

2011 PremierCare Formulary

Prior Authorization Criteria



PA Criteria

<i>Prior Authorization Group</i>	ACNE
<i>Drug Names</i>	TRETINOIN
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	NON COVERAGE Tretinoin is NOT covered for members with the following criteria: A. Using for facial wrinkles or other cosmetic indications
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	Documented ineffectiveness to at least one(1) topical benzoyl peroxide product and at least (1) topical antibiotic

<i>Prior Authorization Group</i>	ACTONEL
<i>Drug Names</i>	ACTONEL
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	Documented ineffectiveness, intolerance, or contraindication to alendronate

<i>Prior Authorization Group</i>	ADAGEN
<i>Drug Names</i>	ADAGEN
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Diagnosis of severe thrombocytopenia
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	Endocrinologist
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	Patient has ineffectiveness from or is not a suitable candidate for bone marrow transplantation

<i>Prior Authorization Group</i>	ADCIRCA
<i>Drug Names</i>	ADCIRCA
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Nitrate therapy
<i>Required Medical Information</i>	Diagnosis of pulmonary arterial hypertension (PAH), (WHO Group 1). PAH been confirmed by right heart catheterization. If patient is an infant, PAH diagnosed by Doppler echocardiogram.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	ADVAIR.SYMBICORT
<i>Drug Names</i>	ADVAIR DISKUS, ADVAIR HFA, SYMBICORT
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	CHART NOTES DOCUMENTING PREVIOUS USE OF SHORT ACTING BETA AGONIST WAS INADEQUATE AND PREVIOUS USE OF QVAR WAS INADEQUATE
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	PLAN YEAR
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	AFINITOR
<i>Drug Names</i>	AFINITOR
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	The following copies of chart notes/laboratory reports are required: 1. Documentation of previous trial/failure of Sutent or Nexavar
<i>Age Restrictions</i>	Patient must be 18 years of age or older
<i>Prescriber Restrictions</i>	Oncologist
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	1. Patient must have previous trial and failure with one of the following: a. Sutent b. Nexavar

<i>Prior Authorization Group</i>	ALDURAZYME
<i>Drug Names</i>	ALDURAZYME
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	The following copies of chart notes/laboratory reports are required: A. Documentation showing patient has at least two of the listed moderate-to-severe symptoms. 1. Impaired vision 2. Recurrent otitis media 3. Recurrent sinopulmonary infections 4. Impaired hearing 5. Upper airway obstruction 6. Malaise and reduced endurance 7. Corneal clouding 8. Macrocephaly 9. Reduced joint range of motion 11. Progressively course facial features 12. Umbilical and inguinal hernias 13. Carpal tunnel syndrome 14. Delayed or regressed mental development 15. Hepatosplenomegaly 15. Cardiac abnormalities and valvular disease 16. Communicating hydrocephalus 17. Spinal cord compression 18. Sleep apnea 19. Short stature 20. Reduced pulmonary function 21. Bone deformities AND Chart notes documenting diagnosis confirmed by alpha-iduronidase activity or enzymatic assay
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	If the patient has previously received at least 26 weeks of Aldurazyme® therapy, they must show an improvement in lung function (forced vital capacity [FVC]) from when therapy was started

<i>Prior Authorization Group</i>	AMITIZA
<i>Drug Names</i>	AMITIZA
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Presence of a mechanical gastrointestinal obstruction
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

Prior Authorization Group APOKYN
Drug Names APOKYN
Covered Uses All FDA approved indications not otherwise excluded from Part D

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration Plan Year

Other Criteria

Prior Authorization Group ARCALYST
Drug Names ARCALYST
Covered Uses All FDA approved indications not otherwise excluded from Part D

Exclusion Criteria Active or chronic infection. Concurrent therapy with other biologics.

Required Medical Information

Age Restrictions 12 years of age and older

Prescriber Restrictions

Coverage Duration Plan Year

Other Criteria

Prior Authorization Group

Drug Names

B VS. D

ABELCET, ACYCLOVIR SODIUM, ALBUTEROL SULFATE, ALIMTA, AMBISOME, AMINOSYN, AMINOSYN 7%/ELECTROLYTES, AMINOSYN II, AMINOSYN II M 3.5%/DEXTRO, AMINOSYN-HBC, AMINOSYN-PF 7%, AMPHOTERICIN B, AMPICILLIN-SULBACTAM, ANZEMET, ARANESP ALBUMIN FREE, ASTRAMORPH, ATGAM, AVASTIN, AZATHIOPRINE, BLEOMYCIN SULFATE, CAMPATH, CARBOPLATIN, CARIMUNE NANOFILTERED, CEFTRIAZONE SODIUM, CELLCEPT, CEREZYME, CLEOCIN, CLINIMIX 2.75%/DEXTROSE 5, CLINISOL SF 15%, COLISTIMETHATE SODIUM, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYKLOKAPRON, CYTARABINE, DOXIL, DOXORUBICIN HCL, DRONABINOL, DURAMORPH, ELOXATIN, ENGERIX-B, EPIRUBICIN HCL, ERYTHROCIN LACTOBIONATE, FABRAZYME, FASLODEX, FENTANYL CITRATE, FLUDARABINE PHOSPHATE, FLUOROURACIL, FOSCARNET SODIUM, FREAMINE III, GAMASTAN S/D, GEMZAR, GENGRAF, GRANISETRON HCL, GRANISOL, HEPATAMINE, HYDROMORPHONE HCL, INTRALIPID, INTRON-A, INTRON-A W/DILUENT, IONOSOL-B/DEXTROSE 5%, IONOSOL-MB/DEXTROSE 5%, IONOSOL-T/DEXTROSE 5%, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, KINERET, LEUCOVORIN CALCIUM, LINCOCIN, MEPERIDINE HCL, MERREM, METHOTREXATE, METHOTREXATE SODIUM, METOCLOPRAMIDE HCL, MITOXANTRONE HCL, MORPHINE SULFATE, MYCOPHENOLATE MOFETIL, NAFCILLIN SODIUM, NAGLAZYME, NEPHRAMINE, NEUPOGEN, ONDANSETRON HCL, ONDANSETRON ODT, ONTAK, PRIMAXIN IV, PROCRT, PROGRAF, PROLASTIN, PROLEUKIN, PULMOZYME, RAPAMUNE, RECOMBIVAX HB, REMICADE, RENAMIN, RITUXAN, SANDOSTATIN LAR DEPOT, SIMULECT, SOMAVERT, TACROLIMUS, TETANUS TOXOID ADSORBED, TIMENTIN, TPN ELECTROLYTES FTV, TREXALL, TRIMETHOBENZAMIDE HCL, TRISENOX, TYGACIL, VELCADE, VIDAZA, VINBLASTINE SULFATE, XOLAIR, ZOSYN, ZYVOX

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

<i>Prior Authorization Group</i>	BANZEL
<i>Drug Names</i>	BANZEL
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	Coverage for 4 years and older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	Documented ineffectiveness or intolerance to two or more of the following medications: felbamate (Felbatol), lamotrigine (Lamictal), topiramate (Topamax)

<i>Prior Authorization Group</i>	BONIVA
<i>Drug Names</i>	BONIVA
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	Documented ineffectiveness, intolerance, or contraindications to alendronate AND Actonel

<i>Prior Authorization Group</i>	BUPHENYL
<i>Drug Names</i>	BUPHENYL
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Chart notes documenting diagnosis of A. argininosuccinic acid synthetase deficiency or B. Carbamoyl Phosphate synthetase deficiency or C. Ornithine Transcarbamoylase deficiency
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	Endocrinologist
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	BYETTA
<i>Drug Names</i>	BYETTA
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Chart notes indicating inability to achieve adequate glycemic control (HbA1c less than 7.0) on metformin or a sulfonylurea and a thiazolidinedione. Lab results including HbA1c greater than 7.0
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	Current drug therapy includes or there is a contraindication to metformin or a sulfonylurea AND current drug therapy includes or there is a contraindication to a thiazolidinedione.

<i>Prior Authorization Group</i>	CAPASTAT
<i>Drug Names</i>	CAPASTAT SULFATE
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	The following copies of chart notes/laboratory reports are required: A. Culture and Sensitivity report showing susceptibility of bacteria to Capastat
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	CELEBREX
<i>Drug Names</i>	CELEBREX
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	For Doses of 50mg to 400mg per day: A. Documented history of NSAID-induced GI adverse effects requiring discontinuation of the NSAID AND addition of a proton pump inhibitor or misoprostol. For Doses greater than 400mg/day a documented diagnosis of familial adenomatous polyposis
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	CHORIONIC GONADOTROPIN
<i>Drug Names</i>	CHORIONIC GONADOTROPIN
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	A. Patient is Female OR B. Treatment of obesity OR C. Presence of precocious puberty OR D. Prostatic carcinoma or other androgen dependant neoplasm
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	CYMBALTA
<i>Drug Names</i>	CYMBALTA
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	APPROVE FOR CHART NOTES DOCUMENTING DIAGNOSIS OF FIBROMYALGIA OR DIABETIC PERIPHERAL NEUROPATHY. FOR ALL OTHER DIAGNOSES PREVIOUS USE OF 30 DAYS OF VENLAFAXINE XR, CITALOPRAM, FLUOXETINE, FLUVOXAMINE, PAROXETINE, PAROXETINE CR, OR SERTRALINE) WITHIN THE PAST 180 DAYS WAS INEFFECTIVE OR NOT TOLERATED
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	PLAN YEAR
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	EMEND
<i>Drug Names</i>	EMEND
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	a. IF BvD Criteria indicates that coverage should be through Medicare Part D: 1. For prevention of post-operative nausea and vomiting, approve OR 2. For prevention of chemotherapy-induced nausea and vomiting; Emend must be administered in combination with a 5HT3 antagonist (such as ondansetron) AND corticosteroid (such as dexamethasone) AND 2. The patient is receiving moderately or highly emetogenic chemotherapy (see NCCN.org for list) or b. Part B will be billed if the medication is being used for cancer treatment and as full replacement of intravenous administration within 48 hours of cancer treatment if the prescriber states: As a full therapeutic replacement for an intravenous anti-emetic drug as part of a cancer chemotherapeutic regimen.

<i>Prior Authorization Group</i>	EMSAM
<i>Drug Names</i>	EMSAM
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	Prior treatment trials including maximum tolerated dose of at least ONE drug from TWO of the following THREE therapeutic classes: a. SSRI (Celexa, Lexapro, Prozac, Zoloft, Paxil), and b. SNRI (Effexor, Cymbalta), and c. MISC (Wellbutrin, Remeron, Nefazodone)

<i>Prior Authorization Group</i>	ENBREL
<i>Drug Names</i>	ENBREL
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	For chronic plaque psoriasis chart notes documenting significant functional disability OR at least 10% body surface area involvement. For rheumatoid arthritis chart notes documenting diagnosis made with Amer. College of Rheumatology. Classification. Chart notes documenting psoriatic arthritis or ankylosing spondylitis.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	Rheumatologist or Dermatologist
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	For Rheumatoid arthritis OR juvenile idiopathic arthritis: Ineffectiveness or contraindication to an 8 week treatment course with methotrexate. FOR plaque psoriasis documented ineffective, intolerance, or contraindication for 60 days of two of the following treatments: topical steroids, phototherapy or photochemotherapy, cyclosporine, methotrexate, acitretin.
<i>Prior Authorization Group</i>	ERAXIS
<i>Drug Names</i>	ERAXIS
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	Coverage for 1. BvD criteria indicated that coverage should be through Medicare Part D. 2.Documented trial with fluconazole was ineffective or not tolerated.
<i>Prior Authorization Group</i>	FANAPT
<i>Drug Names</i>	FANAPT, FANAPT TITRATION PACK
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Chart notes indicating that previous use of 2 or more antipsychotics have been ineffective or are contraindicated
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	FORTEO
<i>Drug Names</i>	FORTEO
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Over 24 months of previous Forteo therapy.
<i>Required Medical Information</i>	Chart notes documenting osteoporosis with at least two of the following fracture risk factors: A. T-Score less than or equal to -2.5 B. Prior fragility fracture (counts as two risk factors) C. Age greater than or equal to 70 D. Family history (1st degree relative)
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan year
<i>Other Criteria</i>	History of ineffectiveness to 2 years of treatment with bisphosphonate therapy including alendronate, risedronate, Boniva or Reclast.

<i>Prior Authorization Group</i>	GAMUNEX
<i>Drug Names</i>	GAMUNEX
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	CIDP: Documentation supporting significant functional disability, slowing of nerve conduction velocity on EMG/NCS, and elevated spinal protein or nerve biopsy confirming diagnosis. Primary Humoral immunodeficiency: Documentation of baseline IgG level and appropriate laboratory findings to support specific diagnosis (i.e. X-linked agammaglobulinemia, CVID, immunoglobulin subclass deficiencies). Laboratory results such as but not limited to: 1) specific antibodies (IgG, IgM, IgA), 2) CBC, 3) flow cytometry, 4) specific antigen tests, as appropriate.

<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	GILENYA
<i>Drug Names</i>	GILENYA
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	DIAGNOSIS OF RELAPSING-REMITTING MS (RRMS) OR SECONDAR-PROGRESSIVE MS WITH RELAPSES (SPMS)
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	NEUROLOGIST
<i>Coverage Duration</i>	PLAN YEAR
<i>Other Criteria</i>	PATIENT HAS EXPERIENCED AT LEAST ONE RELASE IN THE PAST 12 MONTHS AND PREVIOUS USE OF AN INTERFERON BETA 1A HAS BEEN INEFFECTIVE, NOT TOLERATED OR IS CONTRAINDICATED
<i>Prior Authorization Group</i>	GONADOTROPIN-RELEASING HORMONE ANALOGS
<i>Drug Names</i>	LEUPROLIDE ACETATE, LUPRON DEPOT, SYNAREL
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan year
<i>Other Criteria</i>	1. BvD criteria indicates that coverage should be through Medicare Part D 2. If being used for metastatic breast cancer in a pre-menopausal women the disease has progressed or recurred after a 3 month trial of tamoxifen. 2. If the diagnosis is advanced prostate cancer, orchiectomy or estrogen therapy are documented as unacceptable. C. If the diagnosis is endometriosis the patient has completed documented ineffective trial of at least two of the following: oral contraceptives, medroxyprogesterone, and Danazol

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

GROWTH HORMONES

OMNITROPE, TEV-TROPIN

All FDA approved indications not otherwise excluded from Part D

Pediatric: growth plates closed

Chart notes lab result documenting the following: Peds Criteria: ped growth hormone deficiency by pre-treatment, 2 growth hormone (GH) stim tests less than 10 mcg/ml OR pre-treatment, at least one GH stim test less than 15 mcg/ml, AND IGF-I and IGF-BP3 levels below normal for bone age and sex. OR pre-treatment, one GH stim test less than 10 mcg/ml AND disease or condition affecting pituitary function (tumor, surgery, radiation, etc). OR multiple pituitary hormone deficiencies: at least 2 in addition to GHD - Cortisol, thyroid, ACTH, FSH/LH, testosterone/estrogen. OR neonatal hypoglycemia: AGHD (low GH levels are detected during hypoglycemia). Open Growth Plates: Initial bone age and demo of open growth plates (until max bone age met, whichever is shorter) Males up to 16 0/12 years, Females, up to 14 0/12 years. Short Stature / Growth failure: Height less than 2 SD below mean for age and sex OR height velocity greater than 1 SD below mean for age and sex OR Decrease in height greater than 0.5 SD in 1 year (if 2 yrs or older) for age and sex OR Requires weekly dialysis or chronic renal insufficiency (GFR less than 75ml/min /1.73 m2) Adult criteria: Pre-treatment, at least one GH stim test less than 5 mcg/ml (radioimmunoassay) or less than 2.5 mcg/ml if measured by immunoradiometric assay (Clonidine not acceptable) AND At least one known cause for pituitary disease or condition affecting pituitary fxn, including pituitary tumor, surgical damage, hypothalamic disease, irradiation, trauma, or infiltrative diseases AND Other pituitary hormone deficiencies being supplemented: Cortisol, thyroid, ACTH, FSH/LH, testosterone/estrogen AND One or more of the following addit risk factors/abnormalities present: Reduced bone mineral density greater than 1 SD below mean, by WHO criteria OR High risk lipid profile (total cholest greater than 240mg/dL, or LDL greater than 190mg/dL) OR At least 2 pituitary hormone deficiencies other than GH inc: TSH, ACTH, gonadotropins, or ADH*

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Endocrinologist

Plan Year

<i>Prior Authorization Group</i>	HUMIRA
<i>Drug Names</i>	HUMIRA, HUMIRA PEN-CROHNS DISEASE
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	For chronic plaque psoriasis chart notes documenting significant functional disability OR at least 10% body surface area involvement. Chart notes documenting diagnosis of ankylosing spondylitis or psoriatic arthritis. For Crohns disease: chart notes documenting as Fistulizing Crohns disease.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	Rheumatologist, Dermatologist, Gastroenterologist
<i>Coverage Duration</i>	Plan year
<i>Other Criteria</i>	For Rheumatoid arthritis OR juvenile idiopathic arthritis: Ineffectiveness or contraindication to an 8 week treatment course with methotrexate. FOR plaque psoriasis documented ineffective, intolerance, or contraindication for 60 days of two of the following treatments: topical steroids, phototherapy or photochemotherapy, an oral immunomodulator FOR Crohns disease: documented ineffectiveness of two of the following: systemic corticosteroids or an oral immunomodulator

<i>Prior Authorization Group</i>	INCRELEX
<i>Drug Names</i>	INCRELEX
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Benzyl alcohol hypersensitivity, epiphyseal closure, IV administration of Increlex, active malignancy, use in neonates, concurrent use with GH therapy, secondary causes of IGF-1 deficiency.
<i>Required Medical Information</i>	Prior to starting therapy, a height greater than 3 SD below the mean for chronological age and sex, and an IGF-1 level greater than or equal to 3 SD below the mean for chronological age and gender. One stimulation test showing patient has a normal or elevated GH level.
<i>Age Restrictions</i>	Between 2 and 20 years of age
<i>Prescriber Restrictions</i>	Endocrinologist
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	For continuation of therapy, there is an increase in height velocity by greater than 2.5 cm total growth in one year and patient has open epiphyses.

<i>Prior Authorization Group</i>	INTERFERONS/RIBAVIRIN
<i>Drug Names</i>	PEG-INTRON, PEG-INTRON REDIPEN, PEGASYS, RIBASPHERE, RIBAVIRIN
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Patient has received previous treatment with a pegylated interferon.
<i>Required Medical Information</i>	Criteria for Hepatitis C only , Chart notes indicating a detectable HCV RNA levels of higher than 50 IU/ml at start of therapy.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	For chronic hepatitis C, genotype 1 and 4, assess response at 12 weeks. Discontinue if a 2 log drop has not been achieved OR continue therapy for up to 48 weeks total if 2 log drop has been achieved. For chronic hepatitis C, genotype 2 or 3, allow 24 weeks of therapy. For chronic hepatitis B, chronic hepatitis C with AIDS, OR chronic hepatitis C as monotherapy allow 48 weeks therapy. From labeling: "There are no safety and efficacy data on treatment of chronic HCV or HBV for longer than 48 weeks. For patients with HCV, consider discontinuing therapy after 12 to 24 weeks of therapy if the patient has failed to demonstrate an early virologic response, defined as undetectable HCV ribonucleic acid (RNA) or at least a 2 log ₁₀ reduction from baseline in HCV RNA titer by 12 weeks of therapy"

<i>Prior Authorization Group</i>	INVEGA
<i>Drug Names</i>	INVEGA
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Concomitant therapy with Risperidone
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	Psychiatrist
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	For diagnosis of schizophrenia: Documented one month of two or more of the following alternatives were ineffective or not tolerated: risperidone, Clozapine, Seroquel, Seroquel XR, Zyprexa, Zyprexa Zydis, Abilify or Geodon. For the diagnosis of schizoaffective disorder: approve

<i>Prior Authorization Group</i>	INVEGA SUSTENNA
<i>Drug Names</i>	INVEGA SUSTENNA
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	For diagnosis of schizophrenia: Documented one month of two or more of the following alternatives were ineffective or not tolerated: risperidone, Clozapine, Seroquel, Seroquel XR, Zyprexa, Zyprexa Zydys, Abilify or Geodon. For the diagnosis of schizoaffective disorder: approve

<i>Prior Authorization Group</i>	LETAIRIS
<i>Drug Names</i>	LETAIRIS
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D

<i>Exclusion Criteria</i>	AST/ALT level greater than 3 times ULN, pregnancy for females.
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<i>Required Medical Information</i>	Diagnosis of pulmonary arterial hypertension (PAH), (WHO Group 1). NYHA class II or III symptoms. PAH been confirmed by right heart catheterization. If patient is an infant, PAH diagnosed by Doppler echocardiogram.
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<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	LOTRONEX
<i>Drug Names</i>	LOTRONEX
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Male (Female use only)
<i>Required Medical Information</i>	Chart notes documenting diagnosis of irritable bowel syndrome with primary symptom of diarrhea
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	LYRICA
<i>Drug Names</i>	LYRICA
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Chart notes indicating the diagnosis of diabetic neuropathy, post-herpetic neuralgia or fibromyalgia. For post-herpetic neuralgia 1 month trial of gabapentin was ineffective or is not tolerated or contraindicated. For diabetic neuropathy and fibromyalgia , 1 month of duloxetine was ineffective or is not tolerated or is contraindicated. For partial onset seizures, approve.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	For seizures disorders, must be used as adjunctive therapy

<i>Prior Authorization Group</i>	MULTAQ
<i>Drug Names</i>	MULTAQ
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	NEXAVAR
<i>Drug Names</i>	NEXAVAR
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Combination therapy with interferon Alfa or interleukin-2
<i>Required Medical Information</i>	Chart notes documenting diagnosis of hepatocellular carcinoma that is NOT surgically resectable OR diagnosis of advanced renal cell carcinoma.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	Oncologist or Nephrologist
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	Chart notes demonstrate that patient has received previous Nexavar® therapy, and has evidence of clinical improvement from the pretreatment report and or the patient has stable disease (tumor size within 25% of baseline).

<i>Prior Authorization Group</i>	ORFADIN
<i>Drug Names</i>	ORFADIN
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Chart notes indicating 1. documentation that patient is compliant on a protein-restricted diet low in phenylalanine 2. Lab reports demonstrating baseline LFTs are WNL
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	OXYCONTIN
<i>Drug Names</i>	OXYCONTIN
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Patient shows ineffectiveness or contraindications to Morphine Sulfate SR AND Methadone
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	6 months
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	PROMACTA
<i>Drug Names</i>	PROMACTA
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Eltrombopag should not be used in an attempt to normalize platelet counts.
<i>Required Medical Information</i>	For new starts, documentation that previous therapy with corticosteroids, immunoglobulins or splenectomy were insufficient and a pretreatment platelet count less than 30,000/microL or a platelet count less than or equal to 50,000/microL with significant mucous membrane bleeding or risk factors for bleeding are required. For continuation of therapy, an increase in platelet count to a level that is sufficient to avoid clinically important bleeding after at least 4 weeks of maximum dose therapy is required. For continuation of therapy, alanine aminotransferase levels must not be greater than or equal to 3 times the upper limit of normal and must not be progressive, persistent, or accompanied by increased bilirubin, symptoms of liver injury, or hepatic decompensation.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	6 mo initially, 12 mo renewal w/ platelet response, 3 mo renewal w/out platelet response

Other Criteria

<i>Prior Authorization Group</i>	PROVIGIL
<i>Drug Names</i>	PROVIGIL
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Combination with medications used for insomnia
<i>Required Medical Information</i>	Chart Notes including: 1. Diagnosis of excessive daytime sleepiness associated with narcolepsy: confirmation by sleep study. 2. For shift work sleep disorder: documentation from employer of work schedule including night shift. 3. For treatment of excessive sleepiness due to obstructive sleep apnea/hypopnea syndrome: patient is utilizing and compliant with a nasal continuous positive airway pressure (CPAP) or bi-level positive airway pressure (BIPAP) for 1 month and the CPAP/BIPAP is continued in combination with Provigil
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

Prior Authorization Group RANEXA
Drug Names RANEXA
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria
Required Medical Information Chart notes indicating diagnosis of chronic angina
Age Restrictions
Prescriber Restrictions
Coverage Duration Plan Year
Other Criteria

Prior Authorization Group RELISTOR
Drug Names RELISTOR
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria Mechanical gastrointestinal obstruction, known or suspected.

Required Medical Information A. Relistor is being prescribed for treatment of opioid-induced constipation in patients with advanced illness who are receiving palliative care. B. patient must have previous trial/failure of polyethylene glycol.

Age Restrictions
Prescriber Restrictions
Coverage Duration 4 Months
Other Criteria

Prior Authorization Group REVATIO
Drug Names REVATIO
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria Concurrent use of an organic nitrates (i.e. isosorbide mononitrate, isosorbide dinitrate, nitroglycerin)
Required Medical Information Chart notes documenting diagnosis of pulmonary arterial hypertension (PAH)
Age Restrictions
Prescriber Restrictions
Coverage Duration Plan Year
Other Criteria

Prior Authorization Group	REVLIMID
Drug Names	REVLIMID
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Chart notes documenting diagnosis of multiple myeloma or myelodysplastic syndrome. For multiple myeloma therapy will be in combination with dexamethasone. A 1. For diagnosis of multiple myeloma: documented ineffectiveness of one of the following: Melphalan, Carmustine, Cyclophosphamide, Doxorubicin, Doxorubicin liposomal, Bortezomib, Zoledronic Acid, or Thalidomide. 2. AND if the patient has received previous Revlimid therapy, a delay or no disease progression must be documented B. For diagnosis of transfusion-dependent anemia patient has received 2 or more unit of red blood cells within 8 weeks AND if the patient has received previous Revlimid therapy, stabilization of anemia is documented by having experienced one of the following: 50% reduction in blood transfusions. An increase in hemoglobin of at least 1g/dL over baseline. The absence of the pretreatment cytogenetic abnormality or a reduction in the number of abnormal cells of at least 50%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ROMIDEPSIN
Drug Names	ISTODAX
Covered Uses	All FDA covered uses

Exclusion Criteria
Required Medical Information

Age Restrictions	
Prescriber Restrictions	Oncologist

Coverage Duration	Plan year
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Other Criteria	Documentation supporting at least one previous systemic therapy for confirmed cutaneous T-Cell lymphoma was inadequate
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Prior Authorization Group	SABRIL
Drug Names	SABRIL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of infantile spasms for whom the potential benefits outweigh the potential risk of vision loss
Age Restrictions	
Prescriber Restrictions	Registered with Share 1-888-45-SHARE
Coverage Duration	Plan year
Other Criteria	

Prior Authorization Group	SAPHRIS
Drug Names	SAPHRIS
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of A. Diagnosis of schizophrenia or bipolar disorder AND B. Inadequate response to risperidone, Clozapine, Zyprexa, Seroquel, Geodon or Abilify.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	

Prior Authorization Group	SEROQUEL
Drug Names	SEROQUEL, SEROQUEL XR
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PLAN YEAR
Other Criteria	CHART NOTES DOCUMENTING A) 30 DAYS OF RISPERDONE USE WAS INEFFECTIVE OR NOT TOLERATED AND B) 30 DAYS OF ABILIFY, GEODON, ZYPREXA, SAPHRIS, FANAPT, INVEGA OR CLOZAPINE WERE INEFFECTIVE OR NOT TOLERATED

Prior Authorization Group SMOKING CESSATION
Drug Names CHANTIX, NICOTROL INHALER, NICOTROL NS
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria
Required Medical Information Patient must be registered in the Free and Clear comprehensive behavioral smoking cessation program. OTC Gum and Patches are NOT Covered
Age Restrictions
Prescriber Restrictions
Coverage Duration 3 months
Other Criteria

Prior Authorization Group SOMATULINE
Drug Names SOMATULINE DEPOT
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria
Required Medical Information
Age Restrictions
Prescriber Restrictions
Coverage Duration Plan Year
Other Criteria

Prior Authorization Group SPRYCEL
Drug Names SPRYCEL
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria
Required Medical Information Chart notes including: 1. Diagnosis of Chronic myelogenous leukemia (CML) or Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL).
Age Restrictions
Prescriber Restrictions Hematologist or Oncologist
Coverage Duration Plan Year
Other Criteria Previous use of Gleevac was ineffective or not tolerated

Prior Authorization Group SUBOXONE
Drug Names BUPRENORPHINE HCL, SUBOXONE
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria BENZODIAZEPINE OR ALCOHOL DEPENDENCE
Required Medical Information CHART NOTES DOCUMENTING PATIENT IS ENROLLED IN A CHEMICAL DEPENDENCE PROGRAM
Age Restrictions 16 YEARS OLD AND OLDER
Prescriber Restrictions
Coverage Duration 6 MONTHS
Other Criteria

Prior Authorization Group SUTENT
Drug Names SUTENT
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria Combination therapy with interferon alpha or interleukin-2.
Required Medical Information For gastrointestinal stromal tumor (GIST): 1.Chart notes indicating the GIST is unresectable and/or metastatic malignant and 2.Chart notes indicating disease progression while on Gleevec or intolerance to Gleevec. For metastatic renal cell carcinoma: Chart notes indicating the carcinoma is surgically unresectable
Age Restrictions
Prescriber Restrictions Gastroenterologist, Oncologist or Nephrologist
Coverage Duration Plan Year
Other Criteria If the patient has had previous Sutent® therapy, must have documentation there has been no evidence of disease progression since initiating Sutent® therapy.

Prior Authorization Group SYMLIN
Drug Names SYMLIN, SYMLINPEN 120, SYMLINPEN 60
Covered Uses All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria
Required Medical Information Chart notes including 1. HbA1c greater than 7.0 while receiving insulin therapy
Age Restrictions
Prescriber Restrictions Endocrinologist
Coverage Duration Plan Year
Other Criteria Patient will continue use of insulin while receiving Symlin. AND if the pt has had previous Symlin® tx, he/she must show a reduction in their HbA1c since initiating Symlin® tx.

<i>Prior Authorization Group</i>	TARCEVA
<i>Drug Names</i>	TARCEVA
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Pregnant Female
<i>Required Medical Information</i>	Chart notes including: 1. Negative pregnancy test and documenting that patient has no plans to become pregnant and has been educated on the potential risks of Tarceva therapy during pregnancy. 2. For non-small cell lung cancer: A. chart notes indicating the cancer is locally advanced or metastatic (Stage 3 or 4). and B. Chart notes indicating disease progression after completion of or unacceptable toxicity to at least one of the following chemotherapy regimens: a. Platinum-based (e.g. carboplatin, Paroplatin, cisplatin, Platinol, oxaliplatin, or Eloxatin), b. Taxoid-based regimen (e.g. paclitaxel, Taxol, Onxol, Abraxane, docetaxel, or Taxotere). and C. Chart notes indicate patient will not receive Tarceva in combination with any other chemotherapeutic agents or 3. For pancreatic cancer A. Chart notes indicating the cancer is surgically unresectable. and B. Chart notes indicating the cancer is locally advanced or metastatic (Stage 3 or 4) and C. Chart notes that patient will receive combination therapy with gemcitabine.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Oncologist or Nephrologist

Plan Year

If the patient has received previous Tarceva® therapy, the provider has evidence of clinical improvement from the pretreatment report by showing no increase in tumor size and/or progression of disease.

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

TASIGNA

TASIGNA

All FDA approved indications not otherwise excluded from Part D

Plan Year

Chart notes indicating ineffectiveness or intolerance to prior therapy that included imatinib

<i>Prior Authorization Group</i>	TRACLEER
<i>Drug Names</i>	TRACLEER
<i>Covered Uses</i>	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	NON COVERAGE Tracleer is NOT covered for members with the following criteria: A. A female patient of child bearing age that is pregnant or has plans for pregnancy, taking Cyclosporin A, Glyburide, or hypersensitivity to Tracleer.
<i>Required Medical Information</i>	The following copies of chart notes/laboratory reports are required: A. If the patient is female and is of childbearing age, documentation showing she is NOT pregnant, does NOT have plans for pregnancy and is using a reliable method of contraception B. Documentation showing that the patient is not on a drug regimen for cyclosporine and/or glyburide.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	Pulmonologist or Cardiologist
<i>Coverage Duration</i>	6 months
<i>Other Criteria</i>	COVERAGE POLICY Tracleer is covered for members who meet the following criteria: A. If the patient is female and is of childbearing age, she is NOT pregnant, does NOT have plans for pregnancy and is using a reliable method of contraception. (contraindicated). B. treatment of pulmonary arterial hypertension (WHO Group I). WHO Group I includes: Idiopathic PAH, Familial (FPAH), Associated with (APAH) connective tissue disease, Congenital systemic-to pulmonary shunts, Portal Hypertension, HIV Infection, Drugs and toxins, Pulmonary veno-occlusive disease (PVOD), Pulmonary capillary haemangiomatosis (PCH) or Persistent pulmonary hypertension of the newborn (PPNH).

<i>Prior Authorization Group</i>	TYZEKA
<i>Drug Names</i>	TYZEKA
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	Combination therapy with Hepsera®, Baraclude®, Epivir®, Intron A® and/or Infergen®.
<i>Required Medical Information</i>	Lab results: 1. Hepatitis B Viral load greater than 100,000 copies per mL 2. LFT results demonstrating elevated ALT and AST that are two times the upper limit of normal
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	Infectious Disease or Gastroenterologist
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	The patient has received previous Tyzeka® treatment, there is documented clinical improvement shown by a drop in viral load or reduction in the patient's liver aminotransferases. AND the patient is not receiving duplicate therapy that includes Hepsera®, Baraclude®, Epivir®, Intron A® and/or Infergen®.
<i>Prior Authorization Group</i>	VFEND
<i>Drug Names</i>	VFEND, VFEND IV
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Lab results: 1. culture and sensitivity results demonstrating susceptibility to voriconazole
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	Ineffectiveness or intolerance to at least one other antifungal therapy. For Candida infections must have ineffectiveness or intolerance to fluconazole

<i>Prior Authorization Group</i>	VICTOZA
<i>Drug Names</i>	VICTOZA
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Chart notes indicating inability to achieve adequate glycemic control (HbA1c less than 7.0) on metformin or a sulfonylurea and a thiazolidinedione. Lab results including HbA1c greater than 7.0 Current drug therapy includes or there is a contraindication to metformin or a sulfonylurea AND current drug therapy includes or there is a contraindication to a thiazolidinedione.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	VIMPAT
<i>Drug Names</i>	VIMPAT
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Chart notes indicating Vimpat will be used as adjunctive therapy
<i>Age Restrictions</i>	Covered for 17 years and older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	COVERAGE POLICY Vimpat is covered for members who meet the following criteria: A. Currently taking another formulary anticonvulsant such as: Carbamazepine, Divalproex, Gabapentin, Lamotrigine, Levetiracetam, Oxcarbazepine, Phenytoin, Pregabalin, Tiagabine, Topiramate, Valproic acid, or Zonisamide

<i>Prior Authorization Group</i>	XYREM
<i>Drug Names</i>	XYREM
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Chart notes indicating the diagnosis of excessive daytime sleepiness from narcolepsy as confirmed with a sleep study with symptoms that limit the ability to perform normal daily activities. B. OR the diagnosis is documented as cataplexy in patients with narcolepsy as confirmed with a sleep study.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	Diagnosis of narcolepsy with cataplexy may be approved. For narcolepsy without cataplexy: Previous use of Provigil and an amphetamine have been ineffective, not tolerated or is contraindicated.

<i>Prior Authorization Group</i>	ZAVESCA
<i>Drug Names</i>	ZAVESCA
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Lab results including: 1. Hemoglobin concentration great than 9 g/dL OR 2. Platelet count greater than $50 \times 10^9/L$
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	1.Documented ineffectiveness or contraindication to enzyme replacement therapy (Ceredase, Cerezyme) 2. If the patient has previously received 24 months of Zavesca® therapy, they must show a decrease in liver and spleen volume and/or increases in platelet count and/or increases in hemoglobin concentration.

<i>Prior Authorization Group</i>	ZYVOX
<i>Drug Names</i>	ZYVOX
<i>Covered Uses</i>	All FDA approved indications not otherwise excluded from Part D
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Chart notes indication one of the following: 1. Patient has a severe allergy to beta lactamase inhibitors AND/OR other susceptible antibiotics AND Culture and sensitivity documenting infection susceptible to linezolid OR 2. Documentation of ineffectiveness or been intolerant to treatment with other antibiotics that the organism is susceptible OR 3. Culture and sensitivity results indicating Vancomycin-Resistant Enterococcus faecium infection OR 4. Culture and sensitivity results indicating MRSA and patient has failed or is intolerant to Vancomycin
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	Infectious Disease
<i>Coverage Duration</i>	28 days
<i>Other Criteria</i>	