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ACNE

Affected Drugs

ATRALIN®
AVITA®
RETIN-A MICRO®
RETIN-A®
TRETINOIN

Covered Uses

All FDA-approved indications not otherwise excluded from Part D, keratosis follicularis (Darier's disease, Darier-White disease).

Exclusion Criteria

Cosmetic use.

Required Medical Information

N/A

Age Restrictions

Approve for those 12 years of age and older.

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

N/A

ACTEMRA

Affected Drugs

ACTEMRA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D plus patients already started on tocilizumab. Systemic-onset juvenile idiopathic arthritis (JIA).

Exclusion Criteria

Tocilizumab should not be given in combination with tumor necrosis factor (TNF) antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), abatacept, anakinra, or rituximab. Other uses excluded from coverage include JIA [Juvenile Idiopathic Arthritis] types other than systemic onset, Crohn's disease, and Castleman's disease. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria.

Required Medical Information

N/A

Age Restrictions

For indication of systemic-onset JIA [Juvenile Idiopathic Arthritis], may approve for children and adolescents 18 years of age or younger. For rheumatoid arthritis (RA), approve for adults.

Prescriber Restrictions

Adults with RA [Rheumatoid Arthritis], tocilizumab is to be prescribed by a rheumatologist or in consultation with a rheumatologist. Systemic-onset JIA [Juvenile Idiopathic Arthritis], tocilizumab is to be prescribed by a rheumatologist.

Coverage Duration

Authorization will be for 12 months.

Other Criteria

Adults with RA [Rheumatoid Arthritis], approve for patients who have tried one of the following TNF [Tumor necrosis factor] antagonists for at least 2 months, adalimumab, certolizumab pegol, etanercept, golimumab, or infliximab, AND patient must be receiving methotrexate (MTX) or another nonbiologic disease-modifying antirheumatic drug (DMARD) (eg, hydroxychloroquine, leflunomide, sulfasalazine) in combination with tocilizumab. Patients are not required to use MTX [methotrexate] concurrently with tocilizumab if there are contraindications to MTX [methotrexate] or the patient has a

history of intolerance to MTX [methotrexate] or to use other nonbiologic DMARDs [Disease-modifying antirheumatic drugs] concurrently with tocilizumab if there are contraindications or a history of intolerance. Systemic-onset JIA [Juvenile Idiopathic Arthritis], approve for patients who have tried a systemic corticosteroid, and either MTX [methotrexate] or sulfasalazine or another DMARD [Disease-modifying antirheumatic drug] such as etanercept.

ACTIQ/FENTORA

Affected Drugs

ONSOLIS®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Acute and/or postoperative pain including surgery/post-surgery, trauma/post-trauma, acute medical illness (acute abdominal pain, pelvic pain, muscle spasm). Pre-anesthesia (preoperative anxiolysis and sedation and/or supplement to anesthesia. Coverage is not recommended for circumstances not listed in the Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

Breakthrough pain in patients with cancer if patient is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting OR patient is unable to take 2 other short-acting narcotics (eg, oxycodone, morphine sulfate, hydromorphone, etc) secondary to allergy or severe adverse events AND patient is on or will be on a long-acting narcotic (eg, Duragesic), or the patient is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (eg, morphine sulfate, hydromorphone, fentanyl citrate).

ADCIRCA

Affected Drugs

ADCIRCA®

Covered Uses

All FDA approved indications not otherwise excluded from Part D plus Eisenmenger syndrome with pulmonary arterial hypertension (PAH) [men or women]. For Raynaud disease, refer to Levitra.

Exclusion Criteria

Patients taking nitrates. Use of Adcirca for the treatment of erectile dysfunction. Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

N/A

AMPYRA

Affected Drugs

AMPYRA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. Plus patient already started on dalfampridine extended-release for Multiple Sclerosis (MS).

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

MS [Multiple Sclerosis]. If prescribed by, or in consultation with, an MS [Multiple Sclerosis] specialist.

Coverage Duration

Initial approval for MS [Multiple Sclerosis], 2 months. Subsequent authorization for 12 months if patient had a response.

Other Criteria

For initial approval for MS [Multiple Sclerosis], authorize for 2 months. After up to 2 months of dalfampridine extended-release therapy, if MS [Multiple Sclerosis] patient has had a response to therapy as determined by prescribing physician (eg, increased walking distance, improved leg/limb strength, improvement in activities of daily living), then an additional authorization is allowed. Patients may be given another 2-month trial of dalfampridine extended-release for MS [Multiple Sclerosis] (after previous use and discontinuation) if the patient's MS [Multiple Sclerosis] condition has deteriorated or worsened.

ARANESP

Affected Drugs

ARANESP®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

CRF [Chronic Renal Failure] - transferrin saturation less than 20% and patient not receiving iron supplementation where clinically appropriate. CRF [Chronic Renal Failure] and anemia in patients with non-myeloid malignancies - hemoglobin level of the patient (not the result of a recent blood transfusion) greater than 13 g/dL. Lack of initial diagnosis of anemia (hematocrit less than 30% and/or hemoglobin less than 10 g/dL and/or symptomatic with hemoglobin 10-11g/dL).

Required Medical Information

CRF [Chronic Renal Failure] - iron status of the patient has been evaluated (serum transferrin saturation). CRF [Chronic Renal Failure] and anemia of cancer - Hemoglobin level of the patient be monitored prior to each dose when initiating therapy, for dose changes, and at regular intervals when the dose is stabilized. Hemoglobin level of the patient will be monitored prior to each dose when initiating therapy, for dose changes, and at regular intervals when the dose is stabilized. Blood pressure of the patient will be monitored throughout therapy. Patient will be monitored for the occurrence of thrombotic events.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Initiation of therapy and/or dose changes - 6 weeks. Stable on therapy - 12 weeks.

Other Criteria

Once on therapy, compared to pretreatment baseline, the patient must show an objective clinical response (e. g. , hemoglobin rise greater than 1 g/dL and/or hematocrit rise greater than 3%) to an appropriate dose/dose increase and duration of therapy.

B VS D - PART B VERSUS PART D COVERAGE PA

Affected Drugs

ACCUNEB®
ACETYLCYSTEINE
ALBUTEROL SULFATE
AMINOSYN II 3.5%-DEXTROSE 25%®
AMINOSYN II 3.5%-DEXTROSE 5%®
AMINOSYN II 4.25%-DEXTROSE 25%®
AMINOSYN II 5% IN 25% DEXTROSE®
AMINOSYN II IN DEXTROSE®
AMINOSYN II WITH LYTES-CA-DW®
AMINOSYN II®
AMINOSYN M®
AMINOSYN WITH ELECTROLYTES®
AMINOSYN®
AMINOSYN-HBC®
AMINOSYN-HF®
AMINOSYN-PF®
ANZEMET®
AZASAN®
AZATHIOPRINE
BROVANA®
CELLCEPT®
CESAMET®
CHORIONIC GONADOTROPIN
CLINIMIX E®
CLINIMIX®
CLINISOL®
CROMOLYN SODIUM
CYCLOPHOSPHAMIDE
CYCLOSPORINE
CYCLOSPORINE MODIFIED
DIPHThERIA-TETANUS TOXOID®
DUONEB®
EMEND®
ENGERIX-B®
FREAMINE HBC®
FREAMINE III WITH ELECTROLYTES®
FREAMINE III®
GENGRAF

GRANISETRON HCL
GRANISOL
HEPATAMINE®
HEPATASOL®
IMURAN®
INTRALIPID®
IPRATROPIUM BROMIDE
IPRATROPIUM-ALBUTEROL
KYTRIL®
MYFORTIC®
NEBUPENT®
NEORAL®
NEPHRAMINE®
NOVAMINE®
NOVAREL
ONDANSETRON HCL
ONDANSETRON ODT
PERFOROMIST®
PREGNYL®
PREMASOL®
PRIVIGEN®
PROCALAMINE®
PROGRAF®
PROSOL®
PULMICORT®
PULMOZYME®
QUICK MIX W/LYTES®
QUICK MIX WITH LYTES®
RAPAMUNE®
RECOMBIVAX HB®
RENAMIN®
SANDIMMUNE®
TACROLIMUS ANHYDROUS
TETANUS DIPHTHERIA TOXOIDS®
TETANUS TOXOID ADSORBED
TETANUS-DIPHTERIA-DECAVAC®
TOBI®
TRAVASOL WITH DEXTROSE®
TRAVASOL WITH ELECTROLYTES®
TRAVASOL®

TREXALL®
TROPHAMINE®
VENTAVIS®
XOPENEX®
ZOFRAN ODT®
ZOFRAN®

Covered Uses

This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

BYETTA

Affected Drugs

BYETTA®
VICTOZA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Weight loss treatment. Type 1 diabetes. Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

N/A

CIMZIA

Affected Drugs

CIMZIA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patients are excluded if they have an active infection or on are on concurrent biologic response modifier. Patient must also be assessed for the risk of hepatitis B and if appropriate, be tested.

Required Medical Information

Patient must demonstrate inadequate response to at least 1 conventional therapy for Crohn's disease (i. e. , prednisone, budesonide, sulfasalazine, azathioprine, mesalamine, infliximab or adalimumab).

Age Restrictions

Approve for those 18 years of age or older.

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

N/A

DIFFERIN

Affected Drugs

DIFFERIN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Cosmetic use.

Required Medical Information

N/A

Age Restrictions

Approve for those 12 years of age and older.

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

N/A

ENBREL

Affected Drugs

ENBREL®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D, reactive arthritis, inflammatory bowel disease arthritis.

Exclusion Criteria

Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patients are excluded if they have an active infection or on are on concurrent biologic response modifier. Patient must also be assessed for the risk of hepatitis B and if appropriate, be tested.

Required Medical Information

Rheumatoid Arthritis/Juvenil Rheumatoid Arthritis - patient tried at least 1 DMARD [Disease-modifying antirheumatic drug]. Psoriasis - patient must be a candidate for systemic therapy or phototherapy.

Age Restrictions

Psoriasis - Approve for those 18 years of age or older.

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

N/A

EPO

Affected Drugs

EPOGEN®
PROCRIPT®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

CRF [Chronic Renal Failure], Hepatitis C, elective surgery, HIV/zidovudine - transferrin saturation less than 20% and patient not receiving iron supplementation where clinically appropriate. CRF [Chronic Renal Failure], Hepatitis C, elective surgery, HIV/zidovudine, MDS [Myelodysplastic syndrome], and anemia in patients with non-myeloid malignancies - hemoglobin level of the patient (not the result of a recent blood transfusion) greater than 13 g/dL. Lack of initial diagnosis of anemia (hematocrit less than 30% and/or hemoglobin less than 10 g/dL and/or symptomatic with hemoglobin 10-11g/dL).

Required Medical Information

CRF [Chronic Renal Failure], Hepatitis C, elective surgery, HIV/zidovudine - iron status of the patient has been evaluated (serum transferrin saturation). CRF [Chronic Renal Failure], Hepatitis C, elective surgery, HIV/zidovudine, and anemia of cancer - Hemoglobin level of the patient be monitored prior to each dose when initiating therapy, for dose changes, and at regular intervals when the dose is stabilized. Hemoglobin level of the patient will be monitored prior to each dose when initiating therapy, for dose changes, and at regular intervals when the dose is stabilized. Blood pressure of the patient will be monitored throughout therapy. Patient will be monitored for the occurrence of thrombotic events.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Initiation of therapy and/or dose changes - 6 weeks. Stable on therapy - 12 weeks.

Other Criteria

Once on therapy, compared to pretreatment baseline, the patient must show an objective clinical response (e. g. , hemoglobin rise greater than 1 g/dL and/or hematocrit rise greater than 3%) to an appropriate dose/dose increase and duration of therapy.

GROWTH HORMONE

Affected Drugs

GENOTROPIN®
HUMATROPE®
NORDITROPIN NORDIFLEX®
NORDITROPIN®
NUTROPIN AQ®
NUTROPIN®
SAIZEN®
SEROSTIM®
TEV-TROPIN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Severe respiratory impairment or sleep apnea (Prader-Willi syndrome).

Required Medical Information

Growth hormone stimulation tests.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

6 months.

Other Criteria

N/A

HUMIRA

Affected Drugs

HUMIRA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Patients are excluded if they have an active infection or on are on concurrent biologic response modifier.

Required Medical Information

Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patient must also be assessed for the risk of hepatitis B and if appropriate, be tested.

Age Restrictions

Rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, Crohn's disease, plaque psoriasis - Approve for those 18 years of age or older.

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

RA [Rheumatoid Arthritis]/JIA [Juvenile Idiopathic Arthritis] - patient tried at least 1 DMARD [Disease-modifying antirheumatic drug]. Psoriasis - patient must be a candidate for systemic therapy or phototherapy. Crohn's disease - patient tried conventional therapy (corticosteroid, azathioprine, 6-mercaptopurine, methotrexate, certolizumab pegol) or Remicade.

INCRELEX

Affected Drugs

INCRELEX®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Closed epiphyses. Other secondary causes of growth failure. Pre-existing thyroid and/or nutritional deficits. Presence of active or suspected neoplasia.

Required Medical Information

Failure of a growth hormone stimulation test. Genetic testing for growth hormone gene deletion. Lab testing for neutralizing antibodies to growth hormone.

Age Restrictions

Approve for those 2 years of age or older.

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

Height of the patient greater than or equal to 3 standard deviations below the norm for children of the same age and gender prior to beginning Increlex therapy. Basal IGF-1 level greater than or equal to 3 standard deviations below the norm for children of the same age and gender prior to beginning Increlex therapy. Increase in height velocity of 2 cm/year within the first year of Increlex therapy.

INFERGEN

Affected Drugs

INFERGEN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Patient must have compensated liver disease with detectable levels of hepatitis C virus RNA in the serum.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 to 9 months depending on genotype and initial vs. renewal therapy.

Other Criteria

2-log decrease in viral load for renewals.

ITRACONAZOLE

Affected Drugs

ITRACONAZOLE
SPORANOX®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. Tinea corporis. Tinea cruris, faciei, manuum, imbricata, and pedis (nonmoccasin or chronic type). Plantar- or moccasin-type dry tinea pedis. Tinea or pityriasis versicolor. Tinea capitis. Tinea barbae. Treatment of vaginal candidiasis. Prevention of recurrent vulvovaginal or vaginal candidiasis. Treatment or prevention of other superficial, systemic or suspected fungal infections. Patient has been started and stabilized on IV itraconazole therapy or oral itraconazole for a systemic infection and it is being used as continuation therapy.

Exclusion Criteria

Candidiasis hypersensitivity syndrome. Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

LFTs, fungal diagnostic test (e. g. , KOH preparation, fungal culture, or nail biopsy).

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

1, 2, 3, or 6 months depending on the diagnosis (see duration in parentheses in covered uses).

Other Criteria

N/A

IVIG

Affected Drugs

CARIMUNE NF NANOFILTERED®
FLEBOGAMMA®
GAMMAGARD LIQUID®
GAMUNEX®
OCTAGAM®
POLYGAM S-D®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

HSCT - IVIG [Intravenous Immune Globulin] is to be used in patients that have developed severe hypogammaglobulinemia (IgG less than 400) within the first 100 days post transplant.

Age Restrictions

BMT [Bone Marrow Transplant] - patients have to be 20 years of age or older. HIV - patient has to be younger than 13 years of age.

Prescriber Restrictions

N/A

Coverage Duration

4 mos- CIDP, BMT [Bone Marrow Transplant], HSCT 6 months - ITP [Immune thrombocytopenic purpura], Kawasaki, Parvovirus B19 12 months - remaining covered uses.

Other Criteria

Kawasaki disease - IVIG [Intravenous Immune Globulin] is to be used in conjunction with high dose aspirin. BMT [Bone Marrow Transplant] - IVIG [Intravenous Immune Globulin] is to be used within the first 100 days after BMT [Bone Marrow Transplant]. Dermatomyositis - IVIG [Intravenous Immune Globulin] is to be used only if corticosteroid is not a therapeutic option. Hyperimmunoglobulinemia E syndrome - diagnosis has to be coincident with eczema and atopic dermatitis. RRMS - IVIG [Intravenous Immune Globulin] is to be used as 2nd line treatment.

KINERET

Affected Drugs

KINERET®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Active infection or concurrent use of a TNF [Tumor necrosis factor] blocking agent.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

Patient must demonstrate inadequate response or intolerance to at least 1 DMARD [Disease-modifying antirheumatic drug].

NEULASTA

Affected Drugs

NEULASTA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Neulasta treatment within the last 14 days. Treatment of acute afebrile neutropenia.

Required Medical Information

Current and periodic monitoring of WBC count at initiation of and during therapy.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

6 months.

Other Criteria

Neulasta administration will be delayed a minimum of 24 hours after the administration of cytotoxic chemotherapy.

NEUMEGA

Affected Drugs

NEUMEGA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Patient's renal function above or below 30 mL/min for dosage adjustment. Any cardiovascular/fluid comorbidities for monitoring of fluid status (if applicable).

Age Restrictions

Approved for those 18 years of age or older.

Prescriber Restrictions

N/A

Coverage Duration

3 months.

Other Criteria

Treatment not to exceed 21 days per treatment course. Treatment to be discontinued at least two days prior to starting next round of chemotherapy. Discontinue therapy when post-nadir platelet count (not the result of recent platelet transfusions) is greater than 50, 000/³L.

NEUTROPHIL

Affected Drugs

LEUKINE®
NEUPOGEN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D, bone marrow transplantation failure or engraftment delay. Neutropenia AIDS associated with treatment or disease, myelodysplastic syndromes, drug-induced neutropenia.

Exclusion Criteria

Treatment of acute afebrile neutropenia. Patients not at high risk for infection-associated complications or not having prognostic factors that are predictive of poor clinical outcomes.

Required Medical Information

Current and periodic monitoring of WBC count at initiation of and during therapy.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 months.

Other Criteria

Treatment to be halted in the event of excessive leukocytosis.

NUVIGIL

Affected Drugs

NUVIGIL®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. Fatigue associated with MS [Multiple Sclerosis]. Excessive daytime sleepiness (EDS) due to myotonic dystrophy. ADHD [Attention Deficit Hyperactive Disorder] and ADD [Attention Deficit Disorder] in patients less than 18 years. Adjunctive/augmentation for treatment of depression in adults. EDS [Excessive daytime sleepiness] in Parkinson's. Idiopathic hypersomnia. Cancer-related fatigue.

Exclusion Criteria

Alcoholic organic brain syndrome. Enhancement of performance in situations of induced sleep deprivation. Fibromyalgia. Chronic fatigue syndrome. EDS [Excessive daytime sleepiness] associated with primary insomnia. ADHD [Attention Deficit Hyperactive Disorder] in adults. Adjunctive therapy in the treatment of schizophrenia. Seasonal affective disorder. Post-stroke sleep-wake disorders or sleep disorders. Bipolar disorder, including bipolar depression. Hypersomnia, fatigue, or sleepiness due to other specific conditions or of unknown etiology. Fatigue and EDS [Excessive daytime sleepiness] in chronic traumatic brain injury. Fatigue in post-polio patients. Spasticity due to cerebral palsy. Coverage is not recommended for circumstances not listed in Covered Uses.

Required Medical Information

For the FDA-approved indication of obstructive sleep apnea/hypoapnea syndrome patients must have tried CPAP [Continuous positive airway pressure]. For the FDA-approved indication of excessive sleepiness due to shift-work sleep disorder, patients must be working at least 5 overnight shifts per month.

Age Restrictions

ADHD [Attention Deficit Hyperactive Disorder] or ADD [Attention Deficit Disorder] in patients less than 18 years. Adjunctive augmentation treatment for depression must be in adults.

Prescriber Restrictions

Idiopathic hypersomnia must have the diagnosis confirmed by a sleep specialist physician or at an institution that specializes in sleep disorders.

Coverage Duration

Authorization will be for 12 months.

Other Criteria

Excessive sleepiness due to OSAHS [Obstructive sleep apnea/hypoapnea syndrome] if the patient has tried CPAP [Continuous positive airway pressure]. Excessive sleepiness due to SWSD [Shift work sleep disorder] if the patient is working at least 5 overnight shifts per month. ADHD [Attention Deficit Hyperactive Disorder]/ADD [Attention Deficit Disorder] for patients less than 18 years who have tried two alternative medication for ADHD [Attention Deficit Hyperactive Disorder]/ADD [Attention Deficit Disorder] from two different classes as follows: methylphenidate products (e. g. , methylphenidate, dexamethylphenidate), amphetamines (e. g. , mixed amphetamine salts, dextroamphetamine), atomoxetine, bupropion or tricyclic antidepressants (TCAs e. g. , imipramine, desipramine). Adjunctive/augmentation treatment for depression in adults if the patient is concurrently receiving other medication therapy for depression. Idiopathic hypersomnia if the diagnosis is confirmed by a sleep specialist physician or at an institution that specializes in sleep disorders (i. e. , sleep center).

OCTREOTIDE

Affected Drugs

OCTREOTIDE ACETATE
SANDOSTATIN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

N/A

ORENCIA

Affected Drugs

ORENCIA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Patients are excluded if they are on concurrent biologic response modifier.

Required Medical Information

Patient must be evaluated for latent TB with a PPD test and be treated if positive.

Age Restrictions

Approved for those 6 years of age or older.

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

Patient must demonstrate inadequate response to at least 1 DMARD [Disease-modifying antirheumatic drug] or a TNF [Tumor necrosis factor] blocking agent.

OSTEOPOROSIS

Affected Drugs

FORTEO®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Paget's disease, unexplained elevation of alkaline phosphatase, open epiphyses, bone cancer or cancer that has metastasized to the bone, history of breast cancer, prior radiation therapy involving the skeleton, hypercalcemia, treatment with Forteo for greater than or equal to 24 months, concurrent bisphosphonate therapy during treatment with Forteo.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

For diagnosis of primary osteoporosis or hypogonadal osteoporosis patient must have at least one of the following: history of osteoporotic fractures, multiple risk factors for fractures, OR has failed or is intolerant to traditional osteoporosis therapy.

PEGASYS

Affected Drugs

PEGASYS®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

For chronic hepatitis C, patient must have compensated liver disease with detectable levels of HCV RNA in the serum. For chronic hepatitis B, patient must have a positive serum marker for HBV replication, persistently elevated aminotransferase levels greater than 2 times ULN, or signs of chronic hepatitis B on liver biopsy, or cirrhosis of the liver as evidenced by radiological or clinical data, or extrahepatic complications.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Chronic hepatitis C - 3 to 9 months. Chronic hepatitis B - 12 months.

Other Criteria

For chronic hepatitis C, patient must have 2-log decrease in viral load for renewals.

PEGINTRON

Affected Drugs

PEGINTRON REDIPEN®
PEGINTRON®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Patient must have compensated liver disease with detectable levels of hepatitis C virus RNA in the serum.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 to 9 months depending on genotype and initial vs. renewal therapy.

Other Criteria

2-log decrease in viral load for renewals.

PROVIGIL

Affected Drugs

PROVIGIL®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

If diagnosis is narcolepsy require polysomnography, if diagnosis of OSAHS [Obstructive sleep apnea/hypoapnea syndrome] require polysomnography and whether patient using CPAP [Continuous positive airway pressure].

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

N/A

REMICADE

Affected Drugs

REMICADE®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Patients are excluded if they have an active infection or moderate to severe CHF [Congestive Heart Failure].

Required Medical Information

Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patient must also be assessed for the risk of hepatitis B and if appropriate, be tested.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

RA [Rheumatoid Arthritis] - patient tried at least 1 DMARD [Disease-modifying antirheumatic drug]. Remicade is to be used in combination with methotrexate. Crohn's disease - patient tried at least 1 first-line agent (corticosteroid, azathioprine, 6-mercaptopurine, methotrexate, certolizumab pegol, or adalimumab) unless the patient has fistulizing Crohn's disease. Ulcerative colitis - patient tried at least 1 first-line agent such as oral or rectal 5-ASA products or glucocorticosteroids. Psoriasis - patient must be a candidate for systemic therapy or phototherapy.

REVATIO

Affected Drugs

REVATIO®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Concurrent nitrate therapy. PAH [Pulmonary Arterial Hypertension] associated with any of the following: left heart disease, chronic thrombotic disease, embolic disease, compression of pulmonary vessels, lung diseases, hypoxemia, sarcoidosis.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

N/A

REVLIMID

Affected Drugs

REVLIMID®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Pregnancy.

Required Medical Information

If female of child bearing potential, pregnancy excluded by 2 negative urine or serum pregnancy tests. For MM requirement of combination therapy with dexamethasone and at least one prior MM treatment. For MDS [Myelodysplastic syndrome]: diagnosis of anemia due to Low- or Intermediate-1-risk MDS [Myelodysplastic syndrome] associated with a deletion 5q cytogenetic abnormality, transfusion dependent.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

Instruction regarding importance and proper utilization of appropriate contraceptive methods. Monitor CBC on regular basis.

RIBAVIRIN

Affected Drugs

COPEGUS®
REBETOL®
RIBAPAK
RIBASPHERE
RIBAVIRIN

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

History of unstable heart disease, hemoglobin less than 8.5, creatinine clearance less than 50, pregnancy, hemoglobinopathy.

Required Medical Information

Patient must have detectable levels of HCV RNA in the serum and be on an alfa interferon product concurrently.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

4 to 8 months, depending on genotype and initial vs. renewal therapy.

Other Criteria

2-log decrease in viral load for renewals.

SAMSCA

Affected Drugs

SAMSCA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D plus patients already started on tolvaptan for the treatment of hyponatremia.

Exclusion Criteria

Patients requiring intervention to raise serum sodium urgently to prevent or to treat serious neurological symptoms. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria.

Required Medical Information

Serum sodium less than 125 mEq/L at baseline or less marked hyponatremia, defined as serum sodium less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion).

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months.

Other Criteria

For the treatment of clinically significant hypervolemic and euvolemic hyponatremia with serum sodium less than 125 mEq/L at baseline or less marked hyponatremia, defined as less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion).

SANDOSTATIN LAR

Affected Drugs

SANDOSTATIN LAR®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Patient had prior therapy with sandostatin injection (not depot form) and treatment was effective and tolerated.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

N/A

SEROSTIM

Affected Drugs

SEROSTIM®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Weight loss less than 10% of body weight. Other causes of weight loss such as inadequate nutritional intake, malabsorption, opportunistic infections, or hypogonadism.

Required Medical Information

BMI, patient weight.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 weeks.

Other Criteria

Continuation of prescribed HIV (anti-viral) therapy.

SIMPONI

Affected Drugs

SIMPONI®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

Simponi should not be given in combination with a TNF? antagonist (e. g. , adalimumab, certolizumab pegol, etanercept, infliximab), with anakinra, with rituximab, or with abatacept. Plaque psoriasis without psoriatic arthritis. Asthma. Ulcerative colitis. Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

Adults.

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

"Adults with rheumatoid arthritis (RA), approve if the patient has tried one disease-modifying antirheumatic drug [DMARD] (brand or generic, oral or injectable) for at least 2 months, [this includes patients who have tried other biologic DMARDs [Disease-modifying antirheumatic drugs] for at least 2 months] AND the patient will be receiving methotrexate (MTX) in combination with Simponi. Adult RA [Rheumatoid Arthritis] patients are not required to use MTX [methotrexate] concurrently with Simponi if there are contraindications to MTX [methotrexate] or the patient has a history of intolerance to MTX [methotrexate].

SOMATULINE DEPOT

Affected Drugs

SOMATULINE DEPOT®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

Either surgery and/or radiotherapy is not a therapeutic option for the patient or the patient has had inadequate response to surgery and/or radiotherapy.

SOMAVERT

Affected Drugs

SOMAVERT®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Monitor IGF-1 levels at 6 month intervals after IGF-1 levels stabilize within normal range. Monitor LFTs as recommended during therapy.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

Prior to initiation of therapy IGF-1 levels were above age and gender adjusted normal range. If patient has been on therapy for the past 6 months demonstration of significant decrease in IGF-1 levels required. Patients were considered for/received treatment with surgery, radiation therapy, or medical treatment for acromegaly but rejected as inappropriate or had inadequate response.

STELARA

Affected Drugs

STELARA®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on ustekimumab.

Exclusion Criteria

Ustekinumab should not be given in combination with a tumor necrosis factor (TNF) antagonist (eg, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), with anakinra, or with alefacept. Use in children or adolescents aged 18 years or less. Use in the management of psoriatic arthritis without plaque psoriasis. Use in the management of Crohn's disease, or multiple sclerosis. Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

Adults.

Prescriber Restrictions

Plaque psoriasis. Prescribed by a dermatologist or in consultation with a dermatologist.

Coverage Duration

Authorization will be for 12 months.

Other Criteria

Plaque psoriasis in adults. Patient has a minimum body surface area (BSA) of 5% or more, exceptions allowed for patients with less than 5% BSA [Body surface area] if they have plaque psoriasis of palms, soles, head and neck, nails, intertriginous areas or genitalia. Patient has a minimum body surface area (BSA) of 5% or more, exceptions allowed for patients with less than 5% BSA [Body surface area] if they have had an inadequate response to a 3-month trial of either topical therapy OR localized phototherapy (with ultraviolet B [UVB] or oral methoxsalen plus UVA light [PUVA]), and had an inadequate response to a 3-month trial of systemic therapy (with one of the following - MTX [methotrexate], cyclosporine, or acritretin (Soriatane)) or has contraindications to all of these, and has tried a TNF [Tumor necrosis factor] antagonist

(adalimumab, etanercept, infliximab), and has significant disability or impairment in physical or mental functioning according to the treating physician. patient has tried a systemic therapy or phototherapy for 3 months with one of the following - MTX [methotrexate], cyclosporine, or acitretin (Soriatane), or phototherapy with UVB or PUVA for psoriasis. Rarely, a patient may have contraindications to nearly all of these other therapies and exceptions can be made on a case-by-case basis. patient has tried adalimumab, etanercept, or infliximab for plaque psoriasis.

STEROIDS, ANABOLIC

Affected Drugs

OXANDRIN®
OXANDROLONE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Coverage of Oxandrin AND oxandrolone is not recommended in the following circumstances: Management of weight gain, other than detailed in the FDA-approved indications or other covered uses. Management of weight loss. HIV-associated lipodystrophy. Chronkhite-Canada Syndrome. Heart failure in patients with idiopathic dilated cardiomyopathy (IDC), mitral regurgitation, or aortic regurgitation. Athletic performance (ability) enhancement. Anemia of chronic kidney disease. Coverage is not recommended for circumstances not listed in the Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

6 months.

Other Criteria

N/A

SYMLIN

Affected Drugs

SYMLINPEN 120®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D worded as patient has type 1 or 2 diabetes mellitus.

Exclusion Criteria

Weight loss treatment. Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

N/A

TERBINAFINE

Affected Drugs

LAMISIL®
TERBINAFINE HCL

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

LFTs, fungal diagnostic test (e. g. , KOH preparation, positive fungal culture, or nail biopsy).

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

2 months for fingernails only, 3 months if toenail involvement.

Other Criteria

N/A

TESTOSTERONES

Affected Drugs

ANDRODERM®
ANDROGEL®
STRIANT®
TESTIM®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Female, prostate cancer, breast cancer.

Required Medical Information

Before the start of testosterone therapy patient has (or patient currently has) a confirmed low testosterone level (i. e. total testosterone less than 300 ng/dL, free or bioavailable, testosterone less than 5 ng/dL) or absence of endogenous testosterone.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

N/A

THALOMID

Affected Drugs

THALOMID®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Pregnancy.

Required Medical Information

If female of child bearing potential, pregnancy excluded by 2 negative urine or serum pregnancy tests. For MM requirement of combination therapy with dexamethasone. For ENL if have moderate to severe neuritis Thalomid can not be used as monotherapy.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

Instruction regarding importance and proper utilization of appropriate contraceptive methods.

TOPAMAX/ZONEGRAN

Affected Drugs

TOPIRAMATE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Weight loss treatment except if patient is being treated for seizures, bipolar disorder, migraine prevention, bulimia nervosa, binge-eating disorder, etc with topiramate or zonisamide (exceptions are not recommended for patients with seizures, bipolar disorder, migraine headache, bulimia nervosa, binge-eating disorder, etc who are using topiramate or zonisamide only for weight loss OR for patients who are using topiramate or zonisamide to prevent weight gain or produce weight loss caused by other medications such as antipsychotics [eg, clozapine, olanzapine, quetiapine, risperidone, thioridazine] or antidepressants). Smoking cessation therapy (exceptions are not recommended for patients with psychiatric conditions who are using topiramate or zonisamide only for smoking cessation OR patients who have successfully stopped smoking and are using topiramate or zonisamide to prevent relapse). Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

N/A

TOPICAL-ULCERS

Affected Drugs

REGRANEX®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Neoplasm at intended site of application, active wound infection not under control by way of active treatment.

Required Medical Information

Ulcer size after 10 weeks of therapy, does ulcer have adequate blood supply, ulcer extending into subcutaneous tissue or beyond.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 months, then additional 2 months upon renewal.

Other Criteria

N/A

XENAZINE

Affected Drugs

XENAZINE®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Actively suicidal, untreated or inadequately treated depression, impaired hepatic function, current use of monoamine oxidase inhibitors or reserpine.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 months.

Other Criteria

In patients who are taking reserpine, at least 20 days should elapse after stopping reserpine before initiation of Xenazine therapy.

ZORBTIVE

Affected Drugs

ZORBTIVE®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Recently diagnosed or recurrent active neoplasia.

Required Medical Information

Tracking of patient weight for continuation/reapproval of therapy.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

4 weeks.

Other Criteria

Patient is currently receiving and will continue to receive any one or a combination of the following specialized nutritional support: high complex-carbohydrate, low-fat diet, TPN, IPN, PPN, rehydration solutions, electrolyte replacement.

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