMBER RECEIVING DIALYSIS: PAYS UNDER PART B
DENOSUMAB	PROLIA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		A PATIENT WITH EITHER A HISTORY OF OSTEOPORTIC FRACTURE(S) OR GREATER THAN OR EQUAL TO TWO FACTORS FOR FRACTURE (E.G. HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS), OR FAILED AN ADEQUATE TRIAL OF BISPHOSPHONATES, IS INTOLERANT, OR HAS A CONTRAINDICATION TO BISPHOSPHONATES.			12 MONTHS	
DENOSUMAB-XGEVA	XGEVA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	DIAGNOSIS OF MULTIPLE MYELOMA				12 MONTHS	

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ELTROMBOPAG	PROMACTA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	INITIAL: ADEQUATE RESPONSE TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR SUFFICIENT RESPONSE TO SPLENECTOMY. RENEWAL: NO CLINICAL RESPONSE AS DEFINED BY AN INCREASE IN PLATELET COUNT OF GREATER THAN OR EQUAL TO 50 X10 ⁹ /L AT THE MAX DOSE OF 75MG PER DAY FOR 4 WEEKS				INITIAL:1 MONTH RENEWAL: NO RESPONSE AFTER INITIAL:1 MONTH AT MAX DOSE, IF RESPONSE: 12 MONTHS.	
EPOETIN ALFA	EPOGEN PROCRIT	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ANEMIA DUE TO CONCOMITANTLY ADMINISTERED CHEMOTHERAPY: PRE-TREATMENT HEMOGLOBIN EQUAL TO OR GREATER THAN 10 G/DL. PRE-TREATMENT VALUE FOR PATIENTS SCHEDULED FOR ELECTIVE, NONCARDIAC SURGERY, NONVASCULAR SURGERY: HEMOGLOBIN GREATER THAN 13 G/DL.	PATIENTS WITH ANEMIA RELATED TO AZT THERAPY: PRE-TREATMENT HEMOGLOBIN LESS THAN 10 G/DL. CHRONIC RENAL FAILURE WITHOUT DIALYSIS: PRE-TREATMENT HEMOGLOBIN LESS THAN 10 G/DL. PREVIOUS TREATMENT: HEMOGLOBIN BETWEEN 10 AND 12 G/DL.			ANEMIA FROM CHRONIC RENAL FAILURE/AZT/CHEMOTHERAPY:12 MONTHS. ANEMIA FROM ELECTIVE SURGERY: 21 DAYS	PART D MEMBER RECEIVING DIALYSIS: PAYS UNDER PART B
ERIBULIN	HALAVEN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	PREVIOUS TREATMENT WITH AN ANTHRACYCLINE (DAUNORUBICIN, DOXORUBICIN, IDARUBICIN, EPIRUBICIN, OR MITOXANTRONE) AND A TAXANE (DOCETAXEL OR PACLITAXEL).
ESRD BVD DETERMINATION	BONIVA CALCITRIOL CUBICIN HECTOROL HEPARIN SODIUM LEVOCARNITINE MIACALCIN PAMIDRONATE DISODIUM VANCOMYCIN HCL ZEMPLAR	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
FENTANYL TRANSDERMAL PATCH	FENTANYL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	PATIENT ABLE TO TAKE OR HAS NOT FAILED A SUSTAINED-RELEASE MORPHINE PRODUCT. PRESCRIBED FOR AS NEEDED DOSAGE FREQUENCY.				12 MONTHS	
FENTANYL TRANSMUCOSAL AGENTS	FENTANYL CITRATE FENTORA ONSOLIS	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		CANCER: ON A MAINTENANCE DOSE OF CONTROLLED- RELEASE PAIN MEDICATION, AND EITHER A TRIAL AND FAILURE OF 1 IMMEDIATE-RELEASE ORAL PAIN AGENT OR DIFFICULTY SWALLOWING TABLETS/CAPSULES			6 MONTHS	
FINGOLIMOD	GILENYA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	CONTRAINDICATION OR HAS NOT TRIED INTERFERON THERAPY (AVONEX, BETASERON, EXTAVIA, OR REBIF) AND COPAXONE.
FONDAPARINUX	ARIXTRA	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ACUTE DVT/PE TREATMENT: IS STABILIZED ON WARFARIN AND HAS ESTABLISHED AN ORAL ANTICOAGULANT EFFECT WITH A THERAPEUTIC INR BETWEEN 2 TO 3.				HIP REPLACEMENT/FRACTURE SURGERY UP TO 33 DAYS KNEE/ABDOMINAL SURGERY/DVT/PE TREATMENT UP TO 14 DAYS	
HEPATITIS A VACCINE (INACTIVATED) BVD DETERMINATION	HAVRIX VAQTA	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
HEPATITIS B VACCINE BVD DETERMINATION	ENGERIX-B RECOMBIVAX HB	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
IMIQUIMOD	IMIQUIMOD	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			EXTERNAL GENITAL OR PERIANAL WARTS: GREATER THAN OR EQUAL TO 12 YEARS OF AGE. ACTINIC KERATOSIS: GREATER THAN OR EQUAL TO 18 YEARS OF AGE	ACTINIC KERATOSIS: DERMATOLOGIST ONLY. SUPERFICIAL BASAL CELL CARCINOMA: DERMATOLOGIST OR ONCOLOGIST ONLY.	4 MONTHS	PERIANAL GENITAL WARTS: TRIAL/FAILURE OF CONDYLOX. NON-HYPERKERATOTIC, NON-HYPERTROPHIC ACTINIC KERATOSIS ON THE FACE OR SCALP: TRIAL/FAILURE OR CONTRAINDICATION TO TOPICAL 5-FLUOROURACIL. SUPERFICIAL BASAL CELL CARCINOMA: LESS THAN 2CM IN SIZE AND ON THE FACE.
IMIQUIMOD - ZYCLARA	ZYCLARA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NO TRIAL OF OR NO CONTRAINDICATION TO TOPICAL 5-FLUOROURACIL.		OVER 17 YEARS OF AGE	DERMATOLOGIST SUPERVISION.	4 MONTHS	CRITERIA APPLIES TO NEW STARTS ONLY.

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IMMUNE GLOBULIN BVD DETERMINATION	CARIMUNE NF NANOFILTERED GAMASTAN S-D GAMMAGARD S-D GAMMAPLEX GAMUNEX HIZENTRA PRIVIGEN VIVAGLOBIN	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
IMMUNOSUPPRESSANT BVD DETERMINATION	AZATHIOPRINE AZATHIOPRINE SODIUM CELLCEPT CYCLOSPORINE CYCLOSPORINE MODIFIED GENGRAF MYCOPHENOLATE MOFETH MYFORTIC NULOJIX ORTHOCLONE OKT-3 PROGRAF RAPAMUNE SIMULECT TACROLIMUS TORISEL ZORTRESS	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
INFUSIBLE DRUG BVD DETERMINATION	ABELCET ACYCLOVIR SODIUM ADRIAMYCIN AMBISOME AMPHOTEC AMPHOTERICIN B BLEOMYCIN SULFATE CLADRIBINE CYTARABINE DOXIL DOXORUBICIN HCL FLUOROURACIL FOSCARNET SODIUM GANCICLOVIR SODIUM HERCEPTIN IFOSFAMIDE IFOSFAMIDE-MESNA METHOTREXATE MITOMYCIN REMICADE REMODULIN VINBLASTINE SULFATE VINCRIStINE SULFATE	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
MEASLES VIRUS LIVE VACCINE BVD DETERMINATION	ATTENUVAX VACCINE WITH DILUENT	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
METHYLNALTREXONE	RELISTOR	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NOT ON PALLIATIVE CARE.	CONSTIPATION DUE TO OPIOIDS			UP TO 6 MONTHS	
MODAFINIL AND ARMODAFINIL	NUVIGIL PROVIGIL	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NARCOLEPSY; NO TRIAL/FAILURE OR CONTRAINDICATION TO AMPHETAMINE, DEXTROAMPHETAMINE AND/OR METHYLPHENIDATE.				12 MONTHS	
NATALIZUMAB	TYSABRI	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	MULTIPLE SCLEROSIS: NO TRIAL OF AN INTERFERON OR COPAXONE. CROHN'S DISEASE: NO TRIAL OF A TNF-ALPHA INHIBITOR. RENEWAL: CROHN'S: CONTINUED CONCOMITANT CORTICOSTEROID TREATMENT AFTER 6 MONTHS ON NATALIZUMAB, OR REQUIRED MORE THAN 3 MONTHS OF CORTICOSTEROID TREATMENT WITHIN THE PRIOR 12 MONTHS WHILE ON NATALIZUMAB.				MULTIPLE SCLEROSIS: 12 MONTHS. CROHN'S DISEASE: 6 MONTHS. RENEWAL: CROHN'S: 12 MONTHS.	
OFATUMUMAB	ARZERRA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	CHRONIC LYMPHOCYTIC LEUKEMIA: NO FAILED TREATMENT WITH FLUDARABINE AND ALEMTUZUMAB				6 MONTHS	
OMALIZUMAB	XOLAIR	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		INITIAL: PATIENT MEETS THE CRITERIA OF MODERATE TO SEVERE ASTHMA, POSITIVE SKIN PRICK OR RAST TEST, NON-SMOKER, FEV1 LESS THAN 80%. DEMONSTRATED INADEQUATELY CONTROLLED SYMPTOMS ON INHALED CORTICOSTEROIDS AND SECOND ASTHMA CONTROLLER, BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30 IU/ML. RENEWAL: PATIENT REDUCED EXACERBATIONS BY AT LEAST 25% FROM BASELINE, REDUCTION IN ORAL OR INHALED CORTICOSTEROID USE FROM BASELINE.	PATIENT 12 YEARS OF AGE OR OLDER	SPECIALIST IN ALLERGY OR PULMONARY MEDICINE ONLY	12 MONTHS	
PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION	ADCIRCA REVATIO	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		PULMONARY ARTERIAL HYPERTENSION: WHO CLASS I-IV SYMPTOMS		CARDIOLOGIST OR PULMONOLOGIST	12 MONTHS	
PEG-INTERFERON ALFA-2B-SYLATRON	SYLATRON 4-PACK	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	CRITERIA APPLIES TO NEW STARTS ONLY. DURATION LIMITATION OF 5 YEARS OF THERAPY.
PLERIXAFOR	MOZOBI	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		USE IN COMBINATION WITH GRANULOCYTE-COLONY STIMULATING FACTOR (G-CSF) TO MOBILIZE HEMATOPOIETIC STEM CELLS TO THE PERIPHERAL BLOOD FOR COLLECTION AND SUBSEQUENT AUTOLOGOUS TRANSPLANTATION IN PATIENTS WITH NON-HODGKIN'S LYMPHOMA AND MULTIPLE MYELOMA		HEMATOLOGIST OR ONCOLOGIST	4 DOSES (UP TO 8 VIALS) FOR ONE FILL PER DAY.	
QUININE SULFATE	QUALAQUIN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	

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RABIES VACCINE BVD DETERMINATION	IMOVAX RABIES VACCINE RABAVERT	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
RANOLAZINE	RANEXA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	CONTRAINDICATION OR HAS NOT TRIED AT LEAST ONE ANTI-ANGINA AGENT (BETA-BLOCKER, AMLODIPINE, NIFEDIPINE, ISOSORBIDE, OR LONG ACTING NITROGLYCERIN).
RIFAXIMIN	XIFAXAN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	FOR 550 MG STRENGTH: INDICATION OTHER THAN HEPATIC ENCEPHALOPATHY. NO TRIAL OF LACTULOSE MONOTHERAPY.				12 MONTHS	CRITERIA APPLIES TO 550 MG STRENGTH RIFAXIMIN ONLY.
ROMIDEPSIN	ISTODAX	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ABLE TO TOLERATE ORAL MEDICATIONS AND NOT TRIED VORINOSTAT, OR NOT ABLE TO TOLERATE ORAL MEDICATIONS AND NOT TRIED AT LEAST ONE SYSTEMIC THERAPY (RETINOID, INTERFERON, EXTRACORPOREAL PHOTOPHERESIS, DENILEUKIN DIFTTOX, METHOTREXATE, LIPOSOMAL DOXORUBICIN, GEMCITABINE, CHLORAMBUCIL, PENTOSTATIN, ETOPOSIDE, CYCLOPHOSPHAMIDE, TEMOZOLOMIDE, BORTEZOMIB).				12 MONTHS	
SOMATROPIN	GENOTROPIN HUMATROPE NORDITROPIN NORDIFLEX NUTROPIN NUTROPIN AQ NUTROPIN AQ NUSPIN OMNITROPE SAIZEN SEROSTIM TEV-TROPIN ZORBTIVE	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ATHLETIC ENHANCEMENT OR ANTI-AGING PURPOSE. GROWTH FAILURE DUE TO CHRONIC RENAL INSUFFICIENCY(CRI) IF PATIENT HAS HAD A RENAL TRANSPLANT	FOR GROWTH FAILURE DUE TO (CRI): PATIENT HAS NOT UNDERGONE A RENAL TRANSPLANT, PATIENT'S HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER, LACK OF RESPONSE FROM PREVIOUS YEAR, PATIENT HAS REACHED 50TH PERCENTILE FOR TARGET HEIGHT FOLLOWING GROWTH HORMONE THERAPY. FOR HIV/WASTING: THE PATIENT ON ANTIRETROVIRAL THERAPY, MEETS CRITERIA OF WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, 7.5% OVER 6 MONTHS, 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN) OR 23% (WOMEN) OF TOTAL BODY WT. AND A BODY MASS INDEX (BMI) LESS THAN 27KG/M2, OR BMI LESS THAN 20KG/M2. IF CURRENTLY ON GROWTH HORMONE, PATIENT HAS SHOWN CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT OR IF NOT ON GROWTH HORMONE, PATIENT HAS HAD INADEQUATE RESPONSE TO PREVIOUS THERAPY. FOR SHORT-BOWEL SYNDROME: CURRENTLY ON SPECIALIZED NUTRITIONAL SUPPORT.			HIV/AIDS: 3 MONTHS. SHORT BOWEL: 4 WEEK ONCE. ALL OTHER DIAGNOSES: 12 MONTHS.	
TELAPREVIR	INCIVEK	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	PATIENT HAS FAILED THERAPY WITH TELAPREVIR (INCIVEK) OR BOCEPREVIR (VICTRELIS). CURRENTLY TAKING RIFAMPIN. CO-INFECTION WITH HIV OR HEPATITIS B, OR HISTORY OF PREVIOUS SOLID ORGAN TRANSPLANT.	CHRONIC HEPATITIS C, GENOTYPE 1. HCV RNA LEVEL/VIRAL LOAD OF LESS THAN 1,000 IU/ML AT WEEKS TELAPREVIR THERAPY.	PATIENT 18 YEARS OF AGE OR OLDER.	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST) OR SPECIALLY TRAINED GROUP (E.G. EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES).	INITIAL: 8 WEEKS RENEWAL: 4 WEEKS.	CONCURRENT USE OF RIBAVIRIN AND PEGINTERFERON ALFA.

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TESTOSTERONE	ANDRODERM ANDROGEL AXIRON TESTIM TESTOSTERONE TESTOSTERONE ENANTHATE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		CURRENTLY RECEIVING TESTOSTERONE REPLACEMENT. MALE HYPOGONADISM CONFIRMED BY EITHER: 1) LABORATORY CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL OF LESS THAN 250NG/DL (8.7NMOL/L) OBTAINED WITHIN 90 DAYS, OR 2) LABORATORY CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL BETWEEN 250NG/DL AND 350NG/DL (12NMOL/L) TOGETHER WITH A FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 50NG/L (174 PMOL/L) OR 3) MALE DELAYED PUBERTY NOT SECONDARY TO PATHOLOGY.			12 MONTHS	
TETANUS TOXOID VACCINE BVD DETERMINATION	TETANUS TOXOID ADSORBED	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
TETRABENAZINE	XENAZINE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.				NEUROLOGIST	12 MONTHS	
TOCILIZUMAB	ACTEMRA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NO FAILURE OF ENBREL, HUMIRA, REMICADE, SIMPONI OR CIMZIA	DIAGNOSIS: ACTIVE RHEUMATOID ARTHRITIS. RENEWAL: AT LEAST 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT.		RHEUMATOLOGIST	INITIAL: 6 MONTHS. RENEWAL: 6 MONTHS	
TOTAL PARENTERAL NUTRITION AGENT BVD DETERMINATION	AMINOSYN AMINOSYN II AMINOSYN II 3.5% M-DEXTROSE 5% AMINOSYN II 3.5%-DEXTROSE 25% AMINOSYN II 3.5%-DEXTROSE 5% AMINOSYN II 4.25% M-DEXT 10% AMINOSYN II 4.25%-DEXTROSE 25% AMINOSYN II 5% IN 25% DEXTROSE AMINOSYN II IN DEXTROSE AMINOSYN II W/ELECTROLYTES AMINOSYN II W/ELECTROLYTES IN DEX W/CA AMINOSYN M AMINOSYN W/ELECTROLYTES AMINOSYN-HBC AMINOSYN-HF AMINOSYN-PF CLINIMIX CLINIMIX E CLINISOL DEXTROSE 10%-1/4NS DEXTROSE IN WATER DEXTROSE WITH SODIUM CHLORIDE FREAMINE HBC FREAMINE III FREAMINE III WITH ELECTROLYTES HEPATAMINE HEPATASOL INTRALIPID LIPOSYN II LIPOSYN III NEPHRAMIN NOVAMINE PREMASOL PROCALAMINE PROSOL RENAMIN TRAVASOL TROPHAMINE	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
USTEKINUMAB	STELARA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D	INITIAL: PLAQUE PSORIASIS: LESS THAN 10% BODY SURFACE AREA OR PASI SCORE LESS THAN 12. NO TRIAL/FAILURE OF PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORIN. RENEWAL: PHYSICIAN'S GLOBAL ASSESSMENT GREATER THAN 1 OR LESS THAN 50% DECREASE IN PASI SCORE.	WEIGHT GREATER THAN 100KG (220LBS).		DERMATOLOGIST OR RHEUMATOLOGIST	INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS	
VALGANCICLOVIR	VALCYTE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ABLE TO TOLERATE ORAL SOLID MEDICATIONS.		UNDER 16 YEARS OF AGE.		6 MONTHS	
VANDETANIB	VANDETANIB	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	CRITERIA APPLIES TO NEW STARTS ONLY.
VARENICLINE	CHANTIX	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	INITIAL: NOT ENROLLED IN A SMOKING CESSATION PROGRAM. RENEWAL: NOT ABSTAINING FROM CIGARETTE USE DURING THE INITIAL 12 WEEKS OF TREATMENT				INITIAL: 12 WEEKS. RENEWAL: 12 WEEKS.	