

## Medicare Prior Authorization Information

Prior Authorization Group Description: 8-MOP

Drug Name: 8-MOP

Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions: DERMATOLOGIST OR IMMUNOLOGIST

Coverage Duration: 6 MONTHS

Other Criteria:

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Prior Authorization Group Description: ACTIMMUNE

Drug Name: ACTIMMUNE

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions: HEMATOLOGIST, ONCOLOGIST, PEDIATRICIAN OR INFECTIOUS DISEASE SPECIALIST

Coverage Duration: 3 MONTHS

Other Criteria:

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Prior Authorization Group Description: ALBUTEROL

Drug Name: ALBUTEROL SULFATE

Covered Uses: THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Other Criteria:

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Prior Authorization Group Description: ALDARA

Drug Name: ALDARA

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria: SUPERFICIAL BASAL CELL CARCINOMA GREATER THAN 2CM IN SIZE AND ON THE FACE

Required Medical Information:

Age Restrictions: LESS THAN 18 YEARS OF AGE FOR NON-HYPERKERATOTIC, NON-HYPERTROPHIC ACTINIC KERATOSES

Prescriber Restrictions: DERMATOLOGIST OR ONCOLOGIST

Coverage Duration: 16 WEEKS

Other Criteria:

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Prior Authorization Group Description: ALISKIREN

Drug Name: TEKTRUNA | TEKTRUNA HCT

Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information: DOCUMENTATION OF PREVIOUS TREATMENT FAILURE OF 1 ACE INHIBITOR AND 1 ARB AGENT.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration: 12 MONTHS

Other Criteria:

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Prior Authorization Group Description: ALL ANTINEOPLASTICS

Drug Name: ARIMIDEX | AROMASIN | CASODEX | CEENU | EMCYT | FARESTON | FEMARA | GLEEVEC | HEXALEN | IRESSA | KCL 0.15%/D5W/NACL 0.45% | LEUKERAN | LYSODREN | MATULANE | MAXIPIME | NEXAVAR | NILANDRON | REVLIMID | SEROMYCIN | SPRYCEL | SUTENT | TABLOID | TASIGNA | THALOMID | THIOLA | TRETINOIN

Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria: PART B COVERAGE

Required Medical Information:

Age Restrictions:

Prescriber Restrictions: ONCOLOGIST

Coverage Duration: PER COURSE OF THERAPY

Other Criteria:

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Prior Authorization Group Description: ALL INFUSIBLE/INJECTABLE DRUGS

Drug Name: ABELCET | ABILIFY | ACYCLOVIR SODIUM | ADAGEN | ALDURAZYME | AMBISOME | A-METHAPRED | AMIKACIN SULFATE | AMINOSYN | AMINOSYN II | AMINOSYN-HBC | AMINOSYN-HF | AMINOSYN-PF 7% | AMPHOTEC | AMPHOTERICIN B | AMPICILLIN SODIUM | AMPICILLIN-SULBACTAM | ANTIZOL | ATGAM | ATROPINE SULFATE | AZACTAM | AZITHROMYCIN | BICILLIN C-R | BICILLIN L-A | BLEOMYCIN SULFATE | CAMPATH | CARIMUNE NANOFILTERED | CEFAZOLIN SODIUM | CEFEPIME | CEFOTAXIME SODIUM | CEFTRIAZONE IN ISO-OSMOTIC DEXTROSE | CEFTRIAZONE SODIUM | CEFUROXIME SODIUM | CEREDASE | CEREZYME | CHLORPROMAZINE HCL | CHORIONIC GONADOTROPIN | CIMETIDINE HCL | CLINDAMYCIN PHOSPHATE | CYKLOKAPRON | DEPO-MEDROL | DEPO-PROVERA | DEXTROSE 10% | DEXTROSE 2.5%/NACL 0.45% | DEXTROSE 2.5%/SODIUM CHLORIDE 0.45% | DEXTROSE 5% | DEXTROSE 5%/LACTATED RINGER'S | DEXTROSE 5%/NACL 0.2% | DEXTROSE 5%/NACL 0.225% | DEXTROSE 5%/NACL 0.33% | DEXTROSE 5%/NACL 0.45% | DEXTROSE 5%/POTASSIUM CHLORIDE 0.15% | DEXTROSE 5%/SODIUM CHLORIDE 0.2% | DEXTROSE 5%/SODIUM CHLORIDE 0.33% | DEXTROSE 5%/SODIUM CHLORIDE 0.45% | DIGOXIN | DIHYDROERGOTAMINE MESYLATE | DIPHENHYDRAMINE HCL | ELIGARD | ELITEK | EPINEPHRINE HCL | ERYTHROCIN | ERYTHROCIN LACTOBIONATE | FABRAZYME | FAMOTIDINE | FAMOTIDINE PREMIXED | FENTANYL CITRATE | FLUCONAZOLE IN DEXTROSE | FLUCONAZOLE IN NACL | FLUPHENAZINE DECANOATE | FLUPHENAZINE HCL | FOMEPIZOLE | FORTAZ | FREAMINE HBC 6.9% | GAMUNEX | GENTAMICIN SULFATE | HALOPERIDOL DECANOATE | HALOPERIDOL LACTATE | HECTOROL | HEPARIN SODIUM/D5W | HEPARIN SODIUM/NACL 0.9% | HEPARIN SODIUM/SODIUM CHLORIDE 0.9% | HEPATASOL | HYDROMORPHONE HCL | KCL 0.15%/D5W/ NACL 0.3% | KCL 0.15%/D5W/LR | KCL 0.15%/D5W/NACL 0.2% | KCL 0.15%/D5W/NACL 0.225% | KCL 0.15%/D5W/NACL 0.9% | KCL 0.3%/D5W/LR IV LAC RING | KCL 0.3%/D5W/NACL 0.45% | KEPIVANCE | KETOROLAC TROMETHAMINE | LACTATED RINGER'S DEXTROSE 5% VIAFLEX | LACTATED RINGER'S VIAFLEX | LANOXIN | LEUPROLIDE ACETATE | LEVAQUIN | LEVAQUIN PREMIX | LIDOCAINE HCL | LUPRON DEPOT | LUPRON DEPOT-PED | MAXIPIME | MEDROXYPROGESTERONE ACETATE | MEPERIDINE HCL | METHADONE HCL | METHYLPREDNISOLONE ACETATE | METHYLPREDNISOLONE SODIUMSUCCINATE | METRO IV | METRONIDAZOLE IN NACL 0.79% | MITOXANTRONE HCL | MORPHINE SULFATE | NAFACILLIN SODIUM | NAGLAZYME | NALOXONE HCL | NEPHRAMINE | NEUTREXIN | ONTAK | ORENCIA | PAMIDRONATE DISODIUM | PANGLOBULIN NF | PENICILLIN G POTASSIUM | PENICILLIN G SODIUM | PFIZERPEN-G | PHENYTOIN SODIUM | PIPERACILLIN SODIUM | POTASSIUM CHLORIDE 0.075%/D5W/NACL 0.225% | POTASSIUM CHLORIDE 0.15% | POTASSIUM CHLORIDE 0.15%/D5W | POTASSIUM CHLORIDE 0.15%/NACL 0.9% | POTASSIUM CHLORIDE 0.15%D5W/NACL 0.33% | POTASSIUM CHLORIDE 0.15%D5W/NACL 0.45% VIAFLEX | POTASSIUM CHLORIDE 0.22%D5W/NACL 0.45% | POTASSIUM CHLORIDE 0.224%/D5W | POTASSIUM CHLORIDE 0.224%/D5W/NACL 0.45% | POTASSIUM CHLORIDE 0.3%/D5W | POTASSIUM CHLORIDE 0.3%/NACL 0.9% | PREMASOL | PROCHLORPERAZINE EDISYLATE | PROLEUKIN | PROMETHAZINE HCL | PROTONIX | RANITIDINE HCL | RENAMIN | RINGER'S INJECTION | RISPERDAL CONSTA | RITUXAN | SANDOSTATIN LAR DEPOT | SODIUM CHLORIDE | SODIUM CHLORIDE 0.9% | SODIUM CHLORIDE 0.45% VIAFLEX | STERILE WATER IRRIGATION | SULFAMETHOXAZOLE/TRIMETHOPRIM | TAZICEF | TIMENTIN | TOBRAMYCIN SULFATE |

TOBRAMYCIN SULFATE FLIPTOP | TRAVASOL | TRELSTAR DEPOT | TRELSTAR LA | TRISENOX | TROPHAMINE | TYGACIL | VALPROATE SODIUM | VANCOMYCIN HCL | VELCADE | VIDAZA | XOLAIR | ZEMPLAR | ZYPREXA | ZYVOX

Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria: PART B COVERAGE

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration: PER COURSE OF THERAPY

Other Criteria:

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Prior Authorization Group Description: AMNESTEEM

Drug Name: AMNESTEEM

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions: DERMATOLOGIST

Coverage Duration: 6 MONTHS

Other Criteria: PRESCRIBING DOCTOR REGISTER THE MEMBER IN THE IPLEDGE PROGRAM

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Prior Authorization Group Description: ANDRODERM

Drug Name: ANDRODERM

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information: TESTOSTERONE, TOTAL, PLASMA LESS THAN OR EQUAL TO 200NG/DL OR 7NMOL/L, OR TOTAL, PLASMA LESS THAN OR EQUAL TO 300NG/DL OR 10NMOL/L

Age Restrictions: MALE LESS THAN 18 YEARS OF AGE

Prescriber Restrictions:

Coverage Duration: 6 MONTHS

Other Criteria:

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Prior Authorization Group Description: ANDROXY

Drug Name: ANDROXY

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information: TESTOSTERONE, TOTAL, PLASMA LESS THAN OR EQUAL TO 200NG/DL OR 7NMOL/L, OR TOTAL, PLASMA LESS THAN OR EQUAL TO 300NG/DL OR 10NMOL/L

Age Restrictions:

Prescriber Restrictions:

Coverage Duration: 6 MONTHS

Other Criteria:

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Prior Authorization Group Description: ARANESP

Drug Name: ARANESP ALBUMIN FREE | ARANESP ALBUMIN FREE SURE

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria: PART B COVERAGE

Required Medical Information: HEMOGLOBIN OF LESS THAN OR EQUAL TO 10GM/DL, OR HEMATOCRIT OF LESS THAN OR EQUAL TO 30%, AND FERRITIN LESS THAN 100NG/ML OR TRANSFERRIN SATURATION LESS THAN 20%

Age Restrictions:

Prescriber Restrictions:

Coverage Duration: 3 MONTHS

Other Criteria:

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Prior Authorization Group Description: ARIXTRA

Drug Name: ARIXTRA

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: AVODART  
Drug Name: AVODART  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: UROLOGIST  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: AVONEX  
Drug Name: AVONEX  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: KURTZKE EXPANDED DISABILITY STATUS SCALE (EDSS) OF 5.5 OR LESS  
Age Restrictions:  
Prescriber Restrictions: NEUROLOGIST  
Coverage Duration: 3 MONTHS  
Other Criteria: DEMYELINATING EVENT THAT WAS DOCUMENTED BY MRI STUDIES

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Prior Authorization Group Description: BARACLUDGE  
Drug Name: BARACLUDGE  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: HBSAG POSITIVE FOR LONGER THAN SIX MONTHS, SERUM HBV DNA POSITIVE, PERSISTENT OR INTERMITTENT ELEVATION OF ALT/AST, LIVER BIOPSY SHOWING CHRONIC HEPATITIS  
Age Restrictions:  
Prescriber Restrictions: GASTROENTEROLOGIST OR INFECTIOUS DISEASE SPECIALIST  
Coverage Duration: 3 MONTHS  
Other Criteria:

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Prior Authorization Group Description: BETASERON  
Drug Name: BETASERON  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: KURTZKE EXPANDED DISABILITY STATUS SCALE (EDSS) OF 5.5 OR LESS  
Age Restrictions:  
Prescriber Restrictions: NEUROLOGIST  
Coverage Duration: 3 MONTHS  
Other Criteria:

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Prior Authorization Group Description: BISPHOSPHONATES  
Drug Name: BONIVA  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: BMD RESULTS WITH T SCORE GREATER THAN 2.0  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 MONTHS

Other Criteria: BMD RESULTS WITH T SCORE LESS THAN 1.5, MUST HAVE ADDITIONAL RISK FACTORS

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Prior Authorization Group Description: BUPHENYL

Drug Name: BUPHENYL

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions: GASTROENTEROLOGIST OR NEONATAL SPECIALIST

Coverage Duration: 12 MONTHS

Other Criteria:

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Prior Authorization Group Description: BYETTA

Drug Name: BYETTA

Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information: HBA1C

Age Restrictions:

Prescriber Restrictions: ENDOCRINOLOGIST

Coverage Duration: 12 MONTHS

Other Criteria:

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Prior Authorization Group Description: CALCITONIN, SALMON NASAL

Drug Name: FORTICAL

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information: BMD RESULTS WITH T SCORE GREATER THAN 2.0

Age Restrictions:

Prescriber Restrictions:

Coverage Duration: 12 MONTHS

Other Criteria: BMD RESULTS WITH T SCORE LESS THAN 1.5, MUST HAVE ADDITIONAL RISK FACTORS, CAN NOT TOLERATE ORAL BISPHOSPHONATE THERAPY

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Prior Authorization Group Description: CLARAVIS

Drug Name: CLARAVIS

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions: DERMATOLOGIST

Coverage Duration: 6 MONTHS

Other Criteria: PRESCRIBING DOCTOR REGISTER THE MEMBER IN THE IPLEDGE PROGRAM

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Prior Authorization Group Description: COPAXONE

Drug Name: COPAXONE

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information: KURTZKE EXPANDED DISABILITY STATUS SCALE (EDSS) SCORE OF 5.5 OR LESS

Age Restrictions:

Prescriber Restrictions: NEUROLOGIST

Coverage Duration: 3 MONTHS

Other Criteria:

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Prior Authorization Group Description: COZAAR

Drug Name: COZAAR

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: CUPRIMINE  
Drug Name: CUPRIMINE  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: RHEUMATOLOGIST  
Coverage Duration: 6 MONTHS  
Other Criteria:

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Prior Authorization Group Description: CYMBALTA  
Drug Name: CYMBALTA  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions: LESS THAN18YO  
Prescriber Restrictions: NEUROLOGIST OR PSYCHIATRIST  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: CYSTAGON  
Drug Name: CYSTAGON  
Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: APPROPRIATE DOCUMENTATION OF CYSTINOSIS, RENAL FUNCTION TEST, ELECTROLYTE VALUES, DOCUMENTATION OF FANCONI SYNDROME.  
Age Restrictions:  
Prescriber Restrictions: ENDOCRINOLOGIST  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: DENAVIR  
Drug Name: DENAVIR  
Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: DOCUMENTATON OF ACYCLOVIR FAILURE OR CONTRAINDICTION  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 4 DAYS  
Other Criteria:

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Prior Authorization Group Description: DIOVAN  
Drug Name: DIOVAN | DIOVAN HCT  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: DOVONEX

Drug Name: CALCIPOTRIENE | DOVONEX  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: DERMATOLOGIST  
Coverage Duration: 6 MONTHS  
Other Criteria:

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Prior Authorization Group Description: ELIDEL  
Drug Name: ELIDEL  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: DERMATOLOGIST  
Coverage Duration: 3 MONTHS  
Other Criteria:

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Prior Authorization Group Description: EMEND  
Drug Name: EMEND  
Covered Uses: THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration:  
Other Criteria:

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Prior Authorization Group Description: EMLA  
Drug Name: LIDOCAINE/PRILOCAINE  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: DURATION APPROVED AS LISTED IN THE FDA APPROVED LABEL  
Other Criteria:

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Prior Authorization Group Description: EMSAM  
Drug Name: EMSAM  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: PSYCHIATRIST  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: ENBREL  
Drug Name: ENBREL | ENBREL SURECLICK  
Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: RHEUMATOLOGIST OR DERMATOLOGIST  
Coverage Duration: 3 MONTHS

Other Criteria: PATIENT GREATER THAN 18 YEARS OF AGE WITH CHRONIC MODERATE TO SEVERE PLAQUE PSORIASIS OF GREATER THAN 10% BODY SURFACE AREA (BSA)

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Prior Authorization Group Description: EPIVIR HBV

Drug Name: EPIVIR HBV

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information: HBSAG POSITIVE FOR LONGER THAN SIX MONTHS, SERUM HBV DNA POSITIVE, PERSISTENT OR INTERMITTENT ELEVATION OF ALT/AST, LIVER BIOPSY SHOWING CHRONIC HEPATITIS

Age Restrictions:

Prescriber Restrictions: GASTROENTEROLOGIST OR INFECTIOUS DISEASE SPECIALIST

Coverage Duration: 3 MONTHS

Other Criteria:

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Prior Authorization Group Description: EPOGEN

Drug Name: EPOGEN

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information: HEMOGLOBIN OF LESS THAN OR EQUAL TO 10GM/DL, OR HEMATOCRIT OF LESS THAN OR EQUAL TO 30%, AND FERRITIN LESS THAN 100NG/ML OR TRANSFERRIN SATURATION LESS THAN 20%

Age Restrictions:

Prescriber Restrictions:

Coverage Duration: 3 MONTHS

Other Criteria:

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Prior Authorization Group Description: EVISTA

Drug Name: EVISTA

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information: BMD RESULTS WITH T SCORE GREATER THAN 2.5

Age Restrictions:

Prescriber Restrictions:

Coverage Duration: 12 MONTHS

Other Criteria: BMD RESULTS WITH T SCORE LESS THAN 1.5, MUST HAVE ADDITIONAL RISK FACTORS, CAN NOT TOLERATE ORAL BISPHOSPHONATE THERAPY

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Prior Authorization Group Description: EXJADE

Drug Name: EXJADE

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions: HEMATOLOGIST

Coverage Duration: 12 MONTHS

Other Criteria: DIAGNOSIS OF HEMOGLOBINOPATHY OR SICKLE CELL DISEASE WITH IRON OVERLOAD

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Prior Authorization Group Description: FAT EMULSIONS

Drug Name: INTRALIPID | INTRALIPID 20%

Covered Uses: THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Other Criteria:

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Prior Authorization Group Description: FELBATOL  
Drug Name: FELBATOL  
Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria: HEPATIC DYSFUNCTION  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: NEUROLOGIST  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: FENTANYL  
Drug Name: FENTANYL  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 3 MONTHS  
Other Criteria:

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Prior Authorization Group Description: FORTEO  
Drug Name: FORTEO  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria: DIAGNOSIS OF PAGETS DISEASE, A HISTORY OF RADIATION THERAPY, BONE MALIGNANCY, A HISTORY OF HYPERCALCEMIA OR HYPERPARATHYROIDISM  
Required Medical Information: BMD RESULTS WITH T SCORE GREATER THAN 2.5  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 MONTHS  
Other Criteria: CAN NOT TOLERATE ORAL BISPHOSPHONATE THERAPY

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Prior Authorization Group Description: FRAGMIN  
Drug Name: FRAGMIN  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: DURATION APPROVED AS LISTED IN THE FDA APPROVED LABEL  
Other Criteria:

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Prior Authorization Group Description: GABITRIL  
Drug Name: GABITRIL  
Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 MONTHS  
Other Criteria: ADJUNCTIVE THERAPY

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Prior Authorization Group Description: GEODON  
Drug Name: GEODON  
Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:

Age Restrictions:  
Prescriber Restrictions: PSYCHIATRIST  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: GRISEOFULVIN  
Drug Name: GRIFULVIN V | GRISEOFULVIN MICROSIZED  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: POSITIVE DERMATOPHYTE CULTURE  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 WEEKS  
Other Criteria:

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Prior Authorization Group Description: GRIS-PEG  
Drug Name: GRIS-PEG  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: POSITIVE DERMATOPHYTE CULTURE  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 WEEKS  
Other Criteria:

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Prior Authorization Group Description: HEPATITIS B VACCINE  
Drug Name: COMVAX | ENGERIX-B | PEDIARIX | RECOMBIVAX HB | TWINRIX  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria: PART B COVERAGE  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: PER COURSE OF THERAPY  
Other Criteria:

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Prior Authorization Group Description: HEPSERA  
Drug Name: HEPSERA  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: HBSAG POSITIVE FOR LONGER THAN SIX MONTHS, SERUM HBV DNA POSITIVE, PERSISTENT OR INTERMITTENT ELEVATION OF ALT/AST.  
Age Restrictions:  
Prescriber Restrictions: GASTROENTEROLOGIST OR INFECTIOUS DISEASE SPECIALIST OR HEMATOLOGIST  
Coverage Duration: 3 MONTHS  
Other Criteria:

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Prior Authorization Group Description: HUMIRA  
Drug Name: HUMIRA | HUMIRA PEN | HUMIRA PEN-CROHNS DISEASE  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria: CONCURRENT USE WITH KINERET  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: RHEUMATOLOGIST OR DERMATOLOGIST OR GASTROENTEROLOGIST  
Coverage Duration: 3 MONTHS  
Other Criteria: 20% OR GREATER IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT

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Prior Authorization Group Description: HYZAAR  
Drug Name: HYZAAR

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: IDURSULFASE  
Drug Name: ELAPRASE  
Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: APPROPRIATE DOCUMENTATION OF HUNTERS SYNDROME  
Age Restrictions:  
Prescriber Restrictions: ENDOCRINOLOGIST  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: IMMUNOSUPPRESSANT AGENTS  
Drug Name: AZATHIOPRINE | CELLCEPT | CYCLOSPORINE | CYCLOSPORINE MODIFIED | GENGRAF | MYFORTIC | PROGRAF | RAPAMUNE | SIMULECT | ZENAPAX  
Covered Uses: THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration:  
Other Criteria:

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Prior Authorization Group Description: INFERGEN  
Drug Name: INFERGEN  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: INFECTIOUS DISEASE SPECIALIST, GASTROENTEROLOGIST OR HEPATOLOGIST  
Coverage Duration: 3 MONTHS  
Other Criteria:

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Prior Authorization Group Description: INSPRA  
Drug Name: EPLERENONE | INSPRA  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: LEFT VENTRICULAR EJECTION FRACTION (LVEF) OF LESS THAN 40%  
Age Restrictions:  
Prescriber Restrictions: CARDIOLOGIST  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: INTRON A  
Drug Name: INTRON-A | INTRON-A W/DILUENT  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions: LESS THAN 18 YEARS OF AGE

Prescriber Restrictions: GASTROENTEROLOGIST, INFECTIOUS DISEASE OR HEPATOLOGIST  
Coverage Duration: 3 MONTHS  
Other Criteria: ACHIEVED AN EARLY VIRAL RESPONSE (EVR) DEFINED AS A MINIMUM 2 LOG DECREASE IN VIRAL LOAD DURING THE FIRST 12 WEEKS OF TREATMENT

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Prior Authorization Group Description: ITRACONAZOLE  
Drug Name: ITRACONAZOLE  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: POSITIVE DERMATOPHYTE CULTURE  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: PER COURSE OF THERAPY  
Other Criteria:

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Prior Authorization Group Description: KEPPRA  
Drug Name: KEPPRA  
Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 MONTHS  
Other Criteria: ADJUNCTIVE THERAPY

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Prior Authorization Group Description: KINERET  
Drug Name: KINERET  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: BASELINE ABSOLUTE NEUTROPHIL COUNT (ANC) LESS THAN 1 X 10(9)/LITER  
Age Restrictions: GREATER THAN 18 YEARS OF AGE  
Prescriber Restrictions: RHEUMATOLOGIST  
Coverage Duration: 3 MONTHS  
Other Criteria: EXPERIENCED 20% OR GREATER IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT

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Prior Authorization Group Description: KYTRIL  
Drug Name: GRANISETRON HCL  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria: PART B COVERAGE  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: DURATION APPROVED AS LISTED IN THE FDA APPROVED LABEL  
Other Criteria:

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Prior Authorization Group Description: LAMISIL  
Drug Name: TERBINAFINE HCL  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: POSITIVE DERMATOPHYTE CULTURE  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: PER COURSE OF THERAPY  
Other Criteria:

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Prior Authorization Group Description: LEFLUNOMIDE  
Drug Name: LEFLUNOMIDE

Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions: RHEUMATOLOGIST

Coverage Duration: 12 MONTHS

Other Criteria:

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Prior Authorization Group Description: LEUKINE

Drug Name: LEUKINE

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions: HEMATOLOGIST OR ONCOLOGIST

Coverage Duration: 12 MONTHS

Other Criteria:

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Prior Authorization Group Description: LEXAPRO

Drug Name: LEXAPRO

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration: 12 MONTHS

Other Criteria:

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Prior Authorization Group Description: LIDODERM

Drug Name: LIDODERM

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration: 12 MONTHS

Other Criteria:

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Prior Authorization Group Description: LOTRONEX

Drug Name: LOTRONEX

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria: MALES

Required Medical Information:

Age Restrictions: LESS THAN 18 YEARS OF AGE

Prescriber Restrictions:

Coverage Duration: 3 MONTHS

Other Criteria:

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Prior Authorization Group Description: LOVENOX

Drug Name: LOVENOX

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration: 10 DAYS

Other Criteria:

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Prior Authorization Group Description: LYRICA

Drug Name: LYRICA  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: NEUROLOGIST  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: MARINOL  
Drug Name: MARINOL  
Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: ONCOLOGIST  
Coverage Duration: PER COURSE OF THERAPY  
Other Criteria:

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Prior Authorization Group Description: MECASERMIN  
Drug Name: INCRELEX | IPLEX  
Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: GROWTH HORMONE STIMULATION TESTS, IGF-1 AND IGFBG-3 LEVELS  
Age Restrictions:  
Prescriber Restrictions: PEDIATRIC ENDOCRINOLOGIST OR A PEDIATRIC NEPHROLOGIST  
Coverage Duration: 6 MONTHS  
Other Criteria:

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Prior Authorization Group Description: METHOXSALEN  
Drug Name: OXSORALEN | OXSORALEN ULTRA  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: FAILED ONE FORMULARY AGENT FOR PSORIASIS OR VITILIGO, E.G. TOPICAL CORTICOSTEROIDS  
Age Restrictions:  
Prescriber Restrictions: DERMATOLOGIST OR IMMUNOLOGIST  
Coverage Duration: 6 MONTHS  
Other Criteria:

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Prior Authorization Group Description: METHYLTESTOSTERONE  
Drug Name: ANDROID  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: TESTOSTERONE, TOTAL, PLASMA LESS THAN OR EQUAL TO 200NG/DL OR 7NMOL/L, OR TOTAL, PLASMA LESS THAN OR EQUAL TO 300NG/DL OR 10NMOL/L  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 6 MONTHS  
Other Criteria:

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Prior Authorization Group Description: NEULASTA  
Drug Name: NEULASTA  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:

Age Restrictions:  
Prescriber Restrictions: HEMATOLOGIST OR ONCOLOGIST  
Coverage Duration: 3 MONTHS  
Other Criteria:

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Prior Authorization Group Description: NEUPOGEN  
Drug Name: NEUPOGEN  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: HEMATOLOGIST OR ONCOLOGIST  
Coverage Duration: 3 MONTHS  
Other Criteria:

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Prior Authorization Group Description: NIASPAN  
Drug Name: NIASPAN  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: NICOTROL NS  
Drug Name: NICOTROL INHALER | NICOTROL NS  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: CERTIFICATE OF ATTENDANCE TO A SMOKING CESSATION PROGRAM  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 3 MONTHS  
Other Criteria:

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Prior Authorization Group Description: ONDANSETRON  
Drug Name: ONDANSETRON HCL | ONDANSETRON ODT  
Covered Uses: THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration:  
Other Criteria:

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Prior Authorization Group Description: ORFADIN  
Drug Name: ORFADIN  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: PEDIATRIC GASTROENTEROLOGIST OR HEPATOLOGIST OR ENDOCRINOLOGIST  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: OXANDROLONE

Drug Name: OXANDROLONE  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: ENDOCRINOLOGIST  
Coverage Duration: 3 MONTHS  
Other Criteria:

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Prior Authorization Group Description: PANRETIN  
Drug Name: PANRETIN  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: DERMATOLOGIST OR INFECTIOUS DISEASE  
Coverage Duration: 12 MONTHS  
Other Criteria: MORE THAN 10 NEW KS LESIONS IN THE PRIOR MONTH, SYMPTOMATIC LYMPHEDEMA, SYMPTOMATIC PULMONARY KS, OR SYMPTOMATIC VISCERAL INVOLVEMENT

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Prior Authorization Group Description: PAROXETINE  
Drug Name: PAROXETINE HCL  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: DOCUMENTED MEDICAL NEED FOR THE A NON-ORAL DOSAGE FORM  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: PEGASYS  
Drug Name: PEGASYS  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions: LESS THAN 18 YEARS OF AGE  
Prescriber Restrictions: GASTROENTEROLOGIST, INFECTIOUS DISEASE OR HEPATOLOGIST  
Coverage Duration: 3 MONTHS  
Other Criteria: ACHIEVED AN EARLY VIRAL RESPONSE (EVR) DEFINED AS A MINIMUM 2 LOG DECREASE IN VIRAL LOAD DURING THE FIRST 12 WEEKS OF TREATMENT

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Prior Authorization Group Description: PEG-INTRON  
Drug Name: PEG-INTRON | PEG-INTRON REDIPEN | PEG-INTRON REDIPEN PAK 4  
Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions: LESS THAN 18 YEARS OF AGE  
Prescriber Restrictions: GASTROENTEROLOGIST, INFECTIOUS DISEASE OR HEPATOLOGIST  
Coverage Duration: 3 MONTHS  
Other Criteria: ACHIEVED AN EARLY VIRAL RESPONSE (EVR) DEFINED AS A MINIMUM 2 LOG DECREASE IN VIRAL LOAD DURING THE FIRST 12 WEEKS OF TREATMENT

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Prior Authorization Group Description: PEGVISOMANT  
Drug Name: SOMAVERT  
Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: DOCUMENTATION OF PREVIOUS TREATMENT FAILURE (SURGERY

AND /OR RADIATION THERAPY)  
Age Restrictions:  
Prescriber Restrictions: ENDOCRINOLOGIST  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: PENLAC  
Drug Name: CICLOPIROX NAIL LACQUER  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: POSITIVE DERMATOPHYTE CULTURE  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 24 WEEKS  
Other Criteria:

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Prior Authorization Group Description: PENTASA  
Drug Name: PENTASA  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: GASTROENTEROLOGIST  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: PLAVIX  
Drug Name: PLAVIX  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: PRANDIN  
Drug Name: PRANDIN  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: DOCUMENTATION OF PREVIOUS TRIAL OF BIGUANIDINES AND SULFNOUREAS WITH A HBA1C VALUE OF GREATER THAN 8.  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: PRISTIQ  
Drug Name: PRISTIQ  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: DOCUMENTED TREATMENT FAILURE OF FORMULARY SSRI AND SNRI  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: PROCRT  
Drug Name: PROCRT

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: HEMOGLOBIN OF LESS THAN OR EQUAL TO 10GM/DL, OR  
HEMATOCRIT OF LESS THAN OR EQUAL TO 30%, AND FERRITIN LESS THAN 100NG/ML OR  
TRANSFERRIN SATURATION LESS THAN 20%  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 3 MONTHS  
Other Criteria:

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Prior Authorization Group Description: PROGLYCEM  
Drug Name: PROGLYCEM  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: ENDOCRINOLOGIST  
Coverage Duration: 12 MONTHS  
Other Criteria: SEVERAL HYPOGLYCEMIC EPISODES OVER THE LAST 3 MONTHS

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Prior Authorization Group Description: PROLASTIN  
Drug Name: PROLASTIN  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: PULMONOLOGIST  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: PROVIGIL  
Drug Name: PROVIGIL  
Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM  
PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: RANEXA  
Drug Name: RANEXA  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria: PRE-EXISTING QT PROLONGATION, HEPATIC IMPAIRMENT, ON  
CONCOMITANT QT PROLONGING DRUGS, OR CYP3A INHIBITORS  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: CARDIOLOGIST  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: REBIF  
Drug Name: REBIF | REBIF TITRATION PACK  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: KURTZKE EXPANDED DISABILITY STATUS SCALE (EDSS) OF 5.5  
OR LESS  
Age Restrictions:  
Prescriber Restrictions: NEUROLOGIST

Coverage Duration: 3 MONTHS  
Other Criteria: DEMYELINATING EVENT THAT WAS DOCUMENTED BY MRI STUDIES

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Prior Authorization Group Description: REGRANEX  
Drug Name: REGRANEX  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: VASCULAR SURGEON, PODIATRIST, ENDOCRINOLOGIST  
Coverage Duration: 3 MONTHS  
Other Criteria:

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Prior Authorization Group Description: RELENZA  
Drug Name: RELENZA DISKHALER  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: DURATION APPROVED AS LISTED IN THE FDA APPROVED LABEL  
Other Criteria: RISK FOR COMPLICATIONS SECONDARY TO INFLUENZA INFECTION AND WITHIN 48 HOURS

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Prior Authorization Group Description: REMICADE  
Drug Name: REMICADE  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria: PART B COVERAGE  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: RENAGEL  
Drug Name: RENAGEL  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: SERUM PHOSPHORUS LEVELS AND CALCIUM-PHOSPHORUS LEVELS  
Age Restrictions:  
Prescriber Restrictions: NEPHROLOGIST OR ONCOLOGIST  
Coverage Duration: 6 MONTHS  
Other Criteria:

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Prior Authorization Group Description: RESTASIS  
Drug Name: RESTASIS  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: OPHTHALMOLOGIST OR RHEUMATOLOGIST  
Coverage Duration: 6 MONTHS  
Other Criteria:

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Prior Authorization Group Description: REVATIO  
Drug Name: REVATIO  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:

Prescriber Restrictions: PULMONOLOGIST/CARDIOLOGIST  
Coverage Duration: 6 MONTHS  
Other Criteria:

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Prior Authorization Group Description: RIBAVIRIN  
Drug Name: RIBASPHERE | RIBATAB | RIBAVIRIN  
Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions: LESS THAN 18 YEARS OF AGE  
Prescriber Restrictions: GASTROENTEROLOGIST, INFECTIOUS DISEASE OR HEPATOLOGIST  
Coverage Duration: 3 MONTHS  
Other Criteria: ACHIEVED AN EARLY VIRAL RESPONSE (EVR) DEFINED AS A MINIMUM 2 LOG DECREASE IN VIRAL LOAD DURING THE FIRST 12 WEEKS OF TREATMENT

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Prior Authorization Group Description: RIDAURA  
Drug Name: RIDAURA  
Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: RHEUMATOLOGIST  
Coverage Duration: 6 MONTHS  
Other Criteria:

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Prior Authorization Group Description: RILUTEK  
Drug Name: RILUTEK  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: NEUROLOGIST  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: SAPROPTERIN  
Drug Name: KUVAN  
Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: CURRENT LABORTORY VALUES OF PHE (PHENYLALANINE)  
Age Restrictions:  
Prescriber Restrictions: ENDOCRINOLOGIST  
Coverage Duration: 6 MONTHS  
Other Criteria:

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Prior Authorization Group Description: SENSIPAR  
Drug Name: SENSIPAR  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: SERUM PHOSPHORUS LEVELS AND CALCIUM-PHOSPHORUS LEVELS  
Age Restrictions:  
Prescriber Restrictions: NEPHROLOGIST OR ONCOLOGIST  
Coverage Duration: 6 MONTHS  
Other Criteria:

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Prior Authorization Group Description: SEREVENT  
Drug Name: SEREVENT DISKUS

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: SITAGLIPTIN  
Drug Name: JANUVIA  
Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: DOCUMENTATION OF FAILURE OF OR CONTADINDIATIONS FORMULARY AGENTS (BIGUANDINES OR SULFNOUREA'S AND TZD'S), HBA1C VALUES GREATER THAN 7 BUT LESS THAN 8.  
Age Restrictions:  
Prescriber Restrictions: ENDOCRINOLOGIST  
Coverage Duration: 6 MONTHS  
Other Criteria:

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Prior Authorization Group Description: SOMATROPIN  
Drug Name: GENOTROPIN | GENOTROPIN MINIQUICK | HUMATROPE | HUMATROPE COMBO PACK | NORDITROPIN CARTRIDGE | NORDITROPIN NORDIFLEX PEN | NUTROPIN | NUTROPIN AQ | NUTROPIN AQ PEN | SAIZEN | SAIZEN CLICK.EASY | SEROSTIM | ZORBTIVE  
Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: GROWTH HORMONE STIMULATION TESTS, IGF-1 AND IGFBG-3 LEVELS  
Age Restrictions:  
Prescriber Restrictions: PEDIATRIC ENDOCRINOLOGIST OR A PEDIATRIC NEPHROLOGIST  
Coverage Duration: 6 MONTHS  
Other Criteria:

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Prior Authorization Group Description: SONATA  
Drug Name: SONATA | ZALEPLON  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: SLEEP SPECIALIST  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: SOTRET  
Drug Name: SOTRET  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: DERMATOLOGIST  
Coverage Duration: 6 MONTHS  
Other Criteria: PRESCRIBING DOCTOR REGISTER THE MEMBER IN THE IPLEDGE PROGRAM

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Prior Authorization Group Description: STARLIX  
Drug Name: STARLIX  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: DOCUMENTATION OF PREVIOUS TRIAL OF BIGUANIDINES AND

SULFNOUREAS WITH A HBA1C VALUE OF GREATER THAN 8.

Age Restrictions:

Prescriber Restrictions: ENDOCRINOLOGIST

Coverage Duration: 12 MONTHS

Other Criteria:

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Prior Authorization Group Description: SUBOXONE

Drug Name: SUBOXONE

Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions: OPIOID DEPENDENCY SPECIALIST

Coverage Duration: 12 MONTHS

Other Criteria:

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Prior Authorization Group Description: SUBUTEX

Drug Name: SUBUTEX

Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions: OPIOID DEPENDENCY SPECIALIST

Coverage Duration: 12 MONTHS

Other Criteria:

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Prior Authorization Group Description: SUCRAID

Drug Name: SUCRAID

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions: ENDOCRINOLOGIST OR GASTROENTEROLOGIST

Coverage Duration: 12 MONTHS

Other Criteria: STOOL PH LESS THAN 6, AN INCREASE IN BREATH HYDROGEN OF GREATER THAN 10PPM WHEN CHALLENGED WITH SUCROSE

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Prior Authorization Group Description: SYMLIN

Drug Name: SYMLIN | SYMLINPEN 120 | SYMLINPEN 60

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information: HBA1C

Age Restrictions:

Prescriber Restrictions: ENDOCRINOLOGIST

Coverage Duration: 12 MONTHS

Other Criteria:

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Prior Authorization Group Description: SYNAREL

Drug Name: SYNAREL

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions: PEDIATRIC ENDOCRINOLOGIST OR GYNECOLOGIST

Coverage Duration: 6 MONTHS

Other Criteria:

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Prior Authorization Group Description: TAMIFLU

Drug Name: TAMIFLU

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration: INFLUENZA, VIRUSES TYPES A AND B: FOR 5 DAYS.: PROPHYLAXIS: FOR AT LEAST 10 DAYS (UP TO 6 WEEKS).

Other Criteria: REQUIRES MEMBER TO BE HIGH RISK AS DETERMINED BY WORLD HEALTH ORGANIZATION (WHO) CRITERIA, WITH EXPOSURE TO H5N1 VIRUS WITH IN 48 HOURS, DURATION OF COVERAGE IS UPTO 6 WEEKS AFTER LAST KNOWN EXPSOURE.

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Prior Authorization Group Description: TARCEVA

Drug Name: TARCEVA

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions: ONCOLOGIST

Coverage Duration: PER COURSE OF THERAPY

Other Criteria:

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Prior Authorization Group Description: TIKOSYN

Drug Name: TIKOSYN

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions: CARDIOLOGIST

Coverage Duration: 12 MONTHS

Other Criteria:

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Prior Authorization Group Description: TOPAMAX

Drug Name: TOPAMAX | TOPAMAX SPRINKLE

Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration: 12 MONTHS

Other Criteria: ADJUNCTIVE THERAPY

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Prior Authorization Group Description: TRACLEER

Drug Name: TRACLEER

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information: MEAN PULMONARY ARTERY PRESSURE OF AT LEAST 25MMHG

Age Restrictions:

Prescriber Restrictions: CARDIOLOGIST OR PULMONOLOGIST

Coverage Duration: 6 MONTHS

Other Criteria: CARDIOLOGIST OR PULMONOLOGIST

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Prior Authorization Group Description: TRETINOIN

Drug Name: AVITA | TRETINOIN

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions: DERMATOLOGIST

Coverage Duration: 6 MONTHS  
Other Criteria:

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Prior Authorization Group Description: TYKERB  
Drug Name: TYKERB  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: HER2 (HUMAN EPIDERMAL RECEPTOR TYPE 2 )  
Age Restrictions:  
Prescriber Restrictions: ONCOLOGIST  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: TYZEKA  
Drug Name: TYZEKA  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: HBSAG POSITIVE FOR LONGER THAN SIX MONTHS, SERUM HBV DNA POSITIVE, PERSISTENT OR INTERMITTENT ELEVATION OF ALT/AST, LIVER BIOPSY SHOWING CHRONIC HEPATITIS-  
Age Restrictions:  
Prescriber Restrictions: GASTROENTEROLOGIST OR INFECTIOUS DISEASE SPECIALIST  
Coverage Duration: 3 MONTHS  
Other Criteria:

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Prior Authorization Group Description: URSODIOL  
Drug Name: URSODIOL  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: RADIOLOGIC EVIDENCE OF THE PRESENCE OF BILIARY CALCULUS  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: VALCYTE  
Drug Name: VALCYTE  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: INFECTIOUS DISEASE SPECIALIST OR OPHTHALMOLOGIST  
Coverage Duration: PER COURSE OF THERAPY  
Other Criteria:

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Prior Authorization Group Description: VALTREX  
Drug Name: VALTREX  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 7-10 DAY TREATMENT  
Other Criteria:

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Prior Authorization Group Description: XYREM  
Drug Name: XYREM  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:

Age Restrictions:  
Prescriber Restrictions: NEUROLOGIST  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: ZAVESCA  
Drug Name: ZAVESCA  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: GASTROENTEROLOGIST OR HEMATOLOGIST  
Coverage Duration: 12 MONTHS  
Other Criteria: HEMOGLOBIN CONCENTRATION BELOW 9 G PER DL OR A PLATELET COUNT BELOW 50 X 10<sup>9</sup> PER LITER /L

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Prior Authorization Group Description: ZETIA  
Drug Name: ZETIA  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: LIPID PANEL  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: ZOLINZA  
Drug Name: ZOLINZA  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions: ONCOLOGIST  
Coverage Duration: PER COURSE OF THERAPY  
Other Criteria:

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Prior Authorization Group Description: ZONISAMIDE  
Drug Name: ZONISAMIDE  
Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information:  
Age Restrictions:  
Prescriber Restrictions:  
Coverage Duration: 12 MONTHS  
Other Criteria: ADJUNCTIVE THERAPY

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Prior Authorization Group Description: ZYPREXA ZYDIS  
Drug Name: ZYPREXA ZYDIS  
Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D  
Exclusion Criteria:  
Required Medical Information: DOCUMENTED MEDICAL NEED FOR THE ORALLY DISINTEGRATING DOSAGE FORM  
Age Restrictions:  
Prescriber Restrictions: PSYCHIATRIST  
Coverage Duration: 12 MONTHS  
Other Criteria:

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Prior Authorization Group Description: ZYVOX  
Drug Name: ZYVOX

Covered Uses: ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria:

Required Medical Information: VANCOMYCIN-RESISTANT, GRAM-POSITIVE ORGANISM  
DOCUMENTED BY CULTURE AND SENSITIVITY REPORTS

Age Restrictions:

Prescriber Restrictions: INFECTIOUS DISEASE

Coverage Duration: CAP, SKIN SQ TISSUE INFECTION, NOSOCOMIAL PNEUMONIA 10 TO  
14DAYS VRE : 14 TO 28 DAYS

Other Criteria:

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Last update: January 14, 2009