



Presbyterian Senior Care (HMO)/Presbyterian MediCare PPO Formulary
Prior Authorization Criteria
Effective August 31, 2011

Product Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Afinitor (everolimus)	All FDA-approved indications not otherwise excluded from Part D.		Documented trial and failure at therapeutic doses of Sutent (sunitinib) OR Nexavar (sorafenib).			1 year	
Alimta (premetrexed)	All FDA-approved indications not otherwise excluded from Part D.		Malignant Pleural Mesothelioma: • Disease is unresectable or patient is not a candidate for curative surgery. AND • Must be used in combination with cisplatin. Non- Small Cell Lung Cancer: • Confirmed diagnosis of locally advanced or metastatic (Stage III or IV) NSCLC. AND • May be used alone, if there is a prior history of first-line chemotherapy treatment for NSCLC OR it may be used in combination with cisplatin for initial treatment.			1 year	

Aloxi (palonosetron) injection	All FDA-approved indications not otherwise excluded by Part D.		<ul style="list-style-type: none"> • Documented failure with generic ondansetron injection OR generic granisetron injection. AND • One of the following: Receiving a chemotherapy regimen which has a high emetogenic potential OR Receiving a chemotherapy regimen that has moderate emetogenic potential, OR Receiving a chemotherapy regimen which includes an anthracycline and cyclophosphamide in combination. 			6 months	Coverage may fall under Medicare Part B or Part D.
Ambien CR (zolpidem)	All FDA-approved indications not otherwise excluded from Part D.		<ul style="list-style-type: none"> • Documented trial and failure of zolpidem immediate release tablets. OR • Documented intolerance/contraindication to zolpidem immediate release tablets. 			1 year	
Ampyra (dalfampridine)	All FDA approved indications not otherwise excluded by Part D.	Patient must not have a history of seizure.	<ul style="list-style-type: none"> • Documented baseline 25 foot walk test. AND • Documented creatinine clearance. 			Initial Authorization: 3 months. Reauthorization: 6 months	<ul style="list-style-type: none"> • The patient must currently require a walking assistance device for ambulation. • The patient must demonstrate a 20% improvement in the 25

Androderm (testosterone topical patch) AND Androgel (testosterone topical gel)	All FDA-approved indications not otherwise excluded from Part D.	Testosterone replacement is not covered for the treatment of sexual dysfunction.	Documentation of one of the following: <ul style="list-style-type: none"> • At least two low total testosterone levels (drawn on separate days). OR <ul style="list-style-type: none"> • At least two low free testosterone levels (drawn on separate days). OR <ul style="list-style-type: none"> • One low total testosterone level with an elevated LH and FSH. OR <ul style="list-style-type: none"> • One low free testosterone level with an elevated LH and FSH. 			1 year	
Androgel 1.62% (testosterone topical)	All FDA-approved indications not otherwise excluded from Part D.	Testosterone replacement will not be covered for the treatment of sexual dysfunction	Confirmed diagnosis of testosterone deficiency OR absence of endogenous testosterone in males over the age of 18 with: Primary hypogonadism (congenital or acquired) AND two low total testosterone levels (drawn on separate days) with an elevated LH and FSH			1 year	
Anzemet (dolasetron) oral	All FDA-approved indications not otherwise excluded by Part D.		Documented treatment failure with generic ondansetron OR generic granisetron.			6 months	Coverage may fall under Medicare Part B or Part D.
Aplenzin (bupropion hydrobromide)	All FDA-approved indications not otherwise excluded from Part D.		Documented trial and failure of Bupropion XL at a therapeutic dose.			1 year	
Apokyn (apomorphine)	All FDA-approved indications not otherwise excluded by Part D.		All of the following must be met: <ul style="list-style-type: none"> • Documented diagnosis of Parkinson's disease. AND <ul style="list-style-type: none"> • Documented occurrence of hypomobility episodes, "off" episodes ("end of dose wearing off" and unpredictable "on/off" episodes) associated with advanced Parkinson's disease. AND <ul style="list-style-type: none"> • The patient is on an optimized drug regimen that includes levodopa. 		Neurologist	1 year	

Arcalyst (rilonacept)	All FDA-approved indications not otherwise excluded from Part D.		Cryopyrin-Associated Periodic Syndromes (CAPS): <ul style="list-style-type: none"> • Not to be used in combination with Enbrel, Humira, Kineret, Orencia or Remicade. AND <ul style="list-style-type: none"> • Dose does not exceed FDA label maximum for the diagnosis. 	Patient is 12 years of age or older.		1 year	
Arixtra (fondaparinux)	All FDA-approved indications not otherwise excluded from Part D.					1 time up to 32 days	Documented failure of formulary low molecular weight heparin.
Arzerra (ofatumumab)	All FDA-approved indications not otherwise excluded by Part D.		Documented trial and failure of Fludara (fludarabine) AND Campath.			6 months	
Avastin (bevacizumab)	All FDA approved indications not otherwise excluded from Part D.	<ul style="list-style-type: none"> • History of recent hemoptysis or serious hemorrhage. • Use within 28 days following major surgery or until the surgical incision is fully healed. 	<ul style="list-style-type: none"> • Diagnosis and patient history. AND <ul style="list-style-type: none"> • Concurrent or previous medication trials. AND <ul style="list-style-type: none"> • HER2 status for metastatic breast cancer. 		Prescribed by or in consultation with an oncologist.	1 year	
Banzel (rufinamide)	All FDA-approved indications not otherwise excluded from Part D.					1 year	Documented failure of at least two preferred anticonvulsants at therapeutic doses.
Betaseron (Interferon beta 1b)	All FDA-approved indications not otherwise excluded by Part D.		<ul style="list-style-type: none"> • Documented trial and failure on the formulary alternatives, Copaxone AND Rebif. OR <ul style="list-style-type: none"> • The patient is a new member and is currently taking Betaseron. 		Neurologist	1 year	

Botox (Botulinum Toxin Type A)	All FDA-approved indications not otherwise excluded from Part D. Dystonia, Cerebral Palsy, Facial Nerve Disorder/Hemi-facial	Cosmetic use	Severe primary axillary hyperhidrosis and Severe palmar hyperhidrosis: • Documented failure of drying agents, such as topical aluminum chloride. Migraine: • Medical records documenting headaches on		Migraines: must be prescribed by a neurologist.	1 year	
Campath (alemtuzumab)	All FDA approved indications not otherwise excluded from Part D.		Documented diagnosis of B-Cell chronic lymphocytic leukemia (B-CLL).			1 year	
Campral (acamprosate)	All FDA approved indications not otherwise excluded from Part D.		• Diagnosis of alcohol dependence. AND • Patient is abstinent from alcohol at treatment initiation. AND • Documented treatment failure with naltrexone or disulfiram. AND • Documentation of patient participation in an alcoholic recovery program during the entire course of therapy.			3 months	
Cellcept (mycophenolate mofetil)	All FDA-approved indications not otherwise excluded by Part D.						• Documented diagnosis is necessary to determine whether this medication is covered under the Medicare Part B (medical) or Part D (pharmacy) benefit. • Immunosuppressants used to prevent organ transplant rejection are a Part B benefit if the

Cervarix (HPV Vaccine)	All FDA-approved indications not otherwise excluded from Part D	Males		Between the ages of 10 and 25		3 doses per 365 days	
Cinryze (C1 inhibitor)	All FDA-approved indications not otherwise excluded from Part D		• Medical records documenting diagnosis of hereditary angioedema requiring prophylaxis.			6 months	
(cyclosporine) Neoral, Sandimmune	All FDA-approved indications not otherwise excluded by Part D.						<ul style="list-style-type: none"> • Documented diagnosis is necessary to determine whether this medication is covered under the Medicare Part B (medical) or Part D (pharmacy) benefit. • Immunosuppressants used to prevent organ transplant rejection are a Part B benefit if the transplant was covered under Medicare.

Dacogen (decitabine)	All FDA approved indications not otherwise excluded by Part D.		<ul style="list-style-type: none"> • Medical records documenting the indicated diagnosis. 			6 months	
Daliresp (roflumilast)	All FDA-approved indications not otherwise excluded from Part D.	Moderate to severe liver impairment (Child-Pugh B or C).	Documented diagnosis of severe COPD associated with chronic bronchitis and history of exacerbations AND documented trial and failure of combination short-acting bronchodilator and corticosteroid.			1 year	
Dexferrum (iron dextran) injection	All FDA-approved indications not otherwise excluded by Part D.		<ul style="list-style-type: none"> • Treatment of documented chemotherapy-induced iron deficiency anemia. OR • Treatment of documented iron deficiency anemia in a chronic kidney disease patient undergoing chronic hemodialysis. OR • Treatment of documented iron deficiency anemia in a patient who has a documented disorder of the gastrointestinal tract of which symptoms may be aggravated by oral iron therapy, such as Inflammatory bowel disease. OR • Treatment of documented iron deficiency anemia in a patient with documented severe intolerance to or treatment failure of an oral iron product after an adequate trial. Attempts must have been made to identify and treat the underlying cause of the deficiency. 			One time.	<ul style="list-style-type: none"> • Coverage falls under Medicare Part B benefit. • Documented iron deficiency anemia for the listed indications is defined as a hemoglobin <11 g/dl.
Differin (adapalene)	All FDA-approved indications not otherwise excluded from Part D.			Exception required for patients older than 40 years.		6 months	

Dificid (fidaxomicin)	All FDA-approved indications not otherwise excluded by Part D.		A diagnosis of <i>Clostridium difficile</i> -associated diarrhea (CDAD) and must meet the following: a documented trial and failure of oral Vancomycin in a tapered and/or pulsed regimen			1 month	
Effient (prasugrel)	All FDA-approved indications not otherwise excluded by Part D.		Medical records documenting ALL of the following: • The patient has had an acute coronary syndrome (unstable angina, NSTEMI, or STEMI) and was managed with percutaneous coronary intervention. • The patient weighs 60 kg or more. • The patient does not have a history of stroke or transient ischemic attack. • The patient meets one of the following conditions: A. There is a documented allergy	Greater than or equal to 75 years of age.	Cardiologist	one year	
Emend (aprepitant) tablets	All FDA-approved indications not otherwise excluded from Part D.		• Acute or Delayed chemotherapy-induced nausea and vomiting. AND • The patient is receiving highly emetogenic chemotherapeutic agents. AND • The patient has failed 2 formulary antiemetic agents: ondansetron, promethazine or prochlorperazine.			6 months	Coverage may fall under Medicare Part B or Part D.
Emend (fosaprepitant) injection	All FDA-approved indications not otherwise excluded from Part D.		• Documentation that the patient is receiving combination therapy with a 5-HT3 antagonist AND dexamethasone for a cancer chemotherapy regimen which has high emetogenic potential. OR • Documentation that the patient is receiving combination therapy with a 5-HT3 antagonist AND dexamethasone for a cancer			6 months	Coverage may fall under Medicare Part B or Part D.

Emsam (selegiline patch)	All FDA-approved indications not otherwise excluded by Part D.		Documentation of symptoms despite treatment with maximum doses of 2 antidepressants.	Greater than 18 years of age.	Psychiatrist	1 year	
Enbrel (etanercept)	All FDA-approved indications not otherwise excluded from Part D		<p>For All Covered Indications:</p> <ul style="list-style-type: none"> • A minimum of 3 months of current and continuous follow-up. <p>AND</p> <ul style="list-style-type: none"> • A current PPD (tuberculosis) negative skin test within 6 months of starting therapy. <p>Patients should be monitored for an infection or a history of chronic infections.</p> <p>Ankylosing Spondylitis:</p> <ul style="list-style-type: none"> • Documented axial disease with trial and failure or contraindication to NSAIDs. <p>Psoriatic Arthritis, Rheumatoid Arthritis, and Juvenile RA:</p> <ul style="list-style-type: none"> • Documented disease activity with active synovitis in at least 3 sets of joints. AND An adequate trial of methotrexate to a maximum tolerated dose. If methotrexate is contraindicated, the patient must have an adequate trial of one of the following DMARDs: sulfasalazine, hydroxychloroquine, leflunomide, azathioprine or mycophenolate. <p>Plaque Psoriasis:</p> <ul style="list-style-type: none"> • Documented chronic, moderate to severe disease involving 10% or more of the patient's body surface area. AND An adequate trial and failure of or contraindication to methotrexate. AND An adequate trial and failure of phototherapy or photochemotherapy. 			1 year	
Ethylol (amifostine)	All FDA approved indications not otherwise excluded from Medicare Part D.		<p>Documentation that medication is being used for the following:</p> <ul style="list-style-type: none"> • Prevention of xerostomia in patients undergoing postoperative radiation for head and neck cancer. <p>OR</p> <ul style="list-style-type: none"> • Prevention of renal toxicity associated with 		Hematologist or Oncologist	6 months	
Extavia (Interferon beta-1b)	All FDA-approved indications not otherwise excluded by Part D.		<ul style="list-style-type: none"> • Documented trial and failure on the formulary alternatives, Copaxone AND Rebif. <p>OR</p> <ul style="list-style-type: none"> • The patient is a new member and is currently taking Extavia. 		Neurologist	1 year	

Fanapt (iloperidone)	All FDA-approved indications not otherwise excluded by Part D.		Documented trial and failure of 2 atypical antipsychotics.			1 year	
Feraheme (ferumoxytol) injection	All FDA-approved indications not otherwise excluded by Part D.		<ul style="list-style-type: none"> • Treatment of documented chemotherapy-induced iron deficiency anemia. OR • Treatment of documented iron deficiency anemia in a chronic kidney disease patient undergoing chronic hemodialysis. OR • Treatment of documented iron deficiency anemia in a patient who has a documented disorder of the gastrointestinal tract of which symptoms may be aggravated by oral iron therapy, such as Inflammatory bowel disease. OR • Treatment of documented iron deficiency anemia in a patient with documented severe intolerance to or treatment failure of an oral iron product after an adequate trial. Attempts must have been made to identify and treat the underlying cause of the deficiency. 			One time.	<ul style="list-style-type: none"> • Coverage falls under Medicare Part B benefit. • Documented iron deficiency anemia for the listed indications is defined as a hemoglobin <11 g/dl.

Ferlecit (Na ferric gluconate) injection	All FDA-approved indications not otherwise excluded by Part D.		<ul style="list-style-type: none"> • Treatment of documented chemotherapy-induced iron deficiency anemia. OR <ul style="list-style-type: none"> • Treatment of documented iron deficiency anemia in a chronic kidney disease patient undergoing chronic hemodialysis. OR <ul style="list-style-type: none"> • Treatment of documented iron deficiency anemia in a patient who has a documented disorder of the gastrointestinal tract of which symptoms may be aggravated by oral iron therapy, such as Inflammatory bowel disease. OR <ul style="list-style-type: none"> • Treatment of documented iron deficiency anemia in a patient with documented severe intolerance to or treatment failure of an oral iron product after an adequate trial. Attempts must have been made to identify and treat the underlying cause of the deficiency. 			One time.	<ul style="list-style-type: none"> • Coverage falls under Medicare Part B benefit. • Documented iron deficiency anemia for the listed indications is defined as a hemoglobin <11 g/dl.
Forteo (teriparatide)	All FDA-approved indications not otherwise excluded from Part D.		<ul style="list-style-type: none"> • Documented failure of an adequate trial or contraindication to Actonel AND Fosamax. AND <ul style="list-style-type: none"> • The patient is at high risk for fractures. AND <ul style="list-style-type: none"> • The patient has a bone scan and the T score is less than or equal to -2.5. 			1 year	
Fortesta (testosterone gel)	All FDA-approved indications not otherwise excluded from Part D.	Testosterone replacement will not be covered for the treatment of sexual dysfunction	Confirmed diagnosis of testosterone deficiency OR absence of endogenous testosterone in males over the age of 18 with: Primary hypogonadism (congenital or acquired) AND two low total testosterone levels (drawn on separate days) with an elevated LH and FSH OR Hypogonadotropic hypogonadism (congenital or acquired) AND two low total testosterone levels (drawn on separate days) with a low to normal LH and FSH.			1 year	
Gardasil (HPV Vaccine)	All FDA-approved indications not otherwise excluded by Part D.			Age 9 years to 26 years.		Series of 3 injections (6 months)	

granisetron oral	All FDA-approved indications not otherwise excluded from Part D.					6 months	Coverage may fall under Medicare Part B or Part D. If being used for full replacement of
granisetron injection	All FDA-approved indications not otherwise excluded from Part D.					6 months	Coverage may fall under Medicare Part B or Part D.

Halaven (eribulin)	All FDA-approved indications not otherwise excluded from Part D.		Medical records documenting the indicated diagnosis and previous chemotherapy medication trials.		Oncologist	1 year	
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Humira (adalimumab)	All FDA-approved indications not otherwise excluded from Part D.		<p>Ankylosing Spondylitis:</p> <ul style="list-style-type: none"> • Documented axial disease with trial and failure or contraindication to NSAIDs. <p>Psoriatic Arthritis and Rheumatoid Arthritis:</p> <ul style="list-style-type: none"> • Documented disease activity with active synovitis in at least 3 sets of joints. AND An adequate trial (3 months or more) of methotrexate to a maximum tolerated dose. If methotrexate is contraindicated, the patient must have an adequate trial (3 months or more) of one of the following DMARDs: sulfasalazine, hydroxychloroquine, leflunomide, azathioprine or mycophenolate. <p>Crohn's Disease:</p> <ul style="list-style-type: none"> • Documented moderate to severe disease AND an inadequate response to 2 conventional therapies: corticosteroids and 5-ASAs. <p>Plaque Psoriasis:</p> <ul style="list-style-type: none"> • Documented chronic, moderate to severe disease involving 10% or more of the patient's body surface area. AND An adequate trial and failure of or contraindication to methotrexate. AND An adequate trial and failure of phototherapy or photochemotherapy. 			1 year	<p>For All Covered Indications:</p> <ul style="list-style-type: none"> • A minimum of 3 months of current and continuous follow-up. AND • A current PPD (tuberculosis) negative skin test within 6 months of starting therapy. Patients should be monitored for an infection or a history of chronic infections.
Immune Globulin (human) IV	All FDA-approved indications not otherwise excluded by Part D.					1 year	<ul style="list-style-type: none"> • Documented diagnosis and administration is necessary to determine whether this medication is covered under the Medicare Part B (medical) or Part D (pharmacy) benefit.

<p>Immune Globulin (human) SC</p>	<p>All FDA-approved indications not otherwise excluded by Part D.</p>		<p>Documented infusion reaction with IVIG or inability to obtain IV access.</p>			<p>1 year</p>	
<p>Imuran (azathioprine)</p>	<p>All FDA-approved indications not otherwise excluded by Part D.</p>						<ul style="list-style-type: none"> • Documented diagnosis is necessary to determine whether this medication is covered under the Medicare Part B (medical) or Part D (pharmacy) benefit. • Immunosuppressants used to prevent organ transplant rejection are a Part B benefit if the transplant was covered under Medicare.
<p>Incivek (telaprevir)</p>	<p>All FDA approved indications not otherwise excluded from Part D.</p>		<ul style="list-style-type: none"> • Documented chronic hepatitis C genotype 1 AND • to be used in combination with peginterferon alfa and ribavirin AND • previously untreated with boceprevir or telaprevir 	<p>18 years of age or older</p>		<p>12 weeks</p>	

Increlex (mecasermin)	All FDA approved indications not otherwise excluded from Part D.	<ul style="list-style-type: none"> • Secondary forms of IGF-1 deficiency. • Combination treatment with growth hormone. 	<ul style="list-style-type: none"> • Documented severe primary IGF-1 deficiency or GH gene deletion with neutralizing antibodies to GH. AND • Height standard deviation (SD) score less than or equal to negative 3. AND • Basal IGF-1 SD score less than or equal to negative 3. AND • Normal or elevated growth hormone level. AND • Predicted adult height is more than 1.5 SDs below the mid-parenteral height, and growth rate is less than 7 cm/year if less than or 	Ages 2 - 18 years of age		1 Year	
Invega Sustenna (paliperidone palmitate) IM injection	All FDA-approved indications not otherwise excluded by Part D.		Documented trial and failure of risperidone.			1 year	

INFeD (iron dextran) injection	All FDA-approved indications not otherwise excluded by Part D.		<ul style="list-style-type: none"> • Treatment of documented chemotherapy-induced iron deficiency anemia. OR • Treatment of documented iron deficiency anemia in a chronic kidney disease patient undergoing chronic hemodialysis. OR • Treatment of documented iron deficiency anemia in a patient who has a documented disorder of the gastrointestinal tract of which symptoms may be aggravated by oral iron therapy, such as Inflammatory bowel disease. OR • Treatment of documented iron deficiency anemia in a patient with documented severe intolerance to or treatment failure of an oral iron product after an adequate trial. Attempts must have been made to identify and treat the underlying cause of the deficiency. 			One time.	<ul style="list-style-type: none"> • Coverage falls under Medicare Part B benefit. • Documented iron deficiency anemia for the listed indications is defined as a hemoglobin <11 g/dl.
Kineret (anakinra)	All FDA-approved indications not otherwise excluded from Part D.		<p>Moderate to Severe Active Rheumatoid Arthritis:</p> <ul style="list-style-type: none"> • Medical records documenting at least 6 months of current and continuous follow-up by a rheumatologist. <p>AND</p>	Greater than 18 years of age.	Rheumatologist	1 year	
Kombiglyze XR (saxagliptin / metformin)	All FDA-approved indications not otherwise excluded by Part D.		<ul style="list-style-type: none"> • Diagnosis of Diabetes Mellitus Type 2 AND • The patient is currently taking metformin and has inadequate glycemic control at a therapeutic dose requiring the addition of another agent. AND • Upon initiation of therapy: A Hemoglobin A1c of less than 11% within the past 3 months. AND • For continuation of therapy: the Hemoglobin A1c value must be decreasing by 0.15% or more. 			6 months	

Kuvan (sapropterin)	All FDA-approved indications not otherwise excluded from Part D.		<p>Diagnosis of hyperphenylalaninemia caused by tetrahydrobiopterin-(BH4)-responsive phenylketonuria: Initial Authorization: • Documentation showing low baseline phenylalanine (Phe) level (level immediately prior to Kuvan request). AND • Documentation of target blood phenylalanine</p>	Patient is 4 years of age or older		Initial authorization and titration to therapeutic response: 1 month. Reauthorization for stable therapy: 3	
Latuda (lurasidone)	All FDA-approved indications not otherwise excluded by Part D.		<p>• Documentation of diagnosis of schizophrenia. AND • Documented failure of 2 formulary atypical antipsychotics.</p>			1 year	
Letairis (ambrisentan)	All FDA approved indications not otherwise excluded from Medicare Part D.		<p>All of the following must be met: • Diagnosis of pulmonary arterial hypertension (WHO Group 1) Class II or III AND • Documented treatment failure with calcium channel blockers. AND • Documentation of laboratory baseline liver function tests. AND • If the patient is female and of childbearing age, she must have a negative pregnancy test and must be on a reliable method of contraception. AND • Patient, prescriber, and pharmacy must be enrolled in the Letairis Education and Access Program.</p>		Pulmonologist or Cardiologist	1 year	

Leukine (sargramostim)	All FDA-approved indications not otherwise excluded from Part D.	Combination use with Neulasta or Neupogen.	<ul style="list-style-type: none"> • Documentation of neutropenia, post AML chemotherapy. OR <ul style="list-style-type: none"> • Documented failure of Neupogen when used for PBPC mobilization, neutropenia post PBPC transplant, neutropenia post chemotherapy, and neutropenia post BMT. 			6 months	
Lidoderm (lidocaine) topical patch	<ul style="list-style-type: none"> • All FDA-approved indications not otherwise excluded by Part D. • Localized neuropathic pain. 		<p>Documented trial and failure of at least 2 of the following drug categories:</p> <ul style="list-style-type: none"> • SNRI • Anticonvulsants in doses associated with pain management (i.e. gabapentin 1200 mg QD). • Opioid analgesics 			3 months	
Lunesta (eszopiclone)	All FDA-approved indications not otherwise excluded from Part D.		<ul style="list-style-type: none"> • Documented trial and failure of zolpidem immediate release tablets. OR <ul style="list-style-type: none"> • Documented intolerance/contraindication to zolpidem immediate release tablets. 			1 year	
Lyrica (pregabalin)	All FDA-approved indications not otherwise excluded from Part D.		<p>For Seizures:</p> <ul style="list-style-type: none"> • Medical records documenting failure at therapeutic doses of at least two anticonvulsants indicated for the treatment of partial seizures. <p>For Neuropathic Pain and Post-Herpetic Neuralgia:</p> <ul style="list-style-type: none"> • Medical records documenting failure at therapeutic doses of two of the following preferred alternatives: tricyclic antidepressants, SSRI's, SNRI's, gabapentin, lamotrigine, Depakote, or carbamazepine. <p>For Fibromyalgia:</p> <ul style="list-style-type: none"> • Medical records documenting failure of a 			1 year	

Marinol (dronabinol)	All FDA-approved indications not otherwise excluded from Part D.		<p>Chemotherapy-induced nausea or vomiting (CINV):</p> <ul style="list-style-type: none"> • The patient is receiving cancer chemotherapy. <p>AND</p> <ul style="list-style-type: none"> • The patient has failed one 5-HT3 antagonist. <p>AND</p> <ul style="list-style-type: none"> • The patient has failed one of the following: a corticosteroid, anti-histamine, anti-psychotic, or prokinetic. <p>Anorexia associated with weight loss in HIV/AIDS patients:</p> <ul style="list-style-type: none"> • Documented trial and failure or contraindication or intolerance to Megace (megestrol). 			6 months	Coverage may fall under Medicare Part B or Part D.
Multaq (dronaderone)	All FDA approved indications not otherwise excluded by Part D.		<ul style="list-style-type: none"> • Documented diagnosis of atrial fibrillation, paroxysmal atrial fibrillation, or atrial flutter. <p>AND</p> <ul style="list-style-type: none"> • The patient does not have Class IV heart failure OR Class II or III heart failure with a recent decompensation. <p>AND</p> <ul style="list-style-type: none"> • Documented trial and failure of two generic antiarrhythmics or unacceptable side effects to amiodarone. 			1 year	
Myfortic (mycophenolic acid)	All FDA-approved indications not otherwise excluded by Part D.						<ul style="list-style-type: none"> • Documented diagnosis is necessary to determine whether this medication is covered under the Medicare Part B (medical) or Part D (pharmacy) benefit. • Immunosuppressants used to prevent organ transplant rejection are a Part B benefit if the transplant was covered under Medicare.

Neulasta (pegfilgrastim)	All FDA-approved indications not otherwise excluded by Part D.					Diagnosis Dependent	
Neumega (oprelvekin)	All FDA-approved indications not otherwise excluded from Part D.		<p>Thrombocytopenia following myeloablative chemotherapy:</p> <ul style="list-style-type: none"> • Verification that the cancer is a non-myeloid malignancy. <p>AND</p> <ul style="list-style-type: none"> • Documented platelet count less than 30,000 cells/microliter. <p>AND</p> <ul style="list-style-type: none"> • Dose does not exceed FDA label maximum for the diagnosis. 			<p>Initial Authorization: up to 21 days per course.</p> <p>Reauthorization: up to 6 months</p>	

Neupogen (filgrastim)	All FDA-approved indications not otherwise excluded by Part D.					Diagnosis Dependent	
Nulojix (belatacept)	All FDA-approved indications not otherwise excluded from Part D.						<ul style="list-style-type: none"> • Documented diagnosis is necessary to determine whether this medication is covered under the Medicare Part B (medical) or Part D (pharmacy) benefit.
Nutropin, Nutropin AQ, Norditropin, and Tev-Tropin (somatotropin recombinant)	All FDA approved indications not otherwise excluded from Part D, (GHD) in children, (ISS), (SGA), (PWS), (TS), (NS), (GRCRF), (AOGHD), (COGHD), Full thickness skin loss associated with 3rd degree burns		<p>GHD(child), ISS, TS, NS, PWS, GRCRF: Baseline height (BH) \leq to 2 SD of mean or \leq the 3rd %tile for age/gender. Growth rate (GR) $<$ 7cm/year if $<$ 3 years of age and $<$ 4cm/year if $>$ 3 years of age. Bone x-ray is $>$ 2 years behind chronological age. Epiphyses are not closed. Diagnosis of GHD(child): Subnormal response to 2 provocative stimulation tests (\leq 10 ng/ml). Diagnosis of ISS: Predicted adult height not likely to reach 63in for males and 59in for females; absence of comorbidities that should be treated by other means. SGA: Birth weight $<$ 2500g at gestation $>$ 37 weeks or birth weight or length below the 3rd %tile for gestational age who fail to catch up by age 2. BH \leq 2 SD below mean or \leq 3rd %tile for age or gender. Patient \geq 2 years of age. AOGHD: Multiple hormone deficiencies resulting from pituitary/hypothalamic disease, surgery, radiation, or trauma. Low serum IGF-I. COGHD: Diagnosis of GHD as child or adolescent. Subnormal response to 2 provocative tests (\leq 10ng/ml) following a GH washout period (1-3 months). For diagnosis of PWS: only genetic testing.</p>		GHD (child), ISS, SGA, TS, NS, PWS, AOGHD, COGHD: must be prescribed by an endocrinologist GRCRF: Must be prescribed by a nephrologist	1 year	<p>Reauthorization for AOGHD, COGHD: IGF-I is WNL for age and gender. Reauthorization for GHD(child), ISS, SGA, TS, NS, PWS, GRCRF: Increase in growth velocity of \geq 2 cm/year during previous year. Epiphyses are not closed. Not post renal transplant for patients with chronic renal insufficiency. Provocative stimulation tests could include arginine, clonidine, glucagon, insulin, and levodopa. Diagnosis of third degree burn with full thickness skin loss.</p>

Onglyza (saxagliptin)	All FDA-approved indications not otherwise excluded from Part D.		<ul style="list-style-type: none"> • Diagnosis of Diabetes Mellitus Type 2 AND •The patient is concurrently taking metformin or is unable to take metformin due to one of the following: documented intolerance to metformin after titration to a therapeutic dose of 2000mg or more per day, or documented renal disease / dysfunction, or documented hepatic disease. AND •Upon initiation of therapy: A Hemoglobin A1c of less than 11 within the past 3 months. •For continuation of therapy, the Hemoglobin A1c value must be decreasing by 0.15% to 			6 months	
Orencia (abatacept)	All FDA-approved indications not otherwise excluded from Part D.		Documented trial and failure of both Remicade (infliximab) AND Humira (adalimumab).			1 year	The patient must have a current negative PPD (tuberculosis) skin test. Patients should be monitored for an infection or a history of chronic infections.
Pristiq (desvenlafaxine)	All FDA-approved indications not otherwise excluded from Part D.		Documented trial and failure of Effexor XR (velafaxine ER) at a therapeutic dose.			1 year	

Procrit (epoetin alfa)	All FDA-approved indications not otherwise excluded from Part D.		Medical records documenting a current hematocrit less than or equal to 10 mg/dl.			3 months	
Prograf (tacrolimus)	All FDA-approved indications not otherwise excluded by Part D.						<ul style="list-style-type: none"> • Documented diagnosis is necessary to determine whether this medication is covered under the Medicare Part B (medical) or Part D (pharmacy) benefit. • Immunosuppressants used to prevent organ transplant rejection are a Part B benefit if the transplant was covered under Medicare.
Prolia (denosumab)	All FDA approved indications not otherwise excluded by Part D.		<p>Documentation of ALL of the following:</p> <ul style="list-style-type: none"> • The patient is a post menopausal woman with osteoporosis. • T score less than or equal to -2.5 as evidenced via a bone density scan. • The patient is at high risk of fracture. • The patient has had an inadequate response to an intravenous bisphosphonate OR is unable to tolerate an intravenous bisphosphonate due to an allergy or renal insufficiency (CrCl is less than 35mL/min). 			6 months	

Promacta (eltrombopag)	All FDA approved indications not otherwise excluded from Part D.	Cannot be used in combination with Nplate.	Documentation of diagnosis, platelet count, and patient history including prior therapy. Initial authorization: • Platelet count is less than 30,000/mcl. AND • Dose does not exceed the FDA label maximum for the diagnosis.			Initial authorization: 3 months. Reauthorization: 6 months.	The patient and prescriber must be enrolled in the Promacta Cares Program.
Provigil (modafinil)	• All FDA-approved indications not otherwise excluded by Part D. • MS Fatigue		• Narcolepsy: documented failure of stimulatory agents methylphenidate or dextroamphetamine. • Obstructive Sleep Apnea/Hypopnea Syndrome: documented failure of CPAP, with trial lasting at least 2 months, using it for 4 or		Neurologist or Sleep Specialist	1 year	
Rapamune (sirolimus)	All FDA-approved indications not otherwise excluded by Part D.						• Documented diagnosis is necessary to determine whether this medication is covered under the Medicare Part B (medical) or Part D (pharmacy) benefit. • Immunosuppressants used to prevent organ transplant rejection are a Part B benefit if the transplant was covered under Medicare.

Remicade (infliximab)	All FDA-approved indications not otherwise excluded from Part D.		<ul style="list-style-type: none"> • Ankylosing Spondylitis: Documented axial disease with trial and failure or contraindication to NSAIDs. • Psoriatic Arthritis and Rheumatoid Arthritis: Documented disease activity with active synovitis in at least 3 sets of joints. AND An adequate trial of methotrexate to a maximum tolerated dose. If methotrexate is contraindicated, the patient must have an adequate trial of one of the following DMARDs: sulfasalazine, hydroxychloroquine, leflunomide, azathioprine or mycophenolate. • Plaque Psoriasis: Documented chronic, moderate to severe disease involving 10% or more of the patient's body surface area. AND An adequate trial and failure of or contraindication to methotrexate. AND An adequate trial and failure of phototherapy or photochemotherapy. • Crohn's Disease, Fistulizing Crohn's Disease, Ulcerative Colitis, Refractory Ulcerative Colitis: Documented moderate to severe disease AND an inadequate response to 2 conventional therapies: corticosteroids and 5-ASAs. 			1 year	For All Indications: A minimum of 3 months of current and continuous follow-up. AND A current PPD (tuberculosis) negative skin test within 6 months of starting therapy. Patients should be monitored for an infection or a history of chronic infections.
Retin-A (tretinoin)	All FDA-approved indications not otherwise excluded by Part D.	Cosmetic use				6 months	

Revatio (sildenafil)	All FDA-approved indications not otherwise excluded by Part D.		Medical records documenting diagnosis.			1 year	
Rituxan (rituximab)	All FDA-approved indications not otherwise excluded from Part D.	Use in combination with tumor necrosis factor inhibiting drugs such as (Enbrel) etanercept, (Humira) adalimumab, or Remicade (infliximab).	Rheumatoid Arthritis: Documented presence of moderate to severe rheumatoid arthritis.	Equal to or greater than 18 years of age.		Non-Hodgkin's Lymphoma: 1 year. Rheumatoid Arthritis: 1 round of therapy.	Rheumatoid Arthritis: • Documented trial and failure of both Remicade and Humira. AND • Must be given in conjunction with methotrexate OR leflunomide if the patient is intolerant to methotrexate.

Rozerem (ramelteon)	All FDA-approved indications not otherwise excluded from Part D.		<ul style="list-style-type: none"> • Documented trial and failure of zolpidem immediate release tablets. OR <ul style="list-style-type: none"> • Documented intolerance/contraindication to zolpidem immediate release tablets. 			1 year	
Saphris (asenapine)	All FDA-approved indications not otherwise excluded by Part D.		<ul style="list-style-type: none"> • Acute treatment of schizophrenia in adults OR Acute treatment of manic or mixed episodes associated with bipolar 1 disorder in adults. AND			1 year	

Somatuline Depot (lanreotide)	All FDA approved indications not otherwise excluded from Part D.		<ul style="list-style-type: none"> • Documented diagnosis of acromegaly. AND • Documented IGF-1 levels and GH levels. 			<p>Initial coverage: 3 months</p> <p>Reauthorization: 1 Year</p>	<ul style="list-style-type: none"> • Inadequate response to or cannot be treated with surgical resection or radiation therapy. AND • Inadequate response to or intolerance to octreotide. <p>Initiation of therapy:</p> <ul style="list-style-type: none"> • Serum growth hormone level greater than 1 ng/ml after a 2-hour glucose tolerance test. OR • Elevated serum IGF-1 levels as compared to normal reference values by age and gender. <p>Reauthorization of therapy:</p> <ul style="list-style-type: none"> • Normalization of serum IGF-1 levels with previously authorized therapy.
Suboxone (buprenorphine/naloxone)	All FDA-approved indications not otherwise excluded from Part D.	<ul style="list-style-type: none"> • Off-label use solely for pain management. OR • Use of Suboxone primarily for pain management in patients for whom it was originally started for the treatment of opioid dependence. OR • Use in conjunction with opiates. 	<ul style="list-style-type: none"> • The prescriber must be approved to prescribe buprenorphine/naloxone. AND • The patient's pharmacy benefit includes coverage of medications for treating opioid dependence. AND • Use as maintenance therapy for the treatment of opioid dependence. 			<p>Initial therapy: 1 month.</p> <p>Reauthorization: 3 months</p>	

Subutex (buprenorphine)	All FDA-approved indications not otherwise excluded from Part D.	<ul style="list-style-type: none"> • Off-label use solely for pain management. OR • Use of Subutex primarily for pain management in patients for whom it was originally started for the treatment of opioid dependence. OR • Use in conjunction with opiates. 	<ul style="list-style-type: none"> • The prescriber must be approved to prescribe buprenorphine/naloxone. AND • The patient's pharmacy benefit includes coverage of medications for treating opioid dependence. AND • Use as maintenance therapy for the treatment of opioid dependence. AND • Medical records documenting hypersensitivity or intolerance to Suboxone (buprenorphine/naloxone). 			Induction therapy: 7 days. Maintenance therapy: 3 months.	
Symlin (pramlintide)	All FDA-approved indications not otherwise excluded by Part D.				Endocrinologist	1 year	
Synarel (nafarelin nasal)	All FDA approved indications not otherwise excluded from Part D.		Documented diagnosis of endometriosis or central precocious puberty.			6 months	<ul style="list-style-type: none"> • Documented treatment failure with leuprolide. OR • Documented contraindication or intolerance to leuprolide.

Testim (testosterone topical gel)	All FDA-approved indications not otherwise excluded from Part D.	Testosterone replacement is not covered for the treatment of sexual dysfunction.	Documentation of one of the following: <ul style="list-style-type: none"> • At least two low total testosterone levels (drawn on separate days). OR <ul style="list-style-type: none"> • At least two low free testosterone levels (drawn on separate days). OR <ul style="list-style-type: none"> • One low total testosterone level with an elevated LH and FSH. OR <ul style="list-style-type: none"> • One low free testosterone level with an elevated LH and FSH. 			1 year	
Testosterone injection	All FDA-approved indications not otherwise excluded from Part D.	Testosterone replacement is not covered for the treatment of sexual dysfunction.	Documentation of one of the following: <ul style="list-style-type: none"> • At least two low total testosterone levels (drawn on separate days). OR <ul style="list-style-type: none"> • At least two low free testosterone levels (drawn on separate days). OR <ul style="list-style-type: none"> • One low total testosterone level with an elevated LH and FSH. OR <ul style="list-style-type: none"> • One low free testosterone level with an elevated LH and FSH. 			1 year	
Uloric (febuxostat)	All FDA-approved indications not otherwise excluded from Part D.		<ul style="list-style-type: none"> • Documented intolerance to allopurinol. OR <ul style="list-style-type: none"> • Documented treatment failure of allopurinol due to renal insufficiency (CrCl less than or equal to 10 ml/min). 			1 year	Failure of allopurinol at maximum therapeutic dose (600mg/day).
Valcyte (valganciclovir)	All FDA-approved indications not otherwise excluded from Part D.		<ul style="list-style-type: none"> • Documented treatment of cytomegalovirus (CMV) retinitis in adult AIDS patients. OR <ul style="list-style-type: none"> • Documented prevention of CMV disease in kidney, heart, and kidney-pancreas transplant adults patients at high risk. 			1 year	

Vancocin (vancomycin)	All FDA-approved indications not otherwise excluded by Part D.		<ul style="list-style-type: none"> • Diagnosis of Pseudo-Membranous Colitis due to Clostridium difficile AND <ul style="list-style-type: none"> • Documented failure of oral metronidazole. 			10 days per request	
Vandetanib (vandetanib)	All FDA-approved indications not otherwise excluded by Part D.		Documentation that the patient has symptomatic or progressive medullary thyroid cancer and the cancer is unresectable locally advanced or metastatic disease. Documentation of failed therapies.			6 months	Use of a specialty pharmacy is required
Venofer (iron sucrose) injection	All FDA-approved indications not otherwise excluded by Part D.		<ul style="list-style-type: none"> • Treatment of documented chemotherapy-induced iron deficiency anemia. OR <ul style="list-style-type: none"> • Treatment of documented iron deficiency anemia in a chronic kidney disease patient undergoing chronic hemodialysis. OR <ul style="list-style-type: none"> • Treatment of documented iron deficiency anemia in a patient who has a documented disorder of the gastrointestinal tract of which symptoms may be aggravated by oral iron therapy, such as Inflammatory bowel disease. OR <ul style="list-style-type: none"> • Treatment of documented iron deficiency anemia in a patient with documented severe intolerance to or treatment failure of an oral iron product after an adequate trial. Attempts must have been made to identify and treat the underlying cause of the deficiency. 			One time.	<ul style="list-style-type: none"> • Coverage falls under Medicare Part B benefit. • Documented iron deficiency anemia for the listed indications is defined as a hemoglobin <11 g/dl.

Vfend (voriconazole)	All FDA approved indications not otherwise excluded by Part D.		<ul style="list-style-type: none"> • Documented diagnosis of invasive aspergillosis, candida krusei, or an organism known to be resistant to high dose fluconazole and is susceptible to voriconazole. AND • Documentation must include a culture and susceptibility report. 			1 year	
Victrelis (boceprevir)	All FDA-approved indications not otherwise excluded from Part D.	Pregnant women and men whose female partners are pregnant.	<ul style="list-style-type: none"> • Documented chronic hepatitis C genotype 1 AND • to be used in combination with peginterferon alfa and ribavirin AND • previously untreated with boceprevir or telaprevir 	18 years of age or older		1 year	Will not be approved as monotherapy
Viibryd (vilazodone)	All FDA-approved indications not otherwise excluded from Part D.	Concomitant use with MAOI or within 14 days of stopping or starting an MAOI.	<ul style="list-style-type: none"> • Documented diagnosis of major depressive disorder AND a documented trial and failure of an SSRI and an SNRI 			1 year	
Vimpat (lacosamide)	All FDA-approved indications not otherwise excluded by Part D.					1 year	Medical records documenting trial and failure at therapeutic dose of at least two preferred anticonvulsants

Vivitrol (naltrexone IM)	All FDA approved indications not otherwise excluded by Part D.		<ul style="list-style-type: none"> • Documented trial and failure of oral naltrexone. AND <ul style="list-style-type: none"> • Documented trial and failure of ONE of the following: Antabuse (disulfiram) or (Campral) acamprosate. 			6 months	The patient is engaged in a comprehensive management program that includes a psychosocial component of the therapy.
Xenazine (tetrabenazine)	All FDA-approved indications not otherwise excluded from Part D.	<p>Not covered for patients:</p> <ul style="list-style-type: none"> • Who are actively suicidal or who have untreated or inadequately treated depression. OR <ul style="list-style-type: none"> • Who have impaired hepatic function. OR <ul style="list-style-type: none"> • Who are currently taking monoamine oxidase inhibitors or reserpine. 	Diagnosis of Huntington's Disease with chorea.		Neurologist	Initial: 3 months Reauthorization: 1 year	<ul style="list-style-type: none"> • Documentation of disease improvement based on prescriber's assessment of therapy. AND <ul style="list-style-type: none"> • Documentation of monitoring for depression and suicidal ideation.
Xgeva (denosumab)	All FDA-approved indications not otherwise excluded by Part D.		<ul style="list-style-type: none"> • Documented use for the prevention of skeletal related events with bone metastases from solid tumors. AND <ul style="list-style-type: none"> • Documented failure of or intolerance to, or clinical rationale for the avoidance of Zometa or Aredia. AND <ul style="list-style-type: none"> • Documented serum calcium. Evidence of 			6 months	Use of a specialty pharmacy is required

Xifaxan (rifaximin)	All FDA-approved indications not otherwise excluded by Part D.		<p>Travelers' diarrhea:</p> <ul style="list-style-type: none"> • Diagnosis of travelers' diarrhea due to a noninvasive strain of E.Coli. <p>AND</p> <ul style="list-style-type: none"> • Treatment failure with an oral antibiotic such as azithromycin or ciprofloxacin. <p>Hepatic encephalopathy:</p> <ul style="list-style-type: none"> • Documented diagnosis of hepatic encephalopathy. <p>AND</p> <ul style="list-style-type: none"> • Treatment failure or documented intolerance/contraindication to lactulose. 			Travelers' diarrhea: 3 days per request. Hepatic encephalopathy: 1 year	
Xolair (omalizumab)	All FDA-approved indications not otherwise excluded by Part D.		<ul style="list-style-type: none"> • Medical records documenting IgE level greater than or equal to 30 IU/ml. <p>AND</p> <ul style="list-style-type: none"> • Specific evidence of "allergic asthma", supported by clinical and lab findings such as positive skin tests, symptom patterns, etc. <p>AND</p> <ul style="list-style-type: none"> • Failure of an adequate trial of an inhaled corticosteroid, long acting beta-2 agonist combination therapy at maximum doses. <p>AND</p> <ul style="list-style-type: none"> • Evidence of persistent symptoms requiring frequent rescue therapy, practitioner visits despite inhaled corticosteroids, or ER visits. 	Greater than 12 years of age.	Allergist or Pulmonologist	6 months	
Zometa (zoledronic acid)	All FDA-approved indications not otherwise excluded from Part D.		Documentation of diagnosis.			6 months	

Zortress (everolimus)	All FDA-approved indications not otherwise excluded by Part D.		Documented trial and failure of Prograf (tacrolimus) AND Rapamune (sirolimus).			1 year	<ul style="list-style-type: none"> • Documented diagnosis is necessary to determine whether this medication is covered under the Medicare Part B (medical) or Part D (pharmacy) benefit. • Immunosuppressants used to prevent organ transplant rejection are a Part B benefit if the transplant was covered under Medicare.
Zostavax (Herpes Zoster Vaccine)	All FDA-approved indications not otherwise excluded by Part D.			Greater than or equal to 50 years of age.		1 time	Patient does not have a contraindication to Zostavax, such as immunosuppression or active Zoster infection.
Zyprexa Zydis (olanzapine) Orally Disintegrating Tablets	All FDA-approved indications not otherwise excluded from Part D.		<ul style="list-style-type: none"> • The patient is unable to take or swallow oral medications (should not be on other oral medications). OR <ul style="list-style-type: none"> • The patient is "cheeking" the medication. 		Psychiatrist	1 year	
Zytiga (abiraterone)	All FDA-approved indications not otherwise excluded from Part D.	Women who are pregnant or may become pregnant.	<ul style="list-style-type: none"> • Documented diagnosis of metastatic castration-resistant prostate cancer AND <ul style="list-style-type: none"> • Documented prior chemotherapy containing docetaxel AND <ul style="list-style-type: none"> • to be used in combination with prednisone 		Oncologist	1 year	Specialty Pharmacy will be required
Zyvox (linezolid)	All FDA-approved indications not otherwise excluded by Part D.		<ul style="list-style-type: none"> • Infectious Disease Specialist Consult AND <ul style="list-style-type: none"> • Chart notes including culture and sensitivities. AND <ul style="list-style-type: none"> • A contraindication to the other antimicrobials. 			1 time up to 28 days of therapy	Documented failure of other antibacterials that the culture shows sensitivity to.