PRIOR AUTHORIZATION CRITERIA – PUP Select Formulary

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
Adcirca	All FDA-approved indications not otherwise excluded from Part D.	Patients using organic nitrates.	**Pulmonary Arterial Hypertension**: Patients with a confirmed diagnosis of pulmonary arterial hypertension (modified WHO Group I) which is symptomatic.			12 months	
Afinitor	All FDA-approved indications not otherwise excluded from Part D.		**Renal Cell Cancer** 1. Diagnosis of advanced renal cell cancer			1 year	Failure of treatment with sunitinib or sorafenib. Afinitor will be approved for continuation of prior therapy.
Alimta	All FDA-approved indications not otherwise excluded from Part D.		**Non-Small Cell Lung Cancer:** 1. Confirmed diagnosis of locally advanced or metastatic NSCLC; AND 2. One of the following: a. Prior history of first-line chemotherapy treatment for NSCLC. b. Used in combination with cisplatin or carboplatin. c. Tumor response or stable disease after 4 cycles of first-line platinum-based chemotherapy. d. Used as first-line monotherapy in patients 70 years of age or greater. e. Used as first-line monotherapy in patients less than 70 and not eligible for platinum-			1 year	Alimta will be approved for continuation of prior therapy.

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			based chemotherapy (eg, poor performance status or comorbidities).				
Alpha-1 Proteinase Inhibitors: Aralast NP, Glassia, Prolastin Prolastin-C Zemaira	All FDA-approved indications not otherwise excluded from Part D.		**Alpha-1 Antitrypsin (ATT) Deficiency:** 1. Diagnosis of congenital ATT deficiency 2. Serum ATT level ≤ 11 μM /L, or ≤ 80 mg/dL 3. Clinical demonstration of emphysema	18 years and older		1 year	
Ampyra	All FDA approved indications not otherwise excluded from Part D		**Initial Therapy for Multiple Sclerosis:** 1. Diagnosis of multiple sclerosis. 2. Physician confirmation that patient has difficulty walking. **Reauthorization for Multiple Sclerosis:** Physician confirmation that the patient's walking improved with Ampyra therapy.			**Initial Therapy:** 3 months. **Re-authorization:** 1 year.	
Anadrol-50	All FDA approved indications not otherwise excluded from Part D		**Acquired Aplastic Anemia**: 1. History of failure; OR 2. Used in combination with, antilymphocyte globulin or both antilymphocyte globulin and corticosteroid treatment. **Hypoplastic Anemia:** 1. Diagnosis of hypoplastic anemia due to myelotoxic drugs; AND 2. Failure to an erythropoietic stimulating agent. **Pure Red Cell Aplasia**: 1. Diagnosis of pure red cell aplasia. 2. Failure to immunosuppressive therapy. **Chronic Renal Failure:** 1. Diagnosis of chronic renal failure. 2. Failure to an erythropoietic stimulating agent.			12 months	

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Apokyn	All FDA approved indications not otherwise excluded from Part D	Use in combination with 5-HT3 antagonists.	**Advanced Parkinson's Disease:** 1. Confirmed diagnosis of advanced Parkinson's disease; AND 2. Unable to control "off" symptoms with adequate combinations of conventional oral therapy (eg, Comtan, Mirapex, Requip, Sinemet, Stalevo, Symmetrel, Tasmar); AND 3. Used in combination with a non-5-HT3 antagonist antiemetic for initial therapy			1 year	Apokyn will only be approved for intermittent subcutaneous injection.
Aranesp	All FDA approved indications not otherwise excluded from Part D. Refractory anemia in Myelodys-plastic Syndrome.	**Anemia Due to Chronic Renal Failure:** Patient is on dialysis (covered under Part B). **Anemia in cancer patients on chemotherap y:** Patient is not receiving cancer chemotherapy or patient has malignancy for which therapy with Aranesp is contraindicate d. **Other off-label requests:** Hgb greater than 10 gm/dL or Hct greater than 30%	**Initial Therapy for Chronic Renal Failure:** 1. Chronic Renal Failure not on dialysis; AND 2. Hct < 33% OR Hgb < 11 gm/dl (Hgb/Hct levels must be collected within prior 30 days of request); AND 3. Verification of iron evaluation for adequate iron stores. **Reauthorization for Chronic Renal Failure:** 1. Chronic Renal Failure not on dialysis; AND 2. Verification that average Hct was below 36% over a 3-month period; AND 3. Verification of iron evaluation for adequate iron stores; AND 4. One of the following: a. Hgb/Hct reached target range (Hgb 10 to 12 g/dL or Hct 30% to 36%); OR b. Decrease in blood transfusion; OR c. Hgb is ≥ 1 g/dL from pre-treatment level. **Initial Therapy for Chemotherapy:** 1. Verification that other causes of anemia have been ruled out; AND 2. Verification of anemia with one of the following (Hgb/Hct levels collected within prior two weeks of request): a. Hct < 30%; OR b. Hgb < 10 gm/dl; 3. Verification of iron evaluation for adequate iron stores 4. Verification that the cancer is a non-myeloid malignancy. 5. AND one of the following:	.		**Initial Therapy:** Three months for chemotherapy and MDS. Six months for CRF. **Reauthorization:** 12 months for CRF and MDS	Aranesp is subject to Part B vs. Part D review.

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			a. Verification that the patient is concurrently on chemotherapy; OR b. Will be on concomitant chemotherapy for 2 months; OR c. The anemia is caused by cancer chemotherapy. **Reauthorization for Chemotherapy:** 1. Hct < 30% OR Hgb < 10 gm/dl; AND 2. Hgb/Hct reached target range (Hgb 10 to 12 g/dL or Hct 30% to 36%); AND 3. One of the following: a. Decrease in blood transfusion; OR b. Hgb is 1 g/dL; OR c. greater from pre-treatment level. 4. One of the following: a. Verification that the patient is concurrently on chemotherapy; OR b. Will be on concomitant chemotherapy for 2 months; OR c. The anemia is caused by cancer chemotherapy. **Initial Therapy for Myelodysplastic Syndrome:** 1. Hct < 33%; OR Hgb < 11 g/dL (Hgb/Hct levels must be collected within prior 30 days of request); AND 2. One of the following: a. Serum erythropoietin of ≤ 500 mU/mL; OR b. Diagnosis of transfusion-dependent MDS. 3. Verification of adequate iron stores. **Reauthorization of Myelodysplastic Syndrome:** 1. Verification that average Hct was below 36% over a 3 month period; AND 2. One of the following: a. Hgb/Hct reached target range (Hgb 10 to 12 g/dL or Hct 30% to 36%); OR b. Decrease in blood transfusion; OR c. Hgb increase ≥ 1 g/dL from pre-treatment level.				
Arcalyst	All FDA			12 years		1 year	

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	approved indications not otherwise excluded from Part D			and older			
Arzerra	All FDA approved indications not otherwise excluded from Part D		**Chronic lymphocytic leukemia:** 1. Confirmed diagnosis of chronic lymphocytic leukemia (CLL). 2. Relapsed or refractory to two prior CLL regimens containing one or more of the following agents: Campath, Treanda, Leukeran, Cytoxan, Fludara, Nipent, or Rituxan.			24 weeks	Prior authorization applies to new starts only
Avastin	All FDA approved indications not otherwise excluded from Part D. Macular Edema.	**NSCLC**: 1. Squamous cell histology. 2. History of hemoptysis. 3. Performance status is not 0 to 1.	**Colorectal Cancer:** 1. Diagnosis of metastatic colorectal cancer; AND 2. Used in combination with: a. 5-FU; OR b. oxaliplatin plus capecitabine; OR c. capecitabine. **Non-Small Cell Lung Cancer:** 1. Diagnosis of unresectable locally advanced recurrent or metastatic NSCLC; AND 2. Used in combination with paclitaxel and carboplatin. **Renal Cell Cancer**: 1. Diagnosis of metastatic renal cell cancer; AND 2. Used in combination with interferon-alpha **Breast Cancer:** 1. Diagnosis of metastatic breast cancer; AND 2. Used in combination with paclitaxel. **Age-Related Macular Degeneration::** 1. Diagnosis of age-related macular degeneration **Macular Edema:** 1. Diagnosis of macular edema following retinal vein occlusion.		**ARMD, Macular Edema**: Prescribed or recommended by ophthal-mologist	**Colorectal Cancer, RCC, Breast Cancer, ARMD, Macular Edema, Glioblastoma:** 12 months **NSCLC:** 6 months	Avastin will be approved for continuation of prior therapy.

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			Glioblastoma: 1. Relapsed, refractory, or disease progression on one of the following: radiation therapy, temozolomide, nitrosurea, combination PCV, or platinum-based regimen.				
Cellcept Intravenous	All FDA approved indications not otherwise excluded from Part D		**Transplant** 1. Patient received a renal (kidney), cardiac (heart), or hepatic (liver) transplant; AND 2. Patient is unable to take oral formulations of mycophenolate. **Lupus Nephritis:** 1, Diagnosis of lupus nephritis; AND 2. Failure to combination therapy with corticosteroids and cyclophosphamide. 3. Patient is unable to take oral formulations of mycophenolate.			12 months	Cellcept is subject to Part B vs. Part D review (not limited to new starts only). Cellcept will be approved for continuation of prior therapy if Part D.
Cellcept oral	All FDA approved indications not otherwise excluded from Part D Bone marrow/stem cell transplant. Lupus nephritis. Obliterative bronchiolitis.		**Transplant:** 1. Patient received a renal (kidney), cardiac (heart), or hepatic (liver) transplant. 2. Patient received a bone marrow/stem cell transplant. **Lupus Nephritis:** 1. Diagnosis of lupus nephritis; AND 2. Failure to combination therapy with corticosteroids and cyclophosphamide. **Obliterative Bronchiolitis:** Diagnosis of obliterative bronchiolitis following lung transplantation.			12 months	Cellcept is subject to Part B vs. Part D review (not limited to new starts only). Cellcept will be approved for continuation of prior therapy if Part D.

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Cerezyme	All FDA approved indications not otherwise excluded from Part D					12 months	
Chorionic Gonadotropin, Novarel, Pregnyl	All FDA approved indications not otherwise excluded from Part D	Used to promote fertility.	**Prepubertal Cryptorchidism:** Diagnosis of prepubertal cryptorchidism not due to anatomical obstruction. **Male Hypogonadotropic Hypogonadism:** For the treatment of selected cases of hypogonadotropic hypogonadism secondary to pituitary deficiency, verified by low testosterone and low LF or FH, in males.			6 months	
Cimzia	All FDA approved indications not otherwise excluded from Part D		**Moderate to severe Crohn's disease: Initial Therapy:** 1 Failure to one of the following therapies supported by the American College of Gastroenterology Crohn's disease practice guideline: aminosalicylates, azathioprine, corticosteroids, methotrexate, or 6-mercaptopurine.; AND 2. Verification that patient has been evaluated for tuberculosis and treated accordingly. **Reauthorization:** Demonstrated remission or significant clinical response to Cimzia therapy. **RA (initial therapy):** 1. Diagnosis of moderately to severely active RA. 2. Failed MTX or 2 DMARDs 3. Verification that the patient has been evaluated for tuberculosis and treated accordingly.	18 years and older	**CD:** Prescribed or recommended by gastro-enterologist **RA:** Prescribed or recommended by a rheumatologist.	**CD Initial Therapy:** 2 months **CD Reauthorization**: 12 months **RA**: 12 months	**CD:** 400 mg initially and at weeks 2 and 4, followed by 400 mg every 4 weeks. **RA:** 400 mg initially and at weeks 2 and 4, followed by 200 mg every other week or 400 mg every 4 weeks.

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			Reauthorization: Submission of chart documentation demonstrating a positive clinical response.				
Cinryze	All FDA approved indications not otherwise excluded from Part D		**Hereditary Angioedema** 1. For the long term prevention of Hereditary Angioedema (HAE) attacks; AND 2. One of the following: a. Failure to danazol; OR b. Failure to one alkylated androgen		Prescribed by an immunologist, allergist, or rheumatologist	12 months	
Degarelix	All FDA-approved indications not otherwise excluded from Part D.		**Prostate Cancer:** For palliative treatment of advanced prostate cancer and failure to one formulary GnRH agonist product.			12 months	Approve for continuation of prior therapy.
Egrifta	All FDA-approved indications not otherwise excluded from Part D.		**Initial Therapy for HIV-associated Lipodystrophy:** 1. Waist-circumference ≥ 95 cm (37.4 inches) in men or ≥ 94 cm (37 inches) for women; AND 2. Waist-to-hip ratio ≥ 0.94 for men or ≥ 0.88 for women; AND 3. Body mass index (BMI) > 20 kg/m2; AND 4. Fasting blood glucose (FBG) levels ≤ 150 mg/dL (8.33 mmol/L); AND 5. Patient has been on a stable regimen of antiretrovirals (eg, NRTIs, NNRTI, Protease Inhibitors, Integrase Inhibitors) for at least 8 weeks. **Reauthorization for HIV-associated Lipodystrophy:** Documentation of clinical improvement (eg, improvement in VAT, decrease in waist circumference, belly appearance).			6 months	

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Emend	All FDA-approved indications not otherwise excluded from Part D.		**Acute Chemotherapy-Induced Nausea and Vomiting:** 1. Patient is currently receiving moderately or highly emetogenic chemotherapy; AND 2. Patient is concurrently on both a corticosteroid and a 5-HT3 receptor antagonist. **Delayed Chemotherapy-Induced Nausea and Vomiting:** 1. Patient is currently receiving highly emetogenic chemotherapy and a steroid; OR 2. Patient is on an anthracycline and cyclophosphamide. **Prevention of Postoperative Nausea and Vomiting:** For the prevention of postoperative nausea and vomiting when administered prior to the induction of anesthesia.			**Acute CINV, Delayed CINV, PONV**: 6 months	Emend is subject to Part B vs. Part D review.
Enbrel, Enbrel Sureclick	All FDA-approved indications not otherwise excluded from Part D.		**Rheumatoid Arthritis (RA):** 1. Diagnosis of moderate-to-severe RA; AND 2. Failed methotrexate or 2 DMARDs for 3 months. **Juvenile Idiopathic Arthritis (JIA):** 1. Diagnosis of moderate-to-severe poly-articular course JIA; AND 2. Failed NSAID or steroid and methotrexate for three months **Psoriatic Arthritis (PsA)**: 1. Diagnosis of active PsA. 2. Failed methotrexate or 2 DMARDs for 3 months. **Ankylosing Spondylitis (AS)**: 1. Diagnosis of AS. 2. Failed 2 NSAIDs for 3 months. **Plaque Psoriasis (PPs):**	**RA, PsA, AS, PPs:** ≥ 18 years **JIA:** ≥ 2 years	**Initial Therapy for RA, JIA, AS:** Prescribed or recommend-ed by a rheumatolo-gist. **Initial Therapy for PsA:** Prescribed or recommend-ed by a rheumatolo-gist or dermatologist. **Initial Therapy for**	**Initial Therapy:** 3 months for plaque psoriasis; 12 months for other uses **Reauthorization:** 12 months for all uses	All diagnoses require verification that the patient has been evaluated for tuberculosis and has been treated accordingly Reauthoriza-tion of Enbrel for PPs requires a dosage of 50 mg or less per week or less.

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			1. Diagnosis moderate-to-severe chronic (greater than 6 months) plaque psoriasis. 2. Failed systemic therapy with one of the following: methotrexate, cyclosporine, acitretin, hydroxyurea, sulfasalazine, 6-thioguanine, or mycophenolate. **Reauthorization**: Demonstration of clinical response to therapy.		**PPs:** Prescribed or recommend-ed by a dermatologist.		
Epogen, Procrit	All FDA-approved indications not otherwise excluded from Part D.	**Anemia in cancer patients on chemo-therapy:** Patient is not receiving cancer chemo-therapy; OR Patient has malignancy for which therapy with epoetin is contra-indicated. **Chronic Renal Failure:** Patient is on dialysis (covered under Part B). **Other off-label requests:** Hgb greater than 10 gm/dL or Hct greater than 30%	**Anemia due to Chronic Renal Failure**: 1. Chronic Renal Failure not on dialysis; AND 2. Hematocrit (Hct) less than 33% or hemoglobin (Hgb) less than 11 gm/dl (Hgb/Hct levels must be collected within prior 30 days of request). **Reauthorization of CRF**: 1. Chronic Renal Failure not on dialysis; AND 2. Average Hct was below 36% over 3-months: AND 3. One of the following: a. Hgb/Hct reached target (Hgb 10-12 g/dL, Hct 30% to 36%); OR b. Decrease in blood transfusion; OR c. Hgb is 1 g/dL or greater from pre-treatment level. **Anemia in HIV-infected patients**: 1. Anemia is due to zidovudine treatment or due to HIV infection; AND 2. Hgb less than 12 g/dL or Hct less than 36% (Hgb/Hct levels must be collected within prior 30 days of request). **Reauthorization in HIV:** 1, Hct was below 36% over 3 months; AND 2. One of the following: a. Hgb/Hct reached target (Hgb 10-12 g/dL, Hct 30% to 36%); OR b. Decrease in blood transfusion; OR c. Hgb is 1 g/dL or greater from pre-treatment level. **Anemia in cancer patients on Chemotherapy:**			**Initial Therapy Pre-Op**: 1 month **Chemo, HCV, and MDS**: 3 months. **CRF, HIV:** 6 months **Reauthorization CRF, HIV**: 6 months **HCV:** 3 months. **Other uses:** 12 months	Epoetin will be subject to Part B vs. Part D review.

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			1. Verify other causes of anemia have been ruled out; AND 2. Hct less than 30% or Hgb less than 10 gm/dl (Hgb/Hct levels must be collected within prior two weeks of request); AND 3. Cancer is a non-myeloid malignancy; AND 4. Concurrently on chemo, will be on concomitant chemo for 2 months OR anemia is caused by cancer chemotherapy. **Reauthorization in Chemo**: 1. Hct less than 30% or Hgb less than 10 gm/dl; AND 2. One of the following; AND: a. Hgb/Hct reached target (Hgb 10-12 g/dL, Hct 30% to 36%); OR b. Decrease in blood transfusion c. Hgb is 1 g/dL or greater from pre-treatment level. 3. Concurrently on chemotherapy for 2 months or anemia is caused by cancer chemo. **Preoperative use in patients undergoing surgery for reduction of allogeneic blood transfusion (Pre-op):** 1. Hgb greater than 10 to less than 13 g/dL scheduled to undergo elective, non-cardiac/vascular surgery to reduce blood transfusions; OR 2. Patient at high risk for perioperative transfusions with expected blood loss of 2 units or greater. **Refractory anemia in Myelodysplastic Syndrome:** 1. Hct less than 33% or Hgb less than 11 g/dL (Hgb/Hct levels must be collected within prior 30 days of request); AND 2. One of the following: a. Serum erythropoietin of 500 mU/mL or less b. Diagnosis of transfusion-dependent MDS. **Reauthorization for MDS**: 1. Average Hct was below 36% or Hgb below 12				

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			g/dL over 3 months; AND 2. One of the following: a. Hgb/Hct reached target (Hgb 10-12 g/dL, Hct 30% to 36%) b. Decrease in blood transfusion c. Hgb increase of 1 g/dL or more from pre-treatment level. **Treatment of anemia in HCV-infected patients due to ribavirin in combination with interferon or peg-interferon**: 1. Hgb less than 11 g/dL or Hct less than 33% (Hgb/Hct levels must be collected within prior 30 days of request); AND 2. Is concurrently on ribavirin and interferon or peg-interferon alfa for the treatment of HCV and the anemia is due to treatment. **Reauthorization of HCV**: 1. Average Hct was below 36% over a 3 months; And 2. One of the following: a. Hgb/Hct reached target (Hgb 10-12 g/dL, Hct 30% to 36%) b. Decrease in blood transfusion c. Hgb is 1 g/dL or greater from pre-treatment level. **All uses:** Verify iron evaluation for adequate Fe stores.				
Erbitux	All FDA-approved indications not otherwise excluded from Part D. NSCLC.		**Head and Neck Cancer**: 1. One of the following: a. Confirmed diagnosis of locally or regionally advanced squamous cell carcinoma of the head and neck b. Recurrent or metastatic squamous cell head and neck cancer; AND 2. One of the following: a. Used in combination with radiation therapy b. After failure of platinum-based chemotherapy. **Colorectal Cancer**:	**NSCLC:** 18 years and older		6 months	Erbitux will be approved for continuation of prior therapy.

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			1. Confirmed diagnosis of metastatic carcinoma of the colon or rectum; AND 2. One of the following: a. Used in combination with irinotecan-based chemotherapy b. Intolerance to irinotecan-based chemotherapy c. Failure of irinotecan or oxaliplatin-based chemotherapy regimens; AND 3. Tumor expresses wild-type KRAS gene. **NSCLC:** 1. Confirmed diagnosis of recurrent or metastatic NSCLC stage IIIB or IV 2. Used in combination with vinorelbine and cisplatin 3. ECOG performance status 0 to 2. 4. EGFR expression by immunohistochemistry (greater than or equal to 1 tumor cell) 5. No known brain metastases 6. No prior chemotherapy or anti-EGFR therapy				
Actiq, Fentanyl citrate oral trans-mucosal, Fentora, Onsolis	All FDA-approved indications not otherwise excluded from Part D.		**Cancer Pain:** 1. Confirmed diagnosis of malignant pain; AND 2. Demonstrated tolerance to opioids.			12 months	
Abstral	All FDA-approved indications not otherwise excluded from Part D.		**Cancer Pain:** 1. Confirmed diagnosis of malignant pain; AND 2. Demonstrated tolerance to opioids; AND 3. Failure to generic fentanyl.			12 months	
Forteo	All FDA-approved indications not otherwise excluded from Part D.		**Postmenopausal Osteoporosis:** BMD T score of -3.0 or less and a previous fracture resulting from minimal trauma, or both of the following: 1. Patient has a history of fracture resulting from minimal trauma or BMD T score of -2.5 or less; AND 2. One of the following: a. Failure to one oral bisphosphonate			12 months (maximum 2 years of therapy)	Forteo is subject to Part B vs. Part D review.

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			b. Failure, contraindication, intolerance to one injectable bisphosphonate c. Contraindication or intolerance to one oral bisphosphonate and failure to one injectable bisphosphonate. **Hypogonadal Osteoporosis:** BMD T score of -3.0 or less and a previous fracture resulting from minimal trauma, or both of the following: 1. Patient has a history of fracture resulting from minimal trauma or BMD T score of -2.5 or less; AND 2. Failure to a formulary bisphosphonate. **Glucocorticoid-Induced Osteoporosis:** BMD T score of -3.0 or less and a previous fracture resulting from minimal trauma, or both of the following: 1. Patient has a history of fracture resulting from minimal trauma or BMD T score of -1.5 or less; AND 2. Failure to a formulary bisphosphonate.				
Gamastan S/D	All FDA approved indications not otherwise excluded from Part D		**Hepatitis A:** For use before or soon after exposure. **Measles:** For use in susceptible individuals exposed fewer than 6 days previously. **Varicella:** For use in immunocompromised patients. **Rubella:** For pregnant women who will not consider a therapeutic abortion.			12 months	
Gilenya	All FDA approved indications not otherwise excluded from		**Multiple Sclerosis:** Patients with relapsing forms of multiple sclerosis.			12 months	

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	Part D						
Gleevec	All FDA approved indications not otherwise excluded from Part D		**Chronic Myeloid Leukemia (Adults):** Diagnosis of Philadelphia chromosome positive CML. **Chronic Myeloid Leukemia (Children):** Diagnosis of Philadelphia chromosome positive (Ph+) chronic phase CML. **Acute Lymphoblastic Leukemia:** Adult patients with Philadelphia chromosome positive ALL. **Myelodysplastic/Myeloproliferative disease:** Adults diagnosed with MDS/MPD diseases associated with platelet-derived growth factor receptor gene rearrangements. **Aggressive systemic mastocytosis:** 1. Adults diagnosed with aggressive systemic mastocytosis; AND 2. One of the following: a. Patient is without the D816V c-Kit mutation b. c-Kit mutation status unknown. **Hypereosinophilic syndrome and chronic eosinophilic leukemia :** Adults diagnosed with HES or CEL. **Dermatofibrosarcoma protuberans:** Adults with unresectable, recurrent and/or metastatic DFSP. **Gastrointestinal Stromal Tumors**: Patients with a confirmed diagnosis of unresectable and/or metastatic GIST, or diagnosis of primary GIST and history of complete gross resection of Kit (CD 117) positive GIST. **Desmoid Tumors:** Diagnosis of unresectable, metastatic, or recurrent desmoid tumor.			12 months	Gleevec will be approved for continuation of prior therapy.

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Growth Hormones: Genotropin, Genotropin Miniquick, Humatrope, Humatrope Combo Pack, Norditropin Cartridge, Norditropin Nordiflex Pen, Nutropin, Nutropin Aq, Nutropin Aq Pen, Omnitrope, Saizen, Saizen Click Easy, Tev-Tropin	All FDA approved indications not otherwise excluded from Part D: Growth Hormone Deficiency (GHD) in Children Prader-Willi Syndrome (PWS) Small for Gestational Age (SGA) Turner Syndrome (TS) Noonan Syndrome (NS) Growth Retardation associated with Chronic Renal Insufficiency (GRCRF) Idiopathic Short Stature (ISS) Adult Onset Growth	**Chidhood Onset Growth Hormone Deficiency in Adults**: 1. Males with bone age greater than 17 yrs or females with bone age greater than 15 years 2. Closed bone epi-physes on radio-graph 3. Growth velocity less than 2 cm/year during previous year of treatment unless COGHD criteria are met.	**GHD Children:** 1. Diagnosis of GH deficiency based on two GH stimulation tests or low Insulin-like growth factor 1 (IGF-1) levels; AND 2. Demonstrate growth failure based on growth velocity or height shorter than 2 standard deviations (SD) below the mean height for age. **Prader-Willi Syndrome or Small for Gestational Age**: 1. Diagnosis of PWS confirmed by genetic testing; OR 2. Diagnosis of SGA confirmed by birth wt of less than 2500g at gestation of more than 37 wks or at birth weight or length below the 3rd percentile for gestational age who failed to catch up by 2 years of age. **Turner Syndrome**, **Noonan Syndrome**: 1. Treatment of short stature in females w/bone age less than 15 years associated w/TS or NS; OR 2. Treatment of short stature in males w/bone age less than 17 years associated w/NS. **Growth Retardation associated with Chronic Renal Insufficiency**: 1. Diagnosis of chronic renal insufficiency; AND 2. Height shorter than or equal to 2 SD below the median age for children or where growth velocity falls to below 4.5 cm/year. **Reauthorization for GHD in Children, PWS, SGA, TS, NS, GRCRF**: 1. Increase in growth velocity of at least 2 cm/year during previous year of treatment; AND 2. Males with bone age less than 17 yrs or females with bone age less than 15 years. **Idiopathic Short Stature**: 1. Height less than or equal to 2.25 SD below the		**GHD (Child), AOGH, COGHDA, IGHDA, Initial Therapy for TS or NS, and ISS:** Prescribed by an endo-crinologist. **GRCRF:** Prescribed by an endo-crinologist or nephrologist.	12 months	

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	Hormone Deficiency (AOGHD), Childhood Onset GH Deficiency in Adults (COGHDA) Isolated GH Deficiency in Adults (IGHDA)		mean height for age. Growth velocity less than the 25th percentile for bone age; AND 2. Verify open epiphyses on last bone age radiograph; AND 3. Absence of comorbid conditions that should be observed or treated by other means. **Reauthorization of ISS**: 1. Increase in growth velocity of at least 4.5 cm/year during previous year of treatment; AND 2. Males w/bone age less than 17 years or females w/bone age less than 15 years. **Adult Onset Growth Hormone Deficiency**: 1. Pts who have GHD associated with multiple hormone deficiencies because of pituitary disease/insult, hypothalamic disease, surgery, or radiation treatment; AND 2. IGF-1 level less than 77 mcg/L or 2 SD below the mean value, matched by age and gender. **Childhood Onset GH Deficiency in Adults**: 1. Childhood onset in patients who were GH deficient during childhood who have GH deficiency confirmed as an adult before replacement treatment with GH is started; AND 2. Persistent deficiency of GH documented by GH stimulation tests. **Isolated GH Deficiency in Adults**: Documented deficiency of GH documented by 2 GH stimulation tests.				
Halaven	All FDA approved indications not otherwise excluded from Part D.		**Breast Cancer:** 1. Diagnosis of recurrent or metastatic breast cancer; AND 2. Previous treatment with both of the following: a. an anthracycline b. a taxane.			12 months	Halaven will be approved for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
Hexalen	All FDA approved indications not otherwise excluded from Part D.		1. Diagnosis of ovarian cancer 2. Cancer has progressed or recurred following first-line treatment with a cisplatin or alkylating agent-based combination		Prescribed by an oncologist	12 months	Hexalen will be approved for continuation of prior therapy.
Humira, Humira Pen-Crohns Disease	All FDA approved indications not otherwise excluded from Part D.		**Moderate to severe Rheumatoid Arthritis (RA):** 1. Diagnosis of moderate-to-severe RA; AND 2. Failed methotrexate or 2 DMARDs for 3 months. **Juvenile Idiopathic Arthritis (JIA)**: 1. Diagnosis of moderate-to-severe poly-articular course JIA 2. Failed NSAID or steroid and methotrexate for three months. **Psoriatic Arthritis (PsA)**: 1. Diagnosis of active PsA. 2. Failed methotrexate or 2 DMARDs for 3 months. **Ankylosing Spondylitis (AS)**: 1. Diagnosis of AS. 2. Failed 2 NSAIDs for 3 months. **Plaque Psoriasis (PPs):** 1. Diagnosis moderate-to-severe plaque psoriasis. 2. Failed systemic therapy **Crohn's disease (CD)**: 1. Diagnosis of moderate to severe CD; AND 2. Failed one conventional therapy. **Reauthorization**: Demonstration of clinical response to therapy.	**RA, PsA, CD, AS, Plaque Psoria-sis:** 18 years and older. **JIA:** 4 years and older.	**RA, AS, JIA:** Prescribed or recommend-ded by a rheuma-tologist. **PsA:** Prescribed or recommend-ded by a rheuma-tologist or dermatologist. **Plaque Psoriasis:** Prescribed or recommend-ded by a dermatologist. **CD:** Prescribed or recommend-ded by gastro-enterologist.	**Initial Authorization:** 4 months for Plaque Psoriasis; 12 months for other uses. **Reauthorization** 12 months	**RA:** Authorization is for 40 mg every other week unless documented treatment failure to Humira every other week dosing. Then Humira may be approved for every week dosing if other criteria met. **Plaque Psoriasis:** Humira dosage is 80 mg followed by 40 mg every other week. **CD:** 160 mg followed by one dose of 80 mg, followed by 40 mg every week

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
							All diagnoses: Verification that the patient has been evaluated for TB and treated accordingly.
Immune Globulin: Carimune Nanofiltered, Gammagard, Liquid, Gammaplex, Gamunex, Octagam,	All FDA approved indications not otherwise excluded from Part D Bone Marrow Transplant		**Idiopathic Thrombocytopenic Purpura (ITP)**: For patients with ITP who require a rapid temporary increase in platelet count or to control excessive bleeding **B-cell Chronic Lymphocytic Leukemia (CLL)**: 1. Documented hypogammaglobulinemia (IgG less than 600mg/dL); OR 2. History of bacterial infections associated with		**MG**: Prescribed by a neurologist.	**BMT**: 100 days after transplant **KD**: 1 month **MG, GBS**: 1 treatment	Immune Globulin is subject to Part B vs. Part D review. For Part D: For patients in which immune

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
Polygam S/D, Vivaglobin, Hizentra	(BMT). Dermatomyositis. Multifocal Motor Neuropathy. HIV. Guillain-Barre Syndrome (GBS). Lambert-Eaton Myasthenic Syndrome (LEMS). Myasthenia Gravis (MG). Relapsing Remitting Multiple Sclerosis (MS). Stiff-Person Syndrome. Polymyositis.		B-cell CLL. **Bone Marrow Transplantation (BMT)**: 1. Confirmed allogeneic BMT within the last 100 days; AND 2. Documented severe hypogammaglobulinemia (IgG less than 400 mg/dL) **Dermatomyositis and Polymyositis:** Failure or intolerance to one of the following: corticosteroid therapy, methotrexate, azathioprine, or cyclophosphamide. **HIV**: Documented hypogammaglobulinemia (IgG less than 400 mg/dL). **Guillane-Barre Syndrome (GBS)**: 1. Confirmed diagnosis of severe GBS; AND 2. Patients with severe disease requiring aid to walk; AND 3. Onset of muscle weakness within the last 4 weeks. **Acute Myasthenia Gravis (MG) Exacerbation** : 1. Confirmed diagnosis of myasthenia gravis with myasthenic exacerbation, defined by one of the following: a. Difficulty swallowing b. Acute respiratory failure c. Major functional disability responsible for the discontinuation of physical activity. **Relapsing-Remitting Multiple Sclerosis (MS)** : 1. Confirmed diagnosis of relapsing remitting form of MS AND 2. Failure to two of the following: Betaseron, Avonex, Rebif, Copaxone, Tysabri. **Stiff Person Syndrome** : Chart documentation confirming a diagnosis of stiff-person syndrome.			course **ITP, LEMS**: 6 months **Other Uses**: 1year	globulin is administered in the patient's home.
Infergen	All FDA		**Hepatitis C - Treatment Naive Patients:**	**Hepatitis**		**Treatment-**	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
	approved indications not otherwise excluded from Part D		1. For patients with Chronic Hepatitis C without decompensated liver disease 2. Positive HCV antibody 3. HCV RNA level measurement 4. Genotype test result 5. No prior interferon therapy 6. Use in combination with or failure to ribavirin. **Hepatitis C - Continuation of Therapy:** For genotypes 2, 3, or 5: Evidence of delayed virological response **Hepatitis C – Retreatment:** 1. Patient is a partial responder to prior therapy with a peginterferon product. 2. Used in combination with ribavirin.	**C in Treat-ment Naive patients:** 18 years and older.		**Naive: genotypes 2, 3, 5:** 6 months **Genotypes 1, 4, 6. or HIV/HCV:** 12 months **Continuation of treatment in genotypes 2, 3, 5:** 6 months	
Insulin-like Growth Factor: Increlex	All FDA approved indications not otherwise excluded from Part D		**IGF-1 deficiency** 1. All of the following: a. Diagnosis of severe primary IGF-1 deficiency. b. Height standard deviation score of -3.0 or less. c. Basal IGF-1 standard deviation score of -3.0 or less. d. Normal or elevated growth hormone. e. Open finger epiphyses on last bone radiograph **GH gene deletion**: a. Diagnosis of growth hormone gene deletion who have developed neutralizing antibodies to GH; AND b. Have open finger epiphyses on last bone radiograph.			**All Uses:** Insulin-like growth factor will be approved for 1 year.	
Intron-A, Intron-A W/Diluent	All FDA approved indications not otherwise excluded from Part D Multiple		**Hepatitis B - HBeAg positive**: 1. HBsAg positive for at least 6 months; AND 2. HBV DNA level greater than 20,000 IU/mL or 100,000 copies/mL; AND. 3. Without decompensated liver disease; AND 4. One of the following: persistent ALT 2 times ULN or moderate to severe hepatitis or fibrosis on biopsy, or evidence of icteric ALT flare ups.	**Hep B - HBeAg positive, Hep B - HBeAg negative:** 1 year of age or	**RCC:** Prescribed by an oncologist	**HepB+:** 16 weeks **HepB-:** 1 year **HepC: genotypes 2, 3,**	Intron A will be approved for continuation of prior therapy for neoplastic diseases.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Myeloma. Acute Hepatitis C. Metastatic Renal Cell Carcinoma (RCC).		**Hepatitis B - HBeAg negative**: 1. HBsAg positive for at least 6 months; AND 2. HBV DNA level of 2000 IU/mL or more or 11,200 copies/mL; AND 3. Without decompensated liver disease; AND 4. One of the following: persistent ALT 2 times ULN or moderate to severe hepatitis or fibrosis on biopsy, or evidence of icteric ALT flare ups. **Hepatitis C - Treatment Naive Patients**: 1. For patients with Chronic Hepatitis C without decompensated liver disease 2. Positive HCV antibody 3. HCV RNA level measurement 4. Genotype test result 5. No prior interferon therapy 6. Use in combination with or failure to ribavirin. **Hepatitis C - Continuation of Therapy**: For genotypes 2, 3, or 5: evidence of delayed virological response **Non-Hepatitis Diagnoses** Diagnosis of one of the following: 1. Malignant Melanoma 2. Hairy cell leukemia (HCL) 3. Stage III or IV follicular Non-Hodgkin's Lymphoma 4. Condylomata acuminate 5. AIDS-related Kaposi's sarcoma 6. Multiple Myeloma. **Acute Hepatitis C:** Patients with acute hepatitis C. **Metastatic Renal Cell Carcinoma (RCC):** 1. Diagnosis of metastatic RCC; AND 2. Used in combination with Avastin	older. **Hep C - Treatment Naive Patients, Non-Hepatitis Diagno-ses, Acute Hep C, malignant melanom a, HCL, NHL, Warts, Kaposi, multiple myeloma:** 18 years old and older. **Hep C - Treatment Naive Patients (in combi-nation with ribavirin):** 3 years of age and older.		**5:** 6 months **HepC: genotypes 1, 4, 6, HIV/HCV**: 12 months **Acute HepC:** 3 months **HCL, Kaposi, RCC:** 6 months. **Warts:** 3 weeks. **Other uses**: 1year	
Istodax	All FDA approved indications not otherwise		**Cutaneous T-Cell Lymphoma (CTCL):** Confirmed diagnosis of CTCL. Failure to one systemic therapy.			12 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D						
Jevtana	All FDA approved indications not otherwise excluded from Part D		**Prostate Cancer:** 1. Diagnosis of metastatic hormone-refractory or castration-resistant prostate cancer; AND 2. Used in combination with prednisone; AND 3. Previous treatment with a docetaxel-containing chemotherapy regimen; AND 4. Documented disease progression during or after completion of docetaxel therapy.			12 months	Jevtana will be approved for continuation of prior therapy.
Kalbitor	All FDA approved indications not otherwise excluded from Part D		**Hereditary Angioedema** For the treatment of acute Hereditary Angioedema attack.		Prescribed by an immunologist, allergist, or rheumatologis t	12 months	
Ketek	All FDA approved indications not otherwise excluded from Part D		**Community-Acquired Pneumonia:** 1. Diagnosis of CAP in an adult outpatient; AND 2. Failure, intolerance, or resistance to one of the following: azithromycin or clarithromycin.			30 days	
Kineret	All FDA approved indications not otherwise excluded from Part D		**Initial Therapy for Rheumatoid Arthritis (RA):** 1. Moderate to severe active RA; AND 2. Failure with a TNF-alpha-blocker; AND 3. Failure on either methotrexate or at least 1 DMARD. **Reauthorization for RA:** Submission of chart documentation demonstrating positive clinical response.	**RA:** 18 years and older	**RA:** Prescribed or recommend-ded by a rheumatolo-gist.	**Initial Therapy for RA:** Kineret will be approved for 12 months. **Reauthorization for RA:** Kineret will be approved for 1 year.	
Letairis	All FDA approved indications not otherwise excluded from Part D		**Pulmonary Arterial Hypertension**: Patients with a confirmed diagnosis of pulmonary arterial hypertension (modified WHO Group I) which is symptomatic.			12 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
Leukine	All FDA approved indications not otherwise excluded from Part D Treatment of febrile neutropenia (FN). HIV-Related neutropenia (HIVN).		**Bone Marrow/Stem Cell Transplant (BMSCT)**: 1. Patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous/allogeneic BMT; OR 2. Mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis; OR 3. Peripheral stem cell transplant patients who have received myeloablative chemotherapy. **Acute Myeloid Leukemia (AML) Induction or Consolidation Therapy**: For patients with AML following induction or consolidation chemotherapy. **Neutropenia associated with dose dense chemotherapy (NDDC)**: 1. Patient is receiving the National Comprehensive Cancer Network's (NCCN's) Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer; OR 2. A dose-dense regimen for which the incidence of febrile neutropenia is unknown. **Chemotherapy with risk of febrile neutropenia (CFN)**: 1. Patient is receiving a chemotherapy regimen associated with more than 20% incidence of febrile neutropenia; OR 2. Patient is receiving chemotherapy regimen associated with 10-20% incidence of febrile neutropenia and has one or more risk factors associated with chemotherapy-induced infection, febrile neutropenia or neutropenia. **Febrile Neutropenia (FN)**: 1. For patients receiving myelosuppressive anticancer drugs associated with neutropenia; AND 2. Patient either has febrile neutropenia or has a history of febrile neutropenia during a previous course of chemotherapy.	**AML:** Greater than or equal to 55 years old.		**BMSCT, AML, NDDC, CFN, FN (prophylaxis):** 3 months or duration of treatment **FN (treatment):** 1 month **HIVN:** 6 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			HIV-related neutropenia (HIVN): HIV-infected patients with an Absolute Neutrophil Count (ANC) less than or equal to 1,000 cells/mm3 with or without one or more risk factors for developing chronic neutropenia.				
Lotronex	All FDA approved indications not otherwise excluded from Part D	Initial therapy for Irritable Bowel Syndrome (IBS) in the male gender.	**Initial Therapy for Irritable Bowel Syndrome:** 1. Confirmed diagnosis of IBS with diarrhea predominant symptoms for at least 6 months; AND 2. Failure to an antispasmodic and an anti-diarrhea agent. **Reauthorization for IBS:** 1. Recurrence of diarrhea-predominant IBS; AND 2. Documentation of positive clinical response while on Lotronex.	18 years and older.		**Initial Therapy:** 12 weeks **Reauthorization:** 6 months	
Lyrica	All FDA approved indications not otherwise excluded from Part D Central Pain. Neuropathic Pain.		**Seizure Disorder**: As add-on therapy for the diagnosis of partial seizure. **Diabetic Neuropathy**: 1, Diagnosis of Diabetes Mellitus; AND 2. Diagnosis of peripheral neuropathy; AND 3. Failure to gabapentin. **Post-herpetic Neuropathic Pain:** Failure to gabapentin. **Central Pain**: 1. Confirmed diagnosis of central pain (pain caused by a lesion or dysfunction in the CNS: eg, spinal cord lesion, stroke, thalamus lesion). 2. Failure to gabapentin **Fibromyalgia**: Failure to Cymbalta. **Neuropathic Pain**: 1. Confirmed diagnosis of neuropathic pain; AND 2. Failure to gabapentin and one of the following: a. amitriptyline			12 months	Lyrica will be approved for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			b. nortriptyline c. desipramine d. imipramine				
Marinol, Dronabinol	All FDA approved indications not otherwise excluded from Part D		**Nausea and Vomiting Associated with Cancer Chemotherapy (CINV):** 1. Patient is receiving cancer chemotherapy; AND 2. Failure to 5HT-3 receptor antagonist; AND 3. Failure to one of the following agents: a. Antihistamine b. Corticosteroid c. Prokinetic agent d. Antipsychotic. **AIDS Anorexia:** Diagnosis of anorexia with weight loss in patients with AIDS.			**CINV:** 6 months **AIDS anorexia:** 12 months	Dronabinol is subject to Part B vs. Part D review. **CINV:** Marinol will be approved for continuation covered under Part B when patient is receiving chemotherapy .
Miacalcin injectable	All FDA approved indications not otherwise excluded from Part D		**Postmenopausal Osteoporosis:** 1. Failure to a bisphosphonate or selective estrogen-receptor modulator (SERM); AND 2. Failure to Miacalcin Nasal Spray; AND 3. History of vertebral compression fractures, or fractures of the hip or distal radius resulting from minimal trauma, or T score of -2.5 or less. **Initial Therapy for Paget's Disease:** History of failure or intolerance to oral bisphosphonates. **Reauthorization for Paget's Disease**: Serum alkaline phosphatase concentration fails to normalize after the previous 6 months of therapy. **Hypercalcemia:** 1. Corrected total serum calcium of 12 mg/dl; OR 2. Greater or corrected total serum calcium of 6 mEq/L or greater.			**Post-menopausal Osteoporosis**: 12 months **Hypercalcemia**: 1 month **Paget's Disease**: 6 months	Miacalcin is subject to Part B vs. Part D review.
Neulasta	All FDA approved		**Chemotherapy with risk of febrile neutropenia (CFN)**:			**CFN, NDDC, FN (prophylaxis):**	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded from Part D		1. Patient is receiving a chemotherapy regimen associated with more than 20% incidence of febrile neutropenia; OR 2. a. Patients is receiving chemotherapy regimen associated with 10-20% incidence of febrile neutropenia; AND b. Has risk factors associated with chemotherapy-induced infection, febrile neutropenia or neutropenia. **Neutropenia associated with dose dense chemotherapy (NDDC)**: 1. Patients is receiving NCCN's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer; OR 2. A dose-dense regimen for which the incidence of febrile neutropenia is unknown. **Febrile Neutropenia (FN)**: 1. For patients receiving myelosuppressive anticancer drugs associated with neutropenia; AND 2. Patient either has febrile neutropenia or has a history of febrile neutropenia during a previous course of chemotherapy.			3 months or duration of treatment. **FN (treatment):** 1 month.	
Neumega	All FDA approved indications not otherwise excluded from Part D	Patients with myeloablative chemother-apy.	**Thrombocytopenia following chemotherapy** 1. Verification that the cancer is a non-myeloid malignancy; AND 2. Platelet count is less than 50,000 cells/microliter; AND 3. Patients with one or more of the following risk factors: a. Extensive prior cytotoxic chemotherapy b. Prior severe chemotherapy-induced thrombocytopenia c. Receiving chemotherapy regimens associated with high risk for thrombocytopenia.			3 week intervals for up to 6 cycles post-chemotherapy.	
Neupogen	All FDA approved indications not		**Bone Marrow/Stem Cell Transplant (BMSCT)**: 1. For patients with non-myeloid malignancies undergoing myelo-ablative chemotherapy	**AML:** 55 years and older		**BMSCT, AML, NDDC, CFN, FN (prophylaxis):**	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D Treatment of Febrile Neutropenia (FN). Hepatitis C Treatment Related Neutropenia (HCN). HIV-Related Neutropenia (HIVN).		followed by autologous or allogeneic BMT; OR 2. For mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis; OR 3. For peripheral stem cell transplant patients who have received myelo-ablative chemotherapy. **Acute Myeloid Leukemia (AML) Induction or Consolidation Therapy**: For patients with AML following induction or consolidation chemotherapy. **Neutropenia associated with dose dense chemotherapy (NDDC)**: 1. Patient is receiving NCCN's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer; OR 2. A dose-dense regimen for which the incidence of febrile neutropenia is unknown. **Chemotherapy with risk of febrile neutropenia (CFN)**: 1. Patient is receiving a chemotherapy regimen associated with more than 20% incidence of febrile neutropenia; OR 2. Patient is receiving a chemotherapy regimen associated with 10-20% incidence of febrile neutropenia and has risk factors associated with chemotherapy-induced infection, febrile neutropenia or neutropenia. **Febrile Neutropenia (FN)**: 1. For patients receiving myelosuppressive anticancer drugs associated with neutropenia; AND 2. Patient either has febrile neutropenia or has a history of febrile neutropenia during a previous course of chemotherapy. **Severe Chronic Neutropenia (SCN)**: For patients with severe chronic neutropenia. **Hepatitis-C Treatment of Related Neutropenia**			3 months or duration of treatment **FN (treatment):** 1 month **SCN, HCN**: 12 months **HIVN**: 6 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			(HCN): 1. Neutropenia in Hepatitis C virus infected patients undergoing treatment with Peg-Intron or Pegasys after dose reduction; OR 2. For patients with HIV co-infection or status post liver transplant, or established cirrhosis who experience interferon-induced neutropenia due to treatment with Peg-Intron or Pegasys. **HIV-related neutropenia (HVN)**: HIV-infected patients with an ANC less than or equal to 1,000 cells/mm3 with or without one or more risk factors for developing chronic neutropenia.				
Nexavar	All FDA approved indications not otherwise excluded from Part D		One of the following: 1. Diagnosis of renal cell carcinoma with relapse following surgical excision 2. Diagnosis of renal cell carcinoma with medically or surgically unresectable tumor 3. Diagnosis of Stage IV renal cell carcinoma 4. Diagnosis of unresectable hepatocellular carcinoma.		**Hepato-cellular carcinoma:** Prescribed by an oncologist, hepatologist, or gastro-enterologist. **All other indications:** Prescribed by an oncologist.	6 months	Nexavar will be approved for continuation of prior therapy.
Nulojix	All FDA approved indications not otherwise excluded from Part D		**Prophylaxis of organ rejection** 1. For prophylaxis of acute organ rejection of transplanted renal (kidney) 2. Patient is EBV seropositive 3. Used as part of a regimen with basiliximab induction, mycophenolate mofetil, and corticosteroids 4. Panel reactive antibodies less than 50% or greater than 30% in re-transplanted patients.		Prescribed by a kidney transplant specialist.	12 months	Subject to Part B vs. Part D review. Approve for continuation of prior therapy if Part D.
Orencia	All FDA approved indications not otherwise excluded from	.	**Rheumatoid Arthritis (RA):** 1. Diagnosis of moderate-to-severe RA; AND 2. Failed methotrexate or 2 DMARDs. **Reauthorization for RA:**	**RA**: 18 years and older. **JIA:**	Prescribed or recommended by a rheumatolo-gist.	12 months.	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D		Documentation of clinical improvement from ongoing therapy. **Juvenile Idiopathic Arthritis (JIA)**: Failed NSAID or steroid and methotrexate. **Reauthorization for JIA**: Documentation of clinical improvement from ongoing therapy. **All uses:** Verification that the patient has been evaluated for tuberculosis and treated accordingly.	6 years and older.			
Oxandrin, oxandrolone	All FDA approved indications not otherwise excluded from Part D	Weight gain not related to AIDS wasting/ cachexia.	**Bone Pain**: Diagnosis of bone pain due to osteoporosis. **Initial Therapy for AIDS Wasting**: Diagnosis of AIDS wasting/cachexia **Reauthorization for AIDS Wasting**: Verification that the patient's weight has increased a minimum of 2% while taking Oxandrin			**AIDS wasting (Initial):** 3 months **AIDS wasting (Reauth-orization), Bone Pain:** 12 months	
Pegasys	All FDA approved indications not otherwise excluded from Part D Acute Hep C.		**Hepatitis B - HBeAg positive patients:** 1. HBsAg positive for at least 6 months; AND 2. HBV DNA level greater than 20,000 IU/mL or 100,000 copies/mL; AND. 3. Compensated liver disease; AND 4. One of the following: a. ALT (liver enzyme) 2 times upper limits of normal (ULN) b. Moderate-to-severe hepatitis or fibrosis on biopsy. c. Evidence of icteric ALT flare ups **Hepatitis - HBeAg negative patients:** 1. HBsAg positive for at least 6 months; AND 2. HBV DNA level of 2000 IU/mL or more or 11,200 copies/mL; AND 3. Compensated liver disease; AND 4. One of the following: a. ALT 2 times ULN b. Moderate-to-severe hepatitis or fibrosis on	**For all covered uses:** 18 years and older		**Hepatitis B (+):** 48 weeks **Hepatitis B (-):** 1 year **Hepatitis C Genotypes 2,3, 5**: 24 weeks; **Genotypes 1, 4, 6, HIV/HCV**: 48wk. **Hepatitis C Continuation therapy: Genotypes 1,3, 5**:	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			biopsy. c. Evidence of icteric ALT flare ups **Hepatitis C - Treatment Naive Patients**: 1. Chronic Hepatitis C with compensated liver disease; AND 2. Positive HCV antibody HCV RNA; AND 3. HCV RNA level measurement; AND 4. Genotype test result; AND 5. For patients who have not previously been treated with interferon. 6. Used in combination with or failure to ribavirin. **Continuation of Therapy:** A. **For genotypes 1 or 5**: 1. Evidence of delayed virological response B. **For genotype 3:** 1. Baseline HCV RNA more than 600,000 IU/mL; AND 2. Steatosis or advanced fibrosis on liver biopsy. **Hepatitis C Retreatment**: 1. One of the following a. Retreatment in patients who have failed or relapsed following standard or pegylated interferon monotherapy; OR b. For non-responders or relapsers who have significant fibrosis or cirrhosis who have undergone previous regimens of treatment using non-pegylated interferon; OR c. Retreatment in patients with genotype 2 or 3 who have relapsed following 6 month treatment of pegylated interferon plus ribavirin combination therapy. 2. Used in combination with ribavirin. **Acute Hepatitis C:** Patients with acute hepatitis C			24 weeks, **Hepatitis C Retreatment:** 1year **Acute Hepatitis C:** 12 weeks	
Peg-Intron, Peg-Intron Redipen	All FDA approved indications not		**Hepatitis C** - **Treatment Naive Patients**: 1. Chronic Hepatitis C with compensated liver disease; AND	**Treatment Naive Patients:**		**Genotypes 2, 3, 5:** 24 weeks	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D Acute Hep C.		2. Positive HCV antibody HCV RNA; AND 3. HCV RNA level measurement; AND 4. Genotype test result; AND 5. For patients who have not previously been treated with interferon. 6. Used in combination with or failure to ribavirin. **Hepatitis C (Continuation)**: A. **For genotypes 1 or 5**: 1. Evidence of delayed virological response B. **For genotype 3:** 1. Baseline HCV RNA more than 600,000 IU/mL; AND 2. Steatosis or advanced fibrosis on liver biopsy. **Hepatitis C (Retreatment):** 1. One of the following: a. Retreatment in patients who have failed or relapsed following standard or pegylated interferon monotherapy; OR b. For non-responders or relapsers who have significant fibrosis or cirrhosis who have undergone previous regimens of treatment using non-pegylated interferon; OR c. Retreatment in patients with genotype 2 or 3 who have relapsed following 6 month treatment of pegylated interferon plus ribavirin combination therapy. 2. Used in combination with ribavirin. **Acute Hepatitis C:** Patients with acute hepatitis C	3 years and older **Acute Hepatitis C:** 18 years and older		**Genotypes 1, 4, 6, HIV/HCV:** 48 weeks. **Hepatitis C Continuation: Genotypes 1, 3, 5**: 24 weeks **Hepatitis C Retreatment**: 1 year **Acute Hepatitis C:** 12 weeks	
Pradaxa	All FDA-approved indications not otherwise excluded from Part D. Treatment of acute venous		**Stroke prevention in patients with non-valvular atrial fibrillation (AF):** Diagnosis of AF in patients without rheumatic mitral valve disease, a prosthetic heart valve, or mitral valve repair. **Acute VTE:** 1. Diagnosis of acute VTE; AND 2. Failure, contraindication, or intolerance to	**Acute VTE, Prophylaxis of VTE:** Age greater than or equal to 18 years.		**Stroke prevention:** 12 months. **Acute VTE:** 6 months. **Prophylaxis of VTE:**	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
	thromboembolism (VTE). Prophylaxis of VTE after orthopedic surgery.		warfarin. **Prophylaxis of VTE:** Completion of total knee or total hip replacement surgery.			35 days.	
Prograf (intravenous)	All FDA approved indications not otherwise excluded from Part D Lung, pancreas, small bowel, or bone marrow transplant. Severe Uveitis		**Severe Uveitis**: Failure to one corticosteroid. **Transplant**: 1. One of the following: a. Patient received a renal (kidney), cardiac (heart), lung, pancreas, small bowel, or hepatic (liver) transplant. b. Patient received a bone marrow/stem cell transplant. AND 2. Patient is unable to take oral tacrolimus.			12 months	Prograf is subject to Part B vs. Part D review (not limited to new starts only). Prograf will be approved for continuation of prior therapy if Part D.
Prograf (oral)	All FDA approved indications not otherwise excluded from Part D Lung, pancreas, small bowel, or bone marrow/stem cell transplant. Severe uveitis.		**Severe Uveitis**: Failure to one corticosteroid. **Transplant:** Patient received a renal (kidney), cardiac (heart), lung, pancreas, small bowel, hepatic (liver) transplant, bone marrow/stem cell transplant.			12 months	Prograf is subject to Part B vs. Part D review (not limited to new starts only) Prograf will be approved for continuation of prior therapy if Part D.
Proleukin	All FDA approved indications not otherwise excluded from Part D		**Metastatic Renal Cell Carcinoma or Metastatic Melanoma:** 1. Good neurologic or ambulatory performance status; AND 2. Adequate organ function determined by all of the following: a. Normal cardiac stress test results	**All uses:** 18 years and older		3 months	**All uses:** Proleukin will be approved for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			b. FEV1 greater than 2 L on pulmonary function tests c. Creatinine concentration 1.5 mg/dL or less or calculated creatinine clearance > 60 ml/min				
Prolia	All FDA-approved indications not otherwise excluded from Part D.		**Postmenopausal osteoporosis:** 1. Diagnosis of postmenopausal osteoporosis; AND 2. History of vertebral compression fractures or fractures of the hip or distal radius resulting from minimal trauma, or T-score less than or equal to -.2.5; AND 3. One of the following: a. Failure to one oral bisphosphonate b. Failure, contraindication, or intolerance to one injectable bisphosphonate c. Contraindication or intolerance to one oral bisphosphonate and failure to one injectable bisphosphonate.			12 months	
Promacta	All FDA approved indications not otherwise excluded from Part D		**Chronic ITP** 1. Diagnosis of ITP. 2. Failure to corticosteroids, immunoglobulins, or splenectomy.			6 months	
Provigil	All FDA approved indications not otherwise excluded from Part D Idiopathic Hypersomnia.	**Initial Therapy for Shift Work Sleep Disorder (SWSD):** Symptoms do not meet criteria for any other sleep disorder producing insomnia or excessive sleepiness.	**Narcolepsy**: Submission of sleep study confirming the diagnosis of narcolepsy. **Initial Therapy for Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS):** 1. Fully compliant and concurrently using continuous positive airway pressure (CPAP); AND 2. One of the following: a. 15 or more obstructive respiratory events; OR b. More than 5 obstructive apneas, each greater than 10 seconds in duration, per hour of sleep confirmed by a sleep study, and one of the following:			**OSAHS (Initial), SWSD (Initial and Reauthorization**: 3 months **Other uses** 12 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			i. Frequent arousals from sleep associated with apneas ii. Bradycardia iii. Arterial oxygen desaturation in association with apneas. iv. Unintentional sleep episodes v. Daytime sleepiness vi. Unrefreshing sleep vii. Fatigue viii. Insomnia ix. Waking up gasping x. Loud snoring xi. Breathing interruptions during sleep **Reauthorization for Obstructive Sleep Apnea/Hypopnea Syndrome**: Patient continues to be fully compliant on concurrent CPAP and is experiencing relief of symptomatic hypersomnolence with Provigil use. **Shift Work Sleep Disorder**: 1. One of the following: a. Symptoms of excessive sleepiness or insomnia, for at least 3 months, which is temporally associated with a work period that occurs during the habitual sleep phase b. Sleep study demonstrating loss of a normal sleep-wake pattern. AND 2. Sleep disturbance causes significant distress or significant impairment; AND 3. No other disorder accounts for the symptoms. **Reauthorization for Shift Work Sleep Disorder**: 1. Patient is experiencing relief with use of Provigil for excessive sleepiness; AND 2. Sleep disturbance continues to cause clinically significant distress or significant impairment in occupational functioning. **Idiopathic Hypersomnia**: Submission of sleep study confirming the diagnosis of Idiopathic Hypersomnia as defined by the International Classification of Sleep				

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Disorders.				
Qualaquin	All FDA approved indications not otherwise excluded from Part D	1. Severe or complicat-ed P. falci-parum malaria. 2. Prevent-ion of Malaria 3. For treatment or prevent-ion of nocturnal leg cramps.	**Chloroquine-sensitive malaria:** 1. Diagnosis of Malaria; AND 2. History of failure, contraindication or intolerance to chloroquine. **Chloroquine-resistant malaria**: Diagnosis of malaria.			7 days	
Regranex	All FDA approved indications not otherwise excluded from Part D		**Diabetic Neuropathic Ulcers** 1. Diabetic patient with ulcer wound. 2. Debridement being performed as needed; AND 2. At least two of the following are present: a. Stage III or IV wound b. Wound at least 1 cm x 1 cm c. Long-standing wound that does not heal with standard care d. Patients at high risk for amputation (peripheral neuropathy, peripheral vascular disease, skin or nail abnormalities, previous foot ulcer amputation).			Maximum: 5 months	
Remicade	All FDA approved indications not otherwise excluded from Part D		**Rheumatoid Arthritis**: 1. Diagnosis of moderate-to-severe RA 2. Concurrently on methotrexate or failure to methotrexate or 2 DMARDs (azathioprine, cyclosporine, gold, hydroxychloroquine, leflunomide, penicillamine, sulfasalazine) for 3 months. **Psoriatic Arthritis**: 1. Diagnosis of active Psoriatic arthritis 2. Failure or contraindication to methotrexate or 2 of the following for 3 months: cyclosporine, gold, leflunomide, or sulfasalazine for 3 months.	**RA, PsA, AS, Plaque Psoriasis, FCD, UC**: 18 years and older. **Crohn's Disease:** 6 years and older.	**RA, AS**: Prescribed or recommended by a rheumatolo-gist. **PsA:** Prescribed or recommended by a rheumatolo-gist. **Crohn's**	12 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Ankylosing Spondylitis (AS): 1. Diagnosis of AS 2. Failed 2 NSAIDs for 3 months **Plaque Psoriasis:** 1. Diagnosis of moderate-to-severe (greater than 6 months) plaque psoriasis; AND 2. Failure, contraindication, or intolerance to one of the following: methotrexate, cyclosporine, acitretin, hydroxyurea, sulfasalazine, 6-thioguanine, mycophenolate. **Crohn's Disease (CD)**: 1. Moderate to severe CD; AND 2. Failed one of the following: corticosteroids, 6-mercaptopurine, azathioprine, methotrexate, aminosalicylate **Fistulizing Crohn's Disease (FCD)**: 1. Draining fistulas for 3 months; AND 2. On or failed one of the following: 6-mercaptopurine, azathioprine, antibiotics, oral corticosteroids, methotrexate **Ulcerative Colitis (UC)**: 1. Moderate to severe UC; AND 2. Failed on one of the following: corticosteroids, 5-aminosalicylic acid, azathioprine, 6-mercaptopurine, cyclosporine **Sarcoidosis**: Failed one steroid and one immunosuppressant. **Reauthorization:** Demonstration of clinical response to therapy **All uses:** Verification that the patient has been evaluated for tuberculosis (TB) and treated accordingly.		**Disease, Fistulizing Crohn's Disease, UC**: Prescribed by a gastro-enterologist or by gastro-enterologist consult. **Plaque Psoriasis**: Prescribed or recommend-ed by a dermatologist. **Sarcoidosis:** Prescribed or recommended by a pulmonologist.		
Remodulin	All FDA approved indications not otherwise excluded from		**Pulmonary Arterial Hypertension** Patients with a confirmed diagnosis of pulmonary arterial hypertension (modified WHO Group I) which is symptomatic.			12 months	Remodulin is subject to Part B vs. Part D review.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D						
Revatio	All FDA approved indications not otherwise excluded from Part D	**Pulmonary Arterial Hyperten-sion (PAH):** Patients using organic nitrates.	**Pulmonary Arterial Hypertension**: Patients with a confirmed diagnosis of pulmonary arterial hypertension (modified WHO Group I) which is symptomatic.			12 months	
Revlimid	All FDA approved indications not otherwise excluded from Part D		**Myelodysplastic Syndrome (MDS)**: 1. Diagnosis of myelodysplastic syndrome associated with a deletion 5q cytogenic abnormality; AND 2. Patient is transfusion dependent. OR 1. Diagnosis of myelodysplastic syndrome without a deletion 5q cytogenic abnormality; AND 2. Failure of initial treatment with epoetin alfa or darbopoetin alfa, hypomethylating agents (e.g., Vidaza, Dacogen), or immunosuppressive therapy (e.g., antithymocyte globulin, cyclosporine). **Chronic Lymphocytic Leukemia (CLL):** Relapsed or refractory to one prior therapy for CLL.		**MDS, Multiple Myeloma, CLL:** Prescribed by an oncologist or hematologist or by oncology or hematology consult.	**MDS, Multiple Myeloma, CLL**: 6 months	Revlimid will be approved for continuation of prior therapy.
Copegus, Rebetol, Ribapak, Ribasphere, ribavirin	All FDA approved indications not otherwise excluded from Part D		**Hepatitis C**: Adults with a diagnosis of Hepatitis C without decompensated liver disease, and verification of concurrent use with an alfa-interferon product.			12 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
Rituxan	All FDA approved indications not otherwise excluded from Part D Chronic Lymphocytic Leukemia Immune or idiopathic thrombocytopenic purpura Waldenstrom's macro-globulinemia		**Non-Hodgkin's Lymphoma:** One of the following: 1. As first-line treatment of diffuse large B-cell, CD20-positive, non-Hodgkin's lymphoma in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or other anthracycline-based chemotherapy regimens 2. As first-line treatment of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma in combination with chemotherapy 3. As a single-agent maintenance therapy for the treatment of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma in patients achieving a complete or partial response to Rituxan in combination with chemotherapy 4. For the treatment of low-grade, CD20-positive, B-cell non-Hodgkin's lymphoma in patients with stable disease or who achieve a partial or complete response following first-line treatment with CVP chemotherapy 5. Confirmed diagnosis of relapsed or refractory, low grade or follicular CD20-positive, B-cell non-Hodgkin's lymphoma. **Initial Therapy for Rheumatoid Arthritis (RA)**: 1. Diagnosis of moderate/severe RA; AND 2. Used in combination with or failure to methotrexate; AND 3. Failure to a TNF antagonist. **Reauthorization for Rheumatoid Arthritis**: 1. Documentation of clinical improvement from ongoing therapy; AND 2. At least 16 weeks since last Rituxan treatment.	**RA**: 18 years and older.	**RA**: Prescribed by a rheumatolo-gist.	**All uses except RA:** 1 year **RA:** 1 month	Rituxan will be approved for continuation of prior therapy.
Avandia, Avandaryl, Avandamet	All FDA approved indications not otherwise excluded from Part D		**Type 2 Diabetes Mellitus:** 1. Failure, contraindication, or intolerance to at least one drug from one of the following antidiabetic classes: a. metformin/metformin ER b. sulfonylureas c. insulin d. incretin mimetics e. meglitinides		12 months		Avandia, Avandaryl, and Avandamet will be approved for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			f. dipeptidyl peptidase-4 inhibitors. 2. Failure, contraindication, or intolerance to a pioglitazone-containing product.				
Sabril	All FDA approved indications not otherwise excluded from Part D		**Complex Partial Seizures (CPS):** For use as adjunctive therapy in patients who have failed two formulary anticonvulsants. **Infantile Spasms (IS):** Diagnosis of infantile spasms.	**IS:** One month to two years of age. **CPS:** 18 years or and older		12 months	Approve for continuation of prior therapy.
Samsca	All FDA approved indications not otherwise excluded from Part D		**Initial therapy for hypervolemic and euvolemic hyponatremia:** 1. Diagnosis of significant hyponatremia (euvolemic or hypervolemic); AND 2. Treatment has been initiated or re-initiated in a hospital setting prior to discharge. **Reauthorization for hypervolemic and euvolemic hyponatremia:** 1. Documentation of clinical benefit; AND 2. Treatment has been initiated or re-initiated in a hospital setting prior to discharge.		Prescribed by an endocrinol-ogist or nephrologist or by consultation with an endocrinol-ogist or nephrologist	Initial: 1 month. Reauth: 3 months	
Sandostatin, octreotide acetate	All FDA approved indications not otherwise excluded from Part D. Chemotherapy Induced Diarrhea. AIDS-Related Diarrhea.		**Acromegaly**: 1. Inadequate response to surgery and/or radiotherapy or patients who are not a surgical and/or radiotherapy candidate 2. Diagnosis of acromegaly by one of the following: a. Serum growth hormone (GH) level greater than 1 ng/mL after a 2-hour oral glucose tolerance test b. Elevated serum IGF-1 levels as compared to normal reference values by age and gender. **Carcinoid Tumors**: Diagnosis of metastatic carcinoid tumor for symptomatic treatment of severe diarrhea or flushing.			**Acromegaly:** Long term approval. **Tumors, Chemotherapy induced diarrhea, AIDS-related diarrhea:** 6 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Vasoactive Intestinal Peptide Tumors: Diagnosis of metastatic vasoactive peptide tumor, for symptomatic treatment of diarrhea associated with vasoactive peptide tumor. **Cancer Chemotherapy Induced Diarrhea:** 1. Diagnosis of diarrhea due to concurrent cancer chemotherapy; OR 2. Both of the following: a. Diagnosis of complicated diarrhea due to concurrent cancer chemotherapy b. History of failure to standard therapy. **AIDS-related Diarrhea**: 1. Diagnosis of AIDS-related diarrhea. 2. History of failure to standard therapy				
Sandostatin LAR Depot	All FDA approved indications not otherwise excluded from Part D		**Acromegaly**: 1. Inadequate response to surgery and/or radiotherapy or patients who are not a surgical and/or radiotherapy candidate. 2. Patient has shown to respond to and tolerate octreotide injection for at least 2 weeks. **Carcinoid Tumors**: 1. Diagnosis of metastatic carcinoid tumor, for symptomatic treatment of severe diarrhea or flushing; AND 2. Patient has been shown to respond to and tolerate octreotide. **Vasoactive Intestinal Peptide Tumors**: 1. Diagnosis of metastatic vasoactive peptide tumor, for symptomatic treatment of diarrhea associated with vasoactive peptide tumor; AND 2. Patient has been shown to respond to and tolerate octreotide.			**Acromegaly:** Long term approval. **Tumors:** 6 months	
Somatuline Depot	All FDA-approved indications not otherwise excluded from		**Acromegaly**: 1. Patients who require long-term treatment due to: a. Inadequate response to surgery and/or radiotherapy; OR			12 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D		b. Who are not surgical and/or radiotherapy candidates. AND 2. Diagnosis of acromegaly by one of the following: a. Serum growth hormone level greater than 1 ng/mL after a 2-hour oral glucose tolerance test; OR b. Elevated serum IGF-1 levels as compared to normal reference values by age and gender.				
Somavert	All FDA-approved indications not otherwise excluded from Part D		**Initial Therapy for Acromegaly**: 1. One of the following: a. Inadequate response to surgery and/or radiation therapy b. Not a candidate for surgery or radiation. AND 2. Inadequate response or intolerance to octreotide, or lanreotide, or IGF-1 value greater than 900 ng/mL. **Reauthorization for Acromegaly**: Serum IGF-1 level within the age-adjusted normal range.			**Acromegaly (initial):** 12 weeks **Acromegaly (reauthorization) :** 12 months	
Sporanox capsules, itraconazole capsules	All FDA approved indications not otherwise excluded from Part D		**Fungal Infections (except onychomycosis):** Diagnosis of blastomycosis, histoplasmosis, or aspergillosis. **Initial Therapy for Onychomycosis:** 1. Diagnosis of fingernail or toenail onychomycosis confirmed by one of the following: KOH test, fungal culture, or nail biopsy. 2. One of the following a. Severely damaged nails with significant pain b. Paronychias c. Physical dysfunction d. Increased risk of infection **Retreatment of Onychomycosis:** 1. Diagnosis of fingernail or toenail onychomycosis confirmed by one of the following: KOH test, fungal culture, or nail biopsy.			**Fungal Infections (except onychomycosis) :** 12 months **Onychomycosis:** 2 months (finger), 3 months (toe)	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			2. Nine months has elapsed since completion of initial therapy for toenail onychomycosis or three months have elapsed since completion of initial therapy for fingernail onychomycosis. 3. Demonstration of efficacy on initial treatment.				
Sporanox solution	All FDA approved indications not otherwise excluded from Part D		**Fungal Infection (except Onychomycosis)**: 1. Diagnosis of one of the following: a. Blastomycosis b. Histoplasmosis c. Aspergillosis 2. Onychomycosis in patients unable to swallow tablets; OR 3. Diagnosis of febrile neutropenia with suspected fungal infection, or oropharyngeal or esophageal candidiasis. **Initial Therapy for Onychomycosis:** 1. Diagnosis of fingernail or toenail onychomycosis confirmed by one of the following: KOH test, fungal culture, or nail biopsy. 2. One of the following a. Severely damaged nails with significant pain b. Paronychias c. Physical dysfunction d. Increased risk of infection 3. Patient is unable to swallow tablets. **Retreatment of Onychomycosis:** 1. Diagnosis of fingernail or toenail onychomycosis confirmed by one of the following: KOH test, fungal culture, or nail biopsy. 2. Nine months has elapsed since completion of initial therapy for toenail onychomycosis or three months have elapsed since completion of initial therapy for fingernail onychomycosis. 3. Demonstration of efficacy on initial treatment. 4. Patient is unable to swallow tablets.			**Onychomycosis:** 2 months (finger), 3 months (toe) **Other Infections:** 12 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
Sprycel	All FDA approved indications not otherwise excluded from Part D		**Chronic Myeloid Leukemia (CML)**: 1. Diagnosis of Philadelphia chromosome positive or BCR-ABL positive chronic, accelerated, or myeloid or lymphoid blast phase chronic myeloid leukemia; AND 2. Failure to Gleevec. **Acute Lymphoblastic Leukemia (ALL)**: 1. Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia; AND 2. Failure to Gleevec.			12 months	Sprycel will be approved for continuation of prior therapy.
Striant	All FDA approved indications not otherwise excluded from Part D		**Hypogonadism**: 1. Diagnosis of hypogonadism in men with one of the following: a. pre-treatment testosterone level of less than 280 ng/dL or less than 9.7 nmol/L or below the normal reference level provided by the physician's laboratory b. pre-treatment free testosterone level of less than 50 pg/dL or less than 5 ng/dL or less than 0.17 nmol/L or below the normal reference level provided by the physician's laboratory			12 months	
Sutent	All FDA approved indications not otherwise excluded from Part D		**Gastrointestinal Stromal Tumor (GIST):** 1. Diagnosis of GIST 2. Disease progression on or intolerance to Gleevec. **Renal Cell Carcinoma:** One of the following: 1. Diagnosis of renal cell carcinoma with relapse following surgical excision		Prescribed by an oncologist.	12 months	Sutent will be approved for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			2. Diagnosis of renal cell carcinoma with medically or surgically unresectable tumor 3. Diagnosis of Stage IV renal cell carcinoma.				
Sylatron	All FDA approved indications not otherwise excluded from Part D		**Melanoma:** 1. For the adjuvant treatment of melanoma with microscopic or gross nodal involvement 2. Administered within 84 days of surgical resection including complete lymphadenectomy.		Prescribed by an oncologist.	12 months	Sylatron will be approved for continuation of prior therapy.
Symlin, Symlinpen	All FDA approved indications not otherwise excluded from Part D	Diagnosis of gastroparesis.	**Diabetes Mellitus**: 1. Type 1 or type 2 diabetes 2. Concurrent use of insulin therapy	18 years and older.		12 months	
Tarceva	All FDA approved indications not otherwise excluded from Part D First line for Non-Small Cell Lung Cancer (NSCLC). Metastatic RCC.		**Non-Small Cell Lung Cancer (1st Line):** 1. Patients diagnosed with locally advanced or metastatic NSCLC 2. One of the following: a. Known activated EGFR mutation b. Known mutated EGFR gene amplification c. Never smoked **Non-Small Cell Lung Cancer (2nd Line):** Patients diagnosed with locally advanced or metastatic NSCLC after failure of at least one prior chemotherapy regimen. **Pancreatic Cancer:** 1. Patient diagnosed with locally advanced, unresectable or metastatic pancreatic cancer. 2. Used in combination with gemcitabine. **Metastatic RCC:** 1. Diagnosis of metastatic RCC 2. Used in combination with bevacizumab		Prescribed by an oncologist.	6 months	Tarceva will be approved for continuation of prior therapy.
Targretin (oral)	All FDA approved indications not otherwise		Definitive diagnosis of cutaneous T-cell lymphoma (CTCL)			12 months	Targretin will be approved for continuation

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D						of prior therapy.
Tasigna	All FDA approved indications not otherwise excluded from Part D		**Chronic Myelogenous Leukemia**: 1. Diagnosis of Philadelphia chromosome positive chronic or accelerated phase chronic myeloid leukemia; AND 2. Failure to Gleevec.			12 months	Tasigna will be approved for continuation of prior therapy.
Testosterone injectable, Depot Testosterone, Delatestryl	All FDA-approved indications not otherwise excluded from Part D.		**Hypogonadism**: 1. Diagnosis of hypogonadism in men with one of the following: a. pre-treatment testosterone level of less than 280 ng/dL or less than 9.7 nmol/L or below the normal reference level provided by the physician's laboratory b. pre-treatment free testosterone level of less than 50 pg/dL or less than 5 ng/dL or less than 0.17 nmol/L or below the normal reference level provided by the physician's laboratory **Delayed puberty:** Diagnosis of delayed puberty in males. **Breast Cancer:** Diagnosis for the palliative treatment of inoperable breast cancer in women.			**Hypogonadism, Breast Cancer:** 12 months **Delayed puberty:** 6 months	
Topical testost-erone: Androderm, Androgel 1%, Androgel 1.62%	All FDA-approved indications not otherwise excluded from Part D.		**Hypogonadism**: 1. Diagnosis of hypogonadism in men with one of the following: a. pre-treatment testosterone level of less than 280 ng/dL or less than 9.7 nmol/L or below the normal reference level provided by the physician's laboratory b. pre-treatment free testosterone level of less than 50 pg/dL or less than 5 ng/dL or less than 0.17 nmol/L or below the normal reference level provided by the physician's laboratory			12 months	
Thalomid	All FDA-approved indications not otherwise		**Erythema Nodosum Leprosum (ENL)**: Confirmed diagnosis of moderate to severe ENL. **Aphthous stomatitis (AS) or ulcers**:			**ENL, MM:** 1 year **WM, GVHD, and Primary Brain**	Thalomid will be approved for continuation of

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D. Waldenstrom's Macro-globulinemia (WM) Aphthous stomatitis or ulcers (AS) Crohn's Disease, Graft-versus-Host Disease (GVHD) Primary Brain Tumors AIDS-related cachexia or wasting Renal Cell Carcinoma		1. One of the following: a. Diagnosis of HIV-associated aphthous ulcers b. Recurrent aphthous stomatitis in immunocompromised patients. AND 2. Failure to alternative therapies. **Crohn's Disease**: Failure to all of the following standard treatment regimens: 1. Corticosteroids 2. 5-aminodalicylic acid 3. Immunomodulators 4. Remicade. **Graft-versus-Host Disease (GVHD)**: 1. Diagnosis of chronic or refractory GVHD; AND 2. Failure to corticosteroid or one of the following: a. Azathioprine b. Tacrolimus c. Cyclosporine d. Antithymocyte globulin e. Mycophenolate **Primary Brain Tumors:** 1. As adjuvant therapy to current cytotoxic therapies; OR 2. Previous failure to cytotoxic therapies and/or tumor resection. **Initial Therapy for AIDS-related cachexia or wasting:** 1. Diagnosis of AIDS wasting or cachexia defined as chronic unremitting weight loss of more than 10% body weight in the previous 4 months; AND 2. Nutritional evaluation since onset of wasting first occurred. Screened for hypogonadism; AND 3. Failure to respond to hormone replacement therapy in patients with hypogonadism; AND 4. Failure, contraindication or intolerance to standard treatments.			**Tumors, RCC:** 6 months **Other Uses:** 3 months	prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Reauthorization for AIDS-related cachexia or wasting: Weight has stabilized or improved but not at goal weight. **Advanced Renal Cell Carcinoma**: 1. Confirmed diagnosis of metastatic renal cell carcinoma; AND 2. Failure to two of the following: a. Interferon-alfa-2b b. Interleukin-2 c. Sorafenib d. Sunitanib e. Temsirolimus f. Pazopanib				
Topical Retinoids: Atralin, Avita, Retin A, Retin A Micro, Tretin-X, tretinoin	All FDA approved indications not otherwise excluded from Part D	Treatment for cosmetic purposes.				12 months	
Tracleer	All FDA approved indications not otherwise excluded from Part D		**Pulmonary Arterial Hypertension**: Patients with a confirmed diagnosis of pulmonary arterial hypertension (modified WHO Group I) which is symptomatic.			12 months	
Treanda	All FDA approved indications not otherwise excluded from Part D		**Non-Hodgkin's Lymphoma (NHL):** 1. Diagnosis of indolent B-cell NHL. 2. Progression of NHL during or within 6 months of treatment with rituximab or a rituximab-containing regimen.			6 months	Treanda will be approved continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
Tykerb	All FDA approved indications not otherwise excluded from Part D		**Breast Cancer**: 1, Diagnosis of HER2-positive advanced or metastatic breast cancer 2. Confirmation of normal left ventricular ejection fraction.			12 months	Tykerb will be approved for continuation of prior therapy.
Tysabri	All FDA approved indications not otherwise excluded from Part D	**Multiple Sclerosis:** Used in combination with Avonex, Betaseron, Copaxone, Extavia, or Rebif. **Crohn's:** Receiving immunosuppressants or TNF-blockers.	**Relapsing forms of Multiple Sclerosis (MS):** Failure to one of the following: Avonex, Betaseron, Copaxone, Extavia, or Rebif. **Initial Therapy for Crohn's Disease (CD)**: 1. Moderate-to-severe Crohn's disease with evidence of inflammation; AND 2. History of conventional therapy. 3. History of a TNF blocker. **Reauthorization for Crohn's Disease**: Demonstrated remission or significant clinical response to Tysabri.	**Initial therapy for CD**: 18 years and older.	**Relapsing MS:** Prescribing physician is enrolled in the TOUCH Prescribing Program. **Initial Therapy - CD:** Prescribing physician is enrolled in the CD TOUCH Prescribing Program.	**Initial Therapy**: Tysabri will be authorized for 1 year for MS and 3 months for CD **Reauthorization for CD:** Tysabri will be reauthorized for 6 months for patients on steroids. Otherwise, 3 months.	
Vancocin	All FDA approved indications not otherwise excluded from Part D		**Initial Therapy for Pseudo-membranous Colitis**: 1. Diagnosis of pseudo-membranous colitis due to Clostridium difficile; AND 2. Evidence of severe infection defined by one of the following: a. Two of the following: age greater than 60 years, temperature greater than 38.3 C, albumin less than 2.5 g/dL, WBC count > 15,000 cell/mm2. b. One of the following: endoscopic evidence of pseudomembranous colitis or treatment in the intensive care unit. 3. Failure to oral Flagyl. **Reauthorization for Pseudo-membranous Colitis:**			**Pseudomembranous Colitis (Initial):** 14 days. **Pseudomembranous Colitis (Reauth):** 8 weeks. **Staph enterocolitis:** 14 days.	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Recurrence of Clostridium difficile infection after prior treatment with oral Vancocin capsules. **Staphylococcal enterocolitis:** Diagnosis of enterocolitis due to Staphylococcus aureus.				
Vandetanib	All FDA approved indications not otherwise excluded from Part D		**Initial Therapy for Thyroid Cancer:** 1. Confirmed diagnosis of locally advanced or metastatic medullary thyroid cancer 2. Unresectable disease 3. Symptomatic disease or evidence of progressive disease.		Prescribed by an oncologist or endocrinologist	12 months	Vandetanib will be approved for continuation of prior therapy.
Vectibix	All FDA approved indications not otherwise excluded from Part D		**Colorectal Cancer**: 1. Diagnosis of metastatic colorectal cancer. 2. Relapsed, refractory, or disease progression on one standard chemotherapy regimen containing a fluoropyrmidine, oxaliplatin, or irinotecan. 3. Tumor expresses wild-type KRAS gene.			6 months	Vectibix will be approved for continuation of prior therapy.
Ventavis	All FDA approved indications not otherwise excluded from Part D		**Pulmonary Arterial Hypertension** Patients with a confirmed diagnosis of pulmonary arterial hypertension (modified WHO Group I) which is symptomatic.			12 months	Ventavis is subject to Part B vs. Part D review.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
Victrelis	All FDA-approved indications not otherwise excluded from Part D.	Failure with a previous treatment regimen that includes Victrelis or other HCV NS3/4A protease inhibitor [ie, Incivek (telaprevir)], coinfection with HIV, coinfection with hepatitis B virus, and post-organ transplant.	Hepatitis C: (Initial) Diagnosis of chronic hepatitis C genotype 1 infection, positive HCV RNA antibody, HCV RNA level measurement, without decompensated disease, and used in combination with peginterferon alfa and ribavirin. (Reauthorization) Evidence of undetectable HCV RNA at treatment week 24, HCV RNA level measurement at treatment week 8, and used in combination with peginterferon alfa and ribavirin.	Hep C: 18 year and older	Hep C: Prescribed by a hepatologist, gastroenterologist, or ID specialist	Hep C: (Init) 24 wks (Reauth) 8 or 20 wks	Reauthorization will be issued for 8 weeks in the following patients: Previously treatment-naive patients with detectable HCV RNA at treatment week 8 or previous partial responders or relapsers to peginterferon alfa and ribavirin therapy. Reauthorization will be issued for 20 weeks in the following patients: Patients with compensated cirrhosis, previous null responders to peginterferon alfa and ribavirin therapy, or poor interferon responsiveness as determined at treatment week 4.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
Votrient	All FDA-approved indications not otherwise excluded from Part D		**Renal cell carcinoma:** Diagnosis of advanced renal cell cancer.			1 year	Prior authorization applies to new starts only
Vpriv	All FDA-approved indications not otherwise excluded from Part D		**Gaucher's disease** 1. Confirmed diagnosis of Type 1 Gaucher's disease. 2. Symptomatic disease defined by one of the following: a. moderate to severe anemia b. thrombocytopenia c. bone disease d. hepatomegaly e. splenomegaly.			12 months	
Xenazine	All FDA approved indications not otherwise excluded from Part D. Tardive dyskinesia. Tourette's syndrome.		**Initial therapy for Huntington's Disease:** Diagnosis of chorea in patients with Huntington's disease. **Initial therapy for Tardive dyskinesia and Tourette's syndrome:** 1. Stereotypes associated with tardive dyskinesia; OR 2. Both of the following: a. Tics associated with Tourette's syndrome; AND b. Failure, contraindication, or intolerance to Haldol (haloperidol) **Reauthorization for Huntington's Disease, Tardive dyskinesia, and Tourette's syndrome:** Documented clinical response and benefit from therapy.	**Tardive dyskinesia**: 18 years and older	**Huntington:** Prescribed by a neurologist. **Tardive dyskinesia, Tourette:** Prescribed by neurologist or psychiatrist.	**Initial Therapy:** 3 months. **Reauthorization:** 12 months.	
Xgeva	All FDA-approved indications not otherwise excluded from Part D.	Prevention of skeletal-related events in patients with multiple myeloma.	**Prevention of skeletal-related events:** Used for prevention of skeletal-related events in patients with bone metastases from solid tumors.			12 months	

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
Xolair	All FDA approved indications not otherwise excluded from Part D		**Initial Therapy for Allergic Asthma**: 1. Diagnosis of moderate-to-severe persistent allergic asthma, defined by one of the following: a. Daily asthmatic symptoms b. Daily use of inhaled short-acting beta agonists c. Exacerbations affect/limit activity d. Exacerbations 2 or more times per year e. Nocturnal symptoms once a week or more f.. Forced expiratory volume in one second or peak expiratory flow less than or equal to 80% of predicted g. PEF variability greater than 30% h. Measures of asthma control indicate uncontrolled asthma (eg, Asthma Control Test [ACT] score ≤19) AND 2. Baseline IgE level greater than or equal to 30 IU/mL; AND 3. Documented failure to combination therapy with an inhaled corticosteroid at the maximum dosage and a long-acting beta-agonist, or to one combination inhaled corticosteroid/long-acting beta agonist. **Reauthorization for Allergic Asthma**: 1. Documentation of clinical benefit with Xolair treatment (eg, reduction in the frequency of asthma exacerbations, reduction in the use of rescue medications or inhaled corticosteroids, improvement in FEV1, reduction in the frequency of nocturnal symptoms, improvement in asthma control questionnaire).	**Initial treatment**: 12 years and older. **Continuation of therapy:** 6 years and older.	**Initial Therapy**: Prescribed by a pulmonolog-ist or allergist/ immunologist.	**Initial Therapy:** 6 months **Reauthorization:** 1 year	
Zolinza	All FDA approved indications not otherwise excluded from Part D		**Cutaneous T-cell Lymphoma** 1. Definitive diagnosis of cutaneous T-cell lymphoma (CTCL) 2. Failure to two systemic therapies.			12 months	Zolinza will be approved for continuation of prior therapy.

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
Zortress	All FDA-approved indications not otherwise excluded from Part D. Cardiac Transplant.		**Transplant:** Patient received a renal or cardiac transplant.			12 months	Subject to Part B vs. Part D review. Approve for continuation of prior therapy if Part D.
Zytiga	All FDA-approved indications not otherwise excluded from Part D. Prostate cancer: Asymptomatic/ minimally symptomatic without visceral disease. Symptomatic or has visceral disease, and not a candidate for docetaxel-based chemotherapy.		Prostate cancer: Confirmed diagnosis of metastatic hormone-refractory or castration-resistant prostate cancer, used in combination with prednisone, documented disease progression, and one of the following: patient is asymptomatic/minimally symptomatic without visceral disease, or both of the following: patient is symptomatic or has visceral disease, and has previous treatment with docetaxel-based chemotherapy or is not a candidate for docetaxel-based chemotherapy.			12 months	Approve for continuation of prior therapy

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrict-ions	Prescriber Restrictions	Coverage Duration	Other Criteria
Zyvox	All FDA approved indications not otherwise excluded from Part D Chronic osteomyelitis. Prosthetic joint infection.		**Infections**: One of the following: 1. Infections caused by vancomycin-resistant enterococci (VRE) documented by culture and sensitivity (C/S) report. 2. Nosocomial pneumonia caused by methicillin-resistant Staphylococcus aureus (MRSA) documented by C/S report. 3. Nosocomial or community acquired pneumonia (CAP) caused by methicillin susceptible Staphylococcus aureus (MSSA) or Streptococcus pneumoniae documented by C/S report and failure to 2 (or resistance to all) first line antibiotics. 4. Complicated skin and skin structure infections (SSI), including diabetic foot infections, without osteomyelitis caused by MRSA documented by C/S report. 5. Uncomplicated SSI caused by MRSA documented by C/S report or empirical treatment of patients with uncomplicated or community-acquired complicated SSI without osteomyelitis where MRSA infection is likely, in patients who have failed one or has resistance to all of the following: a. trimethoprim-sulfamethoxazole b. tetracycline c. doxycycline d. minocycline e. clindamycin 6. Uncomplicated or complicated SSI without osteomyelitis caused by MSSA, Streptococcus pyogenes, or Streptococcus agalactiae (complicated SSI only) documented by C/S report and failure to two or resistance to all first line antibiotics. 7. Chronic osteomyelitis or prosthetic joint infection due to MRSA or methicillin-resistant Staphylococcus epidermidis (MRSE), and failure to two or resistance to all first line antibiotics. 8. Cutaneous or systemic infection caused by Nocardia (nocardiosis) and failure to 2 (or resistance to all) first line antibiotics. 9. For all indications except CAP and SSI, allow for continuation of therapy when transitioning from intravenous daptomycin, intravenous vancomycin, or intravenous Zyvox therapy. For CAP, allow for continuation of therapy		**Chronic osteomyelitis, prosthetic joint infection, cutaneous or systemic Nocardiosis:** Prescribed by an infectious disease specialist or by consultation with an infectious disease specialist.	**Non-MRSA nosocomial or community acquired pneumonia, SSI:** 14 days **Chronic osteomyelitis, prosthetic joint Infection:** 6 weeks **Cutaneous Nocardiosis:** 3 months **Systemic Nocardiosis:** 12 months **Other uses:** 28 days	**9/19/2011**

The following drugs 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: For Part D usage, the drug still must adhere to FDA approved or compendia approved diagnoses.

- Acetylcysteine
- Acyclovir
- Adriamycin
- Albuterol
- Aminosyn
- Amphotericin
- Anzemet
- Aranesp
- Bleomycin
- Boniva Inj
- Budesonide
- Calcitriol
- Carimune NF
- Carnitor
- Cellcept
- Cladribine
- Clinimix
- Clinimix E
- Clinisol SF
- Cromolyn Sodium
- Cubicin
- Cyclophosphamide
- Cyclosporine
- Cyclosporine Modified
- Cytarabine
- Doxil
- Doxorubicin
- Dronabinol
- Emend
- Engerix-B
- Fluorouracil
- Forteo
- Foscarnet
- Freamine HBC
- Freamine III
- Gamastan S/D
- Gammagard Liquid
- Gamunex
- Gengraf
- Granisetron
- Granisol
- Hectoral
- Hepatamine
- Hepatasol
- Intralipid
- Ipratropium bromide
- Ipratropium bromide/albuterol sulfate
- Levalbuterol
- Levocarnitine
- Lidocaine Ointment/Inj
- Lidocaine/prilocaine
- Miacalcin
- Mycophenolate
- Myfortic
- Nephramine
- Novamine
- Octagam
- Ondansetron
- Ondansetron ODT
- Premasol
- Privigen
- Procalamine
- Procrit
- Prograf
- Prosol
- Pulmicort
- Rapamune
- Recombivax HB
- Remodulin
- Renamin
- Tacrolimus
- Tobi
- Travasol
- Trophamine
- Vancomyin Inj
- Ventavis
- Vinblastine
- Vincasar PFS
- Vincristine
- Xopenex
- Zemplar
- Zenapax