PRESBYTERIAN

Presbyterian Senior Care (HMO) / MediCare PPO Formulary
Prior Authorization Criteria
Effective January 1, 2012

Product Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Actiq (fentanyl transmucosal)	All FDA-approved indications not otherwise excluded by Part D.	Treatment of non-cancer pain, post-op pain, or chronic pain not related to cancer	Documented diagnosis of pain due to cancer. And patient is established on therapy with a long acting opiate and will continue on therapy with a long acting opiate. And patient has failed to achieve control of breakthrough pain using an immediate acting oral opiate.			6 months	
Afinitor (everolimus)	All FDA-approved indications not otherwise excluded from Part D		For renal cell cancer: Medical records documenting trial and failure at therapetutic doses of sunitinib or sorafenib. For subependymal giant cell astrocytoma: documentation of the indicated diagnosis.			one year	
Alimta (pemetrexed disodium)	All FDA-approved indications not otherwise excluded from Part D.		Malignant Pleural Mesothelioma: In combination with cisplatin and in patients who are not candidates for curative surgery or whose disease is unresectable. Nonsquamous Non-Small Cell Lung Cancer: Patients with locally advanced or metastatic disease and is used in combination with cisplatin or as a single-agent after prior history of a first-line chemotherapy agent.			one year	
Aloxi (palonosetron)	All FDA-		For the prevention of acute and delayed			6 months	

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	approved indications not otherwise excluded by Part D.		nausea and vomiting associated with initial and repeat courses in patients treated with moderately emetogenic cancer chemotherapy. For the prevention of acute nausea and vomiting associated with initial and repeat courses in patients treated with highly emetogenic cancer chemotherapy. Documented trial and failure with ondansetron injection or granisetron injection. For the prevention of postoperative nausea and vomiting (PONV) for up to 24 hours following surgery, documentation that member has failed to achieve control of nausea and/or vomiting with IV ondansetron or IV granisetron.				
Androderm (testosterone topical)	All FDA-approved indications not otherwise excluded from Part D.	Testosterone replacement will not be covered for the treatment of sexual dysfunction	Medical records documenting one of the following: At least two low total testosterone levels (drawn on separate days), OR at least two low free testosterone levels (drawn on separate days), OR one low total testosterone level with an elevated LH and FSH OR one low free testosterone level with an elevated LH and FSH.			one year	
Androgel 1% (testosterone topical)	All FDA-approved indications not otherwise excluded from Part D.	Testosterone replacement will not be covered for the treatment of sexual	Medical records documenting one of the following: At least two low total testosterone levels (drawn on separate days), OR at least two low free testosterone levels (drawn on separate days), OR one low total testosterone level with an			one year	

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		dysfunction	elevated LH and FSH OR one low free testosterone level with an elevated LH and FSH.				
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 OR Hypogonadotropic hypogonadism (congenital or acquired) AND two low total testosterone levels (drawn on separate days) with a low to low-normal LH and FSH.			one year	
Anzemet (dolasetron oral)	All FDA-approved indications not otherwise excluded from Part D.		Documented treatment failure with ondansetron OR granisetron.			6 months	
Apokyn (apomorphine)	All FDA approved indications not otherwise exclued from Medicare Part D		All of the following must be met: Documented diagnosis of Parkinson's disease AND Documented occurrence of hypomobility episodes, off episodes (end of dose wearing off and unpredictable on/off episodes) associated with advanced Parkinson's disease AND will be used as an adjunct to other medications for Parkinson's		Prescriber must be a neurologist	one year	
Aralast NP (proteinase	All FDA-					6 months	Documented

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inhibitor human)	approved indications not otherwise excluded from Part D.						diagnosis is necessary to determine whether this medication is covered under the Medicare Part B (medical) or Part D (pharmacy) benefit.
Arcalyst (rilonacept)	All FDA-approved indications not otherwise excluded from Part D.		Cryopyrin-Associated Periodic Syndromes (CAPS), drug will not be used in combination with Enbrel, Humira, Kineret, Orencia or Remicade, AND 2. Dose does not exceed FDA label maximum for the diagnosis.	Patient is 12 years of age or older.		Annual	
Arixtra (fondaparinux)	All FDA-approved indications not otherwise excluded from Part D.		Medical records documenting failure of formulary low molecular weight heparin.			one time up to 32 days	
Arzerra (ofatumumab)	All FDA-approved indications not otherwise excluded by Part D.		Documented trial and failure of Fludara and Campath			6 months	
Avastin (bevacizumab)	All FDA approved indications not otherwise excluded from	1. History of recent hemoptyis or serious hemorrhage. 2.	1. Diagnosis and patient history, 2. Concurrent or previous medication trials, 3. HER2 status for metastatic breast cancer		Prescribed by or in consultation with an oncologist.	one year	

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	Part D.	Bevacizumab should not be used within 28 days following major surgery or until the surgical incision is fully healed.					
Avonex (interferon beta-1a)	All FDA-approved indications not otherwise excluded from Part D		Medical records documenting trial and failure on the formulary alternatives, Copaxone and Rebif, or if the patient is a new member to the plan and is currently taking Avonex		Neurologist	one year	
Banzel (rufinamide)	All FDA-approved indications not otherwise excluded from Part D.		Medical records documenting failure at therapeutic doses of at least two formulary anticonvulsants.			one year	
Botox (botulinum toxin type A)	All FDA-approved indications not otherwise excluded from Part D. Dystonia, Cerebral Palsy, Facial Nerve Disorder/Hemi-facial Spasm,	Cosmetic use	Severe primary axillary hyperhydrosis: Medical records documenting failure of drying agents such as topical aluminum chloride. Migraines: Medical records documenting headaches on 15 or more days per month AND headaches lasting at least 4 hours per day AND failure with two oral prophylactic therapies. Severe palmar hyperhidrosis: Medical records documenting failure of drying agents such as topical aluminum chloride. Urinary		Migraines: must be prescribed by a neurologist.	one year	

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	Migraines, Severe palmar hyperhydrosis		incontinence: documentation of detrusor overactivity associated with a neurologic condition in patients who have trial/failure of two anticholinergic medications.				
Campath (alemtuzumab)	All FDA approved indications not otherwise excluded from Part D		Diagnosis of B-Cell chronic lymphocytic leukemia (B-CLL)			one year	
Campral (acamprosate)	All FDA approved indications not otherwise excluded from Part D		Diagnosis of Alcohol dependence and member is abstinent at treatment initiation. Documentation from physician confirming alcohol abstinence and patient participation in an alcoholic recovery program during the entire course of therapy. Documentation of trial/failure with naltrexone or disulfiram.			3 months	
Carimune (human immune globulin IV)	All FDA-approved indications not otherwise excluded by Part D.		Documented diagnosis			one year	
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

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							(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
Cervarix (HPV vaccine)	All FDA-approved indications not otherwise excluded from Part D	Males		Between the ages of 9 and 25		3 doses per 365 days	
(cyclosporine) Neoral, Sandimmune	All FDA-approved indications not otherwise excluded from 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

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							covered under Medicare
Daunoxome (daunorubicin)	All FDA-approved indications not otherwise excluded from Part D.		Documentation of diagnosis for which the medication is indicated.			one year	
Dexferrum (iron dextran) injection	All FDA-approved indications not otherwise excluded by Part D.		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.			1 time	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 patient older than 40 years of age		6 months	

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Effient (prasugrel)	All FDA-approved indications not otherwise excluded by Part D.		Medical records documenting all of the following: 1.The patient has had an acute coronary syndrome (unstable angina, NSTEMI, or STEMI) and was managed with percutaneous coronoary intervention. 2. The patient weight will be submitted. 3. The patient does not have a history of stroke or transient ischemic attack. 4. The patient meets one of the following conditions: a. There is a documented allergy to Plavix. b. There is a documented treatment failure with Plavix. OR c. The patient is considered to be at high risk for stent thrombosis.	Patient must be less than 75 years of age.	Cardiologist	one year	
Emend (aprepitant oral)	All FDA-approved indications not otherwise excluded from Part D		Prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy. Prevention of nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy. Failure of 2 formulary agents: ondansetron, granisetron, or promethazine. For the prevention of postoperative nausea and vomiting (PONV) following surgery, documentation that member has failed to achieve control of nausea and/or vomiting with IV ondansetron or IV granisetron.			6 months	Coverage may fall under Medicare Part B or Part D
Emend (fosaprepitant) injection	All FDA-approved indications not		Documentation that the patient is receiving combination therapy with a 5-HT3 antagonist AND dexamethasone for a			6 months	Coverage may fall under Medicare Part B or Part D.

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	otherwise excluded from Part D.		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 chemotherapy regimen which includes anthracycline and cyclophosphamide in combination OR Documentation that the patient is receiving a cancer chemotherapy regimen which has moderate emetogenic potential and has failed antiemetic therapy with a 5-HT3 antagonist in combination with dexamethasone.				
Enbrel (etanercept)	All FDA-approved indications not otherwise excluded from Part D		Medical records documenting: A minimum of 3 months of current and continuous follow-up AND 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.			one year	
Ethyol (amifostine)	All FDA approved indications not otherwise exclued from Medicare Part D		Documentation that amifostine being used for the following: prevention of xerostomia in patients undergoing postoperative radiation for head and neck cancer or prevention of renal toxicity associated with repeat courses of cisplatin.		Prescriber must be a hematologist or oncologist	6 months	
Extavia (interferon beta-1b)	All FDA-approved		Medical records documenting trial and failure on the formulary alternatives,		Neurologist	one year	

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	indications not otherwise excluded from Part D.		Copaxone and Rebif, or if the patient is a new member to the plan and is currently taking Extavia.				
Feraheme (ferumoxytol) injection	All FDA-approved indications not otherwise excluded from Part D.		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.	Coverage falls under Medicare Part B benefit. Documented iron deficiency anemia for the listed indications is defined as a hemoglobin <11 g/dl.
Ferrlecit (Na ferric gluconate) injection	All FDA-approved indications not otherwise excluded from Part D.		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			One time.	Coverage falls under Medicare Part B benefit. Documented iron deficiency anemia for the listed indications is defined as a hemoglobin <11

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			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.				g/dl.
Forteo (teriparatide)	All FDA-approved indications not otherwise excluded from Part D.		Treatment of men and women with osteoporosis who have an increased risk for fractures, who have failed or are intolerant to an oral bisphosphonate, and the T score is less than or equal to -2.5.			one year	
Fortesta (testosterone topical)	All FDA-approved indications not otherwise excluded from Part D.	Testosterone replacement will not be covered for the treatment of sexual dysfunction	Medical records documenting one of the following: At least two low total testosterone levels (drawn on separate days), OR at least two low free testosterone levels (drawn on separate days), OR one low total testosterone level with an elevated LH and FSH OR one low free testosterone level with an elevated LH and FSH.			one year	
Gamastan S/D (human immune globulin IM)	All FDA-approved indications not otherwise excluded by Part D.		Medical records documenting diagnosis. For Immunoglobulin Deficiency: Patient must have infusion reactions with IVIG or inability to obtain IV access.			one year	
Gammagard liquid (human immune globulin IV)	All FDA-approved indications not		Documented diagnosis			one year	

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Gamunex (human immune globulin IV)	All FDA-approved indications not otherwise excluded by Part D.		Documented diagnosis			one year	
Gardasil (HPV vaccine)	All FDA-approved indications not otherwise excluded by Part D.			Age 9 years to 26 years.		Series of 3 injections (one year)	
granisetron injection (Kytril)	All FDA-approved indications not otherwise excluded from Part D.					6 months	Coverage may fall under Medicare Part B or Part D.
granisetron oral (Kytril)	All FDA-approved indications not otherwise excluded from Part D.					6 months	Coverage may fall under Medicare Part B or Part D.
Hizentra (human immune globulin SQ)	All FDA-approved indications not		Medical records documenting diagnosis. Patient must have infusion reactions with IVIG or inability to obtain IV access.			one year	

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Humira (adalimumab)	All FDA-approved indications not otherwise excluded from Part D		Medical records documenting: A minimum of 3 months of current and continuous follow-up AND 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.			one year	
Imuran (azathioprine)	All FDA-approved indications not otherwise excluded from Part D.					one year	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
Increlex (mecasermin)	All FDA approved indications not otherwise	Secondary forms of IGF-1 deficiency. Combination	Must have documented severe primary IGF-1 deficiency or GH gene deletion with neutralizing antibodies to GH. Height standard deviation score less than or equal	Ages 2 - 18 years of age		one year	

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	excluded from Part D.	treatment with growth hormone.	to negative 3 AND basal IGF-1 standard deviation score less than or equal to negative 3, AND normal or elevated growth hormone levels AND predicted adult height more than 1.5 standard deviations below the mid-parenteral height and growth rate less than 7 cm/year if less than or equal to 3 years old and less than 5 cm if greater than 3 years old AND open epiphyses on bone radiograph.				
INFeD (iron dextran) injection	All FDA-approved indications not otherwise excluded from Part D.		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	Coverage falls under Medicare Part B benefit. Documented iron deficiency anemia for the listed indications is defined as a hemoglobin <11 g/dl.
Kuvan (sapropterin)	All FDA-approved indications not otherwise		Diagnosis of hyperphenylalaninemia caused by tetrahydrobiopterin-(BH4)-responsive phenylketonuria: Initial Authorizations: 1. Documentation showing	Patient is 4 years of age or older		Initial auth and titration to therapeutic response: 1	

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	excluded from Part D.		low baseline phenylalanine (Phe) level (level immediately prior to Kuvan request) AND 2. Documentation of target blood phenylalanine level for the patient AND 3. Patient on phenylalanine restricted diet while taking Kuvan, 4. Dose does not exceed FDA label maximum for the diagnosis. Reauthorization: 1. Recent phenylalanine level is at target range AND 2. Patient is continuing a phenylalanine restricted diet.			month. Reauth for stable therapy: 3 months.	
Leukine (sargramostim)	All FDA-approved indications not otherwise excluded from Part D	Combination use with Neulasta or Neupogen	Documentation of neutropenia, post AML chemotherapy. 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)	All FDA-approved indications not otherwise excluded by Part D.					3 months	
Lunesta (eszopiclone)	All FDA-approved indications not otherwise excluded from Part D.		Documented trial and failure of zolpidem immediate release oral tablets or documented intolerance/contraindication to zolpidem immediate release			one year	
Lyrica (pregabalin)	All FDA-approved		For Seizures, medical records documenting failure at therapeutic doses of at least two			one year	

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	indications not otherwise excluded from Part D.		anticonvulsants indicated for the treatment of partial seizures, including carbamazepine, gabapentin, lamotrigine, levetiracetam, oxcarbazepine, topiramate, or zonisamide. For Neuropathic Pain and post-herpetic neuralgia, 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. For Fibromyalgia, medical records documenting failure of a tricyclic antidepressant and gabapentin.				
Marinol (dronabinol)	All FDA-approved indications not otherwise excluded from Part D		Nausea or vomiting associated with cancer chemotherapy (CINV). Patient is receiving cancer chemotherapy and has failed one 5-HT3 antagonist and one of the following: corticosteroid, anti-histamine, anti-psychotic, or prokinetic. For treatment of anorexia associated with weight loss in patients with HIV/AIDS documented trial and failure or contraindication or intolerance to Megestrol oral suspension			6 months	Coverage may fall under Medicare Part B or Part D
Multaq (dronedarone)	All FDA approved indications not otherwise excluded by Part D.		Paroxysmal or persistent atrial fibrillation or paroxysmal or persistent atrial flutter. The member does not have Class IV heart failure or Class II or III heart failure with a recent decompensation.			one year	
Myfortic (mycophenolic acid)	All FDA-approved					one year	Documented diagnosis is

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	indications not otherwise excluded by Part D.						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	Documented diagnosis is necessary to determine whether this medication is covered under the Medicare Part B (medical) or Part D (pharmacy) benefit.
Neumega (oprelvekin)	All FDA-approved indications not otherwise excluded from Part D.		Thrombocytopenia following myeloablative chemotherapy. 1. Verification that the cancer is a non-myloid malignacy AND 2. Platelet count is less than 30,000 cells/microliter 3. Dose does not exceed FDA label maximum for the diagnosis.			Initial authorization: up to 21 days per course. Reauthorization: up to 6 months	
Neupogen (filgrastim)	All FDA-approved					Diagnosis Dependent	

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	indications not otherwise excluded by Part D.						
Norditropin (growth hormone)	All FDA approved indications not otherwise excluded from Part D Growth Hormone Deficiency (GHD) in children, Idiopathic short stature (ISS), Small for gestational age or Intrauterine growth retardation (SGA), Prader-Willi Syndrome (PWS), Turner Syndrome (TS), Noonan Syndrome (NS), Growth retardation associated with Chronic Renal		GHD(child), ISS, TS, NS, PWS, GRCRF: Baseline height less than or equal to 2 SD below mean or at or below the 3rd percentile for age or gender. Growth rate less than 7cm/year if less than 3 years of age and less than 4cm/year if greater than 3 years of age. Bone x-ray is greater than 2 years behind chronological age. Epiphyses are not closed. Diagnosis of GHD(child): Subnormal response to 2 provocative stimulation tests (less than or equal to 10 ng/ml). For diagnosis of ISS: Predicted adult height not likely to reach 63in for males and 59in for females, and absence of comorbid conditions that should be treated by other means. SGA: Diagnosis confirmed by birth weight less than 2500g at gestation more than 37 weeks or birth weight or length below the 3rd percentile for gestational age who fail to catch up by age 2. Baseline height less than or equal to 2 SD below mean or at or below 3rd percentile for age or gender. Patient age 2 years and older. AOGHD: Multiple hormone deficiencies (hypopituitarism) resulting from pituitary or hypothalamic disease, surgery, radiation therapy or		GHD (child), ISS, SGA, TS, NS, PWS, AOGHD, COGHD: must be prescribed by an endocrinologist. GRCRF: Must be prescribed by a nephrologist	one year	

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	Insufficiency (GRCRF), Adult Onset Growth Hormone Deficiency (AOGHD), Childhood Onset Growth Hormone Deficiency (COGHD), Full thickness skin loss associated with 3rd degree burns		trauma. Low serum IGF-I. COGHD: Clinical diagnosis of GHD as child or adolescent. Subnormal response to 2 provocative tests (less than or equal to 10ng/ml) following a GH washout period (1-3 months). For diagnosis of PWS: only genetic testing. Reauthorization for AOGHD, COGHD: IGF-I is in normal range for age and gender. Reauthorization for GHD(child), ISS, SGA, TS, NS, PWS, GRCRF: Increase in growth velocity of at least 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.				
Noxafil (posaconazole)	All FDA-approved indications not otherwise excluded by Part D.		Documentation of diagnosis for which the medication is indicated.			one year	
Orencia (abatacept)	All FDA-approved indications not otherwise excluded from Part D		Documented trial and failure of both Remicade (infliximab) and Humira (adalimumab). The patient must have a current PPD (tuberculosis) negative skin test.			one year	Patients should be monitored for an infection or a history of chronic infections.

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Pristiq (desvenlafaxine)	All FDA-approved indications not otherwise excluded by Part D.		Documented trial and failure of Effexor XR (velafaxine ER) at a therapeutic dose.			one year	
Privigen (human immune globulin IV)	All FDA-approved indications not otherwise excluded by Part D.		Documented diagnosis			one year	
Procrit (epoetin alfa)	All FDA-approved indications not otherwise excluded by Part D.					3 months	Documented diagnosis is necessary to determine whether this medication is covered under the Medicare Part B (medical) or Part D (pharmacy) benefit.
Prograf (tacrolimus)	All FDA-approved indications not otherwise excluded by Part D.					one year	Documented diagnosis is necessary to determine whether this medication is covered under the Medicare Part B (medical) or Part D (pharmacy) benefit. Immunosuppressants

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							used to prevent organ transplant rejection are a Part B benefit if the transplant was covered under Medicare
Promacta (eltrombopag olamine)	All FDA approved indications not otherwise excluded from Part D.	Coverage will not be provided when used in combination with Nplate	Initial authorization: 1. Platelet count is less than 30000/mcl, 2. Dose does not exceed the FDA label maximum for the diagnosis, 3. Treatment failure or contraindication to at least two of the following treatments: Corticosteroids, immunoglobulin, or splenectomy.			3 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		For Narcolepsy, medical records documenting failure on formulary agents methylphenidate or dextroamphetamine. For Obstructive Sleep Apnea/Hypopnea Syndrome, medical records documenting use of CPAP for at least 2 months and is using it for 4 or more hours per night. Diagnosis of Shift Work Sleep Disorder. For MS Fatigue, a diagnosis of MS.		Neurologist or Sleep Specialist	one year	
Rapamune (sirolimus)	All FDA-approved indications not otherwise excluded by Part D.					one year	Documented diagnosis is necessary to determine whether this medication is covered under the Medicare Part B

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							(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
Relistor (methylnaltrexone)	All FDA-approved indications not otherwise excluded by Part D.		Patients must have an advanced illness for which they are receiving palliative care. And documented diagnosis of opiod-induced constipation. And failure of polyethylene glycol or lactulose.	18 years and older		6 months	
Remicade (infliximab)	All FDA-approved indications not otherwise excluded from Part D		Medical records documenting: A minimum of 3 months of current and continuous follow-up AND 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.			one year	
Rituxan (rituximab)	All FDA-approved indications not otherwise excluded from Part D.	Will not be approved for use in combination with tumor necrosis factor inhibiting drugs		Equal to or greater than 18 years of age.		RA: one month, all other indications will be one year	

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Rozerem (ramelteon)	All FDA-approved indications not otherwise excluded from Part D.		Documented trial and failure of zolpidem immediate release oral tablets or documented intolerance/contraindication to zolpidem immediate release			one year	
Somatuline Depot (lanreotide)	All FDA-approved indications not otherwise excluded by Part D.					Initial coverage: 3 months Reauthorization: One Year	Documented diagnosis is necessary to determine whether this medication is covered under the Medicare Part B (medical) or Part D (pharmacy) benefit.
Suboxone (buprenorphine/naloxone)	All FDA-approved indications not otherwise excluded from Part D	Will not be approved for use in conjunction with medications that have agonist activity at the mu receptor	The prescriber must be approved to prescribe buprenorphine/naloxone. For use as maintenance therapy for the treatment of opioid dependence. A recent urine drug screen must be submitted with each request.			Initial therapy: one month. Reauthorization: 3 months then 6 months thereafter	Justification must be provided for use in combination with benzodiazepines or other sedative/hypnotics.
Subutex (buprenorphine sublingual)	All FDA-approved indications not otherwise excluded from Part D	Will not be approved for use in conjunction with medications that have agonist	The prescriber must be approved to prescribe buprenorphine. For use as maintenance therapy for the treatment of opioid dependence. A recent urine drug screen must be submitted with each request. Medical records documenting hypersensitivity or intolerance to			Initial therapy: one month. Reauthorization: 3 months then 6 months thereafter	Justification must be provided for use in combination with benzodiazepines or other sedative/hypnotics.

Product Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		activity at the mu receptor.	buprenorphine/naloxone or the patient is pregnant or lactating.				
Symlin (pramlintide)	All FDA-approved indications not otherwise excluded by Part D.				Endocrinologist	one year	
Synarel (nafarelin acetate)	All FDA approved indications not otherwise excluded from Part D.		Domumented diagnosis of endometriosis or central precocious puberty. Documented contraindication, intolerance, or treatment failure with leuprolide.			6 months	
Testim (testosterone topical)	All FDA-approved indications not otherwise excluded from Part D.	Testosterone replacement will not be covered for the treatment of sexual dysfunction	Medical records documenting one of the following: At least two low total testosterone levels (drawn on separate days), OR at least two low free testosterone levels (drawn on separate days), OR one low total testosterone level with an elevated LH and FSH OR one low free testosterone level with an elevated LH and FSH.			one year	
Testosterone Injection	All FDA-approved indications not otherwise excluded by Part D.					One year	Documented diagnosis is necessary to determine whether this medication is covered under the Medicare Part B (medical) or Part D

Product Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							(pharmacy) benefit.
Tev-Tropin (growth hormone)	All FDA approved indications not otherwise excluded from Part D Growth Hormone Deficiency (GHD) in children, Idiopathic short stature (ISS), Small for gestational age or Intrauterine growth retardation (SGA), Prader-Willi Syndrome (PWS), Turner Syndrome (TS), Noonan Syndrome (NS), Growth retardation associated with Chronic Renal Insufficiency (GRCRF), Adult Onset Growth		GHD(child), ISS, TS, NS, PWS, GRCRF: Baseline height less than or equal to 2 SD below mean or at or below the 3rd percentile for age or gender. Growth rate less than 7cm/year if less than 3 years of age and less than 4cm/year if greater than 3 years of age. Bone x-ray is greater than 2 years behind chronological age. Epiphyses are not closed. Diagnosis of GHD(child): Subnormal response to 2 provocative stimulation tests (less than or equal to 10 ng/ml). For diagnosis of ISS: Predicted adult height not likely to reach 63in for males and 59in for females, and absence of comorbid conditions that should be treated by other means. SGA: Diagnosis confirmed by birth weight less than 2500g at gestation more than 37 weeks or birth weight or length below the 3rd percentile for gestational age who fail to catch up by age 2. Baseline height less than or equal to 2 SD below mean or at or below 3rd percentile for age or gender. Patient age 2 years and older. AOGHD: Multiple hormone deficiencies (hypopituitarism) resulting from pituitary or hypothalamic disease, surgery, radiation therapy or trauma. Low serum IGF-I. COGHD: Clinical diagnosis of GHD as child or adolescent. Subnormal response to 2		GHD (child), ISS, SGA, TS, NS, PWS, AOGHD, COGHD: must be prescribed by an endocrinologist. GRCRF: Must be prescribed by a nephrologist	one year	

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	Hormone Deficiency (AOGHD), Childhood Onset Growth Hormone Deficiency (COGHD), Full thickness skin loss associated with 3rd degree burns		provocative tests (less than or equal to 10ng/ml) following a GH washout period (1-3 months). For diagnosis of PWS: only genetic testing. Reauthorization for AOGHD, COGHD: IGF-I is in normal range for age and gender. Reauthorization for GHD(child), ISS, SGA, TS, NS, PWS, GRCRF: Increase in growth velocity of at least 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.				
Uloric (febuxostat)	All FDA-approved indications not otherwise excluded from Part D		Medical records documenting intolerance to allopurinol. Or Documented treatment failure of allopurinol due to renal insufficiency (CrCl less than or equal to 10 ml/min). Or Failure of allopurinol at maximal therapeutic doses (600mg/day).			one year	
Valcyte (valganciclovir)	All FDA-approved indications not otherwise excluded from Part D.		Treatment of cytomegalovirus (CMV) retinitis in adult AIDS patients. Prevention of CMV disease in kidney, heart, and kidney-pancreas transplant adults patients at high risk. Prevention of CMV disease in kidney and heart pediatric transplant patients at high risk.			one year	
Vancocin (vancomycin)	All FDA-approved		Failure of oral metronidazole or documentatin of severe C.Diff infection			C. Diff: 10 days per request, other	

Product Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded by Part D.		(WBC greater than 15000 or Serum Creatine greater than 1.5 times premorbid level)			diagnosis 1 month	
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.		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	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		Documented diagnosis of Invasive aspergillosis, Candida Krusei, or an organism known to be resistant to high dose fluconazole and is susceptible to			one year	

Product Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded by Part D.		voriconazole. Documentation must include a culture report or susceptibility report				
Victrelis (boceprevir)	All FDA-approved indications not otherwise excluded from Part D.	Pregnant women and men whose female partners are pregnant.	Documented chronic hepatitis C genotype 1 AND to be used in combination with peginterferon alfa and ribavirin AND previously untreated with boceprevir or telaprovir	18 years of age or older		one 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.	Documented diagnosis of major depressive disorder AND a documented trial and failure of an SSRI and an SNRI.			one year	
Vimpat (lacosamide)	All FDA-approved indications not otherwise excluded by Part D.		Medical records documenting trial and failure at therapeutic dose of at least two formulary anticonvulsants			one year	
Vivitrol (naltrexone IM)	All FDA approved indications not otherwise excluded by Part D.		For treatment of opiod abuse: Documented trial and failure of oral naltrexone. For treatment of alcohol abuse: Documented trial and failure of oral naltrexone and one of the following: disulfiram or acamprosate.			6 months	Patient is engaged in a comprehensive management program that includes a psychosocial component of the therapy.
Xenazine (tetrabenazine)	All FDA-approved	Xenazine is not covered for	Diagnosis of Huntington's Disease with chorea. Chart notes documenting that the		Neurologist	Initial: 3 months Reauthorization:	

Product Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded from Part D	members who are actively suicidal, or patients with untreated or inadequately treated depression, with impaired hepatic function, or patients currently taking monoamine oxidase inhibitors or patients taking reserpine.	patient's disease has improved based on prescriber's assessment while on therapy. Documentation that member is being monitored for depression and suicidal ideation.			one year	
Xgeva (Denosumab)	All FDA-approved indications not otherwise excluded by Part D.		Documented diagnosis for the prevention of skeletal related events with bone metastases from solid tumors. Documented failure or intolerance, or clinical rationale for the avoidance of Zometa. Documented serum calcium levels.			6 months	Use of a specialty pharmacy is required
Xifaxan (rifaximin)	All FDA-approved indications not otherwise excluded by Part D.		Traverers' diarrhea: Diagnosis of travelers' diarrhea due to noninvasive strain of E.Coli, treatment failure with an oral antibiotic such as azithromycin or ciprofloxacin. Hepatic encephalopathy: Documented diagnosis of hepatic encephalopathy and documented treatment			travelers' diarrhea: 3 days per request. Hepatic encephalopathy: one year	

Product Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			failure or documented intolerance/contraindication to lactulose.				
Xolair (omalizumab)	All FDA-approved indications not otherwise excluded by Part D.		Medical records documenting IgE level greater than or equal to 30 IU/ml AND specific evidence of allergic asthma, supported by clinical and lab findings such as positive skin tests, symptom patterns, etc. AND inadequate control with an inhaled corticosteroid and a long acting beta-2 agonist combination therapy at maximum doses AND 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 from Part D.		Documented trial and failure of tacrolimus and sirolimus			one year	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

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							organ transplant rejection are a Part B benefit if the transplant was covered under Medicare
Zostavax (live zoster vaccine)	All FDA-approved indications not otherwise excluded by Part D.		Documentation that patient does not have a contraindication to use Zostavax, such as immunosuppression or active Zoster infection.	Greater than or equal to 50 years of age.		one time	
Zytiga (abiraterone)	All FDA-approved indications not otherwise excluded from Part D.	Women who are pregnant or may become pregnant.	Documented diagnosis of metastatic castration-resistant prostate cancer AND documented prior chemotherapy containing docetaxel AND to be used in combination with prednisone.		Oncologist	one year	
Zyvox (linezolid)	All FDA-approved indications not otherwise excluded by Part D.		Infectious Disease Specialist Consult, chart notes and culture and sensitivity report, and failure of other antimicrobials that the culture shows sensitivity to or contraindication to the other antimicrobials			one time up to 28 days therapy.	