



Prior Authorization Criteria
2010

CMS Approved PA Criteria 2010 v6
Last updated 7-1-2010

Prior_Authorization_Group_Desc	Actemra
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	ANC (Abosolute Neutrophil Count) less than 500: Platelet Count less than 50,000
Required_Medical_Information	Diagnosis. Labs: ANC and Platelet Count.The patient must have had an inadequate response to conventional treatment including methotrexate with or without one or more disease modifying anti-rheumatic drugs (DMARDs) +/- NSAIDs for at least 3 consecutive months within the last 12 months, unless contraindicated or intolerant. The patient has had an inadequate response to one the TNF antagonist therapy Remicade, Humira, or Enbrel. An inadequate response can be defined as therapy was ineffective, not tolerated, or other clinical circumstance exists that precludes use.
Age_Restrictions	
Prescriber_Restrictions	Licensed Practioner highly familiar with the use and monitoring of special biologic response modifiers
Coverage_Duration	Plan year
Other_Criteria	

Prior_Authorization_Group_Desc	Actimmune
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Hypersensitivity to interferon gamma, E. coli derived proteins, or any component of the formulation
Required_Medical_Information	Medical documentation of FDA approved diagnosis.
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 year
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage.ONLY APPLIES to NEW STARTS

Prior_Authorization_Group_Desc	Aldurazyme
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Patients outside of the recommended age range.
Required_Medical_Information	Diagnosis
Age_Restrictions	Patients must be greater than 5 years old
Prescriber_Restrictions	
Coverage_Duration	1 year

Other_Criteria	
Prior_Authorization_Group_Desc	Alferon N
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	APPROVE for the treatment of refractory or recurring external condylomata acuminata (genital or venereal warts): Intralesional dosage: Adults: 0.05 ml (250,000 IU) per wart intralesionally twice weekly for up to 8 weeks. The maximum recommended dose per treatment session is 0.5 ml (2.5 million IU). The minimum effective dose of interferon alfa-n3 has not been established. Genital warts usually begin to disappear after several weeks of treatment. Treatment should be continued for a maximum of 8 weeks. In clinical trials, many patients who had a partial resolution of warts during treatment experienced further resolution of their warts after cessation of treatment. Of the patients who had complete resolution, half had complete resolution by the end of treatment and half had complete resolution of venereal warts during the 3 months after treatment cessation. Thus, it is recommended that no further treatment be given for 3 months after the initial 8-week course unless the lesions enlarge or new warts appear. Studies to determine the efficacy of a second treatment course have not been conducted. Hepatitis C infection (NOTE: Best results seen with pegylated interferon and ribavirin combination):If MD is any of the following specialist: Gastroenterologist, Hepatologist, Transplant specialist, Infectious Disease specialist) AND the following labs are provided: HCV RNA levels, AST/ALT levels, Viral genotype, with or without results of liver biopsy,send to Prof. Services for clinical pharmacist review.
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	6mo-1yr (diagnosis dependent)
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage. Coverage Duration: Dx: Chronic Hep C Approve x 24 weeks if: 1) Patient is less than 60 years old, AND 2) MD is a gastroenterologist, infectious disease specialist or hepatologist, AND 3) Persistently elevated ALT (greater than 6 months) (normal 0 -45), AND 4) Positive HCV RNA, AND 5) Liver biopsy showing either portal or bridging fibrosis, and at least moderate degrees of inflammation and necrosis, AND Limit #2 kits per month x 24 weeks (6 months). If requesting for 48 weeks duration, approve if: 1) All above criteria is met (for 24 wk approval), AND 2) Very high HCV RNA level (greater than 2million copies/ml), OR 3) HCV genotype 1, OR 4) Cirrhosis on biopsy (with otherwise high likelihood of response) Limit #2 kits/mo x 48 weeks (12 months).

Prior_Authorization_Group_Desc	Amevive
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Patients with mild psoriasis, patients also using other immunosuppressive agents, patients currently receiving phototherapy, patients also diagnosed with HIV/AIDs.
Required_Medical_Information	The prior authorization should be maintained for a lifetime limit of 180 days due to the lack of available studies of Amevive's safety and effectiveness beyond two treatment cycles. The first and second treatment cycles, each consisting of 12 weeks, must be separated by at least a 12-week interval. Retreatment with the second 12-week course may be initiated provided the CD4+ T-cell count is within the normal range. The physician should monitor CD4+ T-cell counts during treatment, dosing should be withheld if the CD4+ T-cell count is less than 250 /mm ³ and treatment should be discontinued if the count remains less than 250 /mm ³ for one month. Per manufacturer guidelines, Amevive should not be used concomitantly with other immunosuppressive agents or in patients currently receiving phototherapy. Amevive is contraindicated in patients with HIV/AIDs because it reduces CD4+ T-cell counts and, thus, may accelerate progression of HIV infection or increase complications of the disease.
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 year, lifetime limit of 180 days
Other_Criteria	

Prior_Authorization_Group_Desc	Apokyn
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	Advanced Parkinson's Disease: 1. Confirmed diagnosis of advanced Parkinson's disease, AND 2. Unable to control 'off' symptoms with adequate combinations of conventional oral therapy, AND 3. Used in combination with a non-5-HT ₃ antagonist antiemetic for initial therapy, AND 4. Not used in combination with 5-HT ₃ antagonists
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 year
Other_Criteria	

Prior_Authorization_Group_Desc	Aralast, Zemaira
---------------------------------------	-------------------------

Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Emphysema present that is caused by environment or cigarette smoking as causative factors, patients with selective IgA deficiencies (IgA less than 15 mg/dL) who have known antibodies against IgA (anti-IgA antibody), anaphylaxis to IgA products.
Required_Medical_Information	Diagnosis
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	Lifetime
Other_Criteria	

Prior_Authorization_Group_Desc	Aranesp
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Uncontrolled hypertension, known hypersensitivity to the active substance or any excipients, iron stores are inadequate, pre-treatment Hgb greater than 12 g/dl
Required_Medical_Information	Initiation of therapy: 1. Patients do not have uncontrolled hypertension 2. Patients do not have an allergy to any component of epoetin or allergy to mammalian cell derived products 3. Patients do not have an allergy to albumin 4. At least one of the below stated diagnosis and lab values For both epoetin and darbepoetin, patients must have one of the following diagnosis with specified lab values, Chronic renal failure requiring dialysis. Chronic renal failure not requiring dialysis with the following lab values: Hb less than 10g/dL, HCT less than 30%, TSAT greater than 20%, Ferritin greater than 100ng/dL, Non-myeloid malignancies where anemia is due to the effect of concomitantly administered chemotherapy and the following lab values: Hb \geq 11g/dL, TSAT greater than 20%, Ferritin greater than 100ng/dL. For epoetin only, patients must have one of the following diagnosis with specified lab values: Zidovudine treated HIV patients with the following lab values: Zidovudine dose \geq 4,200mg/week, Endogenous erythropoietin levels \geq 500mU/mL, Ferritin greater than 100ng/dL, TSAT greater than 20%, Reduction of allogeneic blood transfusion in patients undergoing elective, non-cardiac, non-vascular surgery with the following lab values: Hb greater than 10g/dL to \geq 12g/dL
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	3 months
Other_Criteria	

Prior_Authorization_Group_Desc	Arcalyst
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Rilonacept is not considered medically necessary when members have the following concomitant conditions: Active Tuberculosis, HIV, Hepatitis B, Hepatitis C, Neonatal-Onset Multisystem inflammatory disease, or currently utilizing tumor necrosis factor inhibitors or interleukin-1 blockers.
Required_Medical_Information	Diagnosis
Age_Restrictions	The patient must be 12 years and older
Prescriber_Restrictions	
Coverage_Duration	1 year
Other_Criteria	

Prior_Authorization_Group_Desc	Arixtra
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	Diagnosis
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 year
Other_Criteria	

Prior_Authorization_Group_Desc	Avonex
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Hypersensitivity to human albumin (Avonex(R) lyophilized powder vials and Rebif(R) prefilled syringes), hypersensitivity to natural or recombinant interferon
Required_Medical_Information	Approvable for treatment of MS when written by or consulted on by a neurologist.
Age_Restrictions	
Prescriber_Restrictions	Prescribing physician must be a neurologist
Coverage_Duration	1 year, only extend for 1 month at a time beyond this duration
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage.

Prior_Authorization_Group_Desc	Betaseron
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Hypersensitivity to E. coli-derived products, natural or recombinant interferon beta, albumin human or any other component of the formulation
Required_Medical_Information	Approvable for treatment of MS when written by or consulted on by a neurologist.
Age_Restrictions	
Prescriber_Restrictions	Prescribing physician must be a nuerologist
Coverage_Duration	1 year
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage.

Prior_Authorization_Group_Desc	Ceredase
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Patients less than 2 years old.
Required_Medical_Information	Diagnosis
Age_Restrictions	Must be at least 2 years of age.
Prescriber_Restrictions	
Coverage_Duration	Lifetime
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage.

Prior_Authorization_Group_Desc	Cerezyme
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	Diagnosis of non-neuropathic Gaucher's disease with one of the following: anemia, thrombocytopenia, bone disease, hepatomegaly or splenomegaly, it has been designated an orphan product for use in the treatment of types I, II, and III Gaucher's disease, safety and effectiveness have not been established in children less than 2 years old.
Age_Restrictions	Patient must be at least 2 years of age
Prescriber_Restrictions	
Coverage_Duration	1 year
Other_Criteria	

Prior_Authorization_Group_Desc	Chorionic gonadotropin, Pregnyl
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Pregnancy or suspected pregnancy, Use for infertility or sexual dysfunction.
Required_Medical_Information	Category X –Human chorionic gonadotropin may cause fetal harm when administered to a pregnant woman. Diagnosis required
Age_Restrictions	Must be at least 4 years of age
Prescriber_Restrictions	
Coverage_Duration	1 year
Other_Criteria	

Prior_Authorization_Group_Desc	Copaxone
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	A neurologist should be consulted to review the patient and determine the need as opposed to other options. It is associated with numerous adverse reactions (chest pain, CNS pain, pruritus, rash, nausea, diarrhea, injection site reaction, etc.) and additional guidance from a neurologist will be helpful in determining the most effective therapy for the patient.
Age_Restrictions	Must be at least 18 year of age
Prescriber_Restrictions	Prescribing physician must be a neurologist
Coverage_Duration	1 year
Other_Criteria	

Prior_Authorization_Group_Desc	Desmopressin
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Patients with hypersensitivity to desmopressin acetate, patients with existing or history of hyponatremia, patients with moderate to severe renal impairment
Required_Medical_Information	Per manufacturer guidelines, desmopressin should not be used in patients with known hypersensitivity to desmopressin acetate, existing or history of hyponatremia or moderate to severe renal impairment.
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 year

Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage. IV therapy is only approved in instances where oral therapy is neither appropriate or tolerable.
-----------------------	--

Prior_Authorization_Group_Desc	Eligard, leuprolide
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	Must have a dx of at least one: Prostatic Carcinoma, Endometriosis, Uterine Leiomyomata (Fibroids), Central Precocious Puberty, Amenorrhea.
Age_Restrictions	Patient must be at least 18 years of age for all diagnoses, except for central precocious puberty
Prescriber_Restrictions	Prescriber is an individual highly familiar with prescribing and monitoring
Coverage_Duration	3 mo - 2 yrs (diagnosis dependent)
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage. PA must be reviewed by a clinical pharmacist if requesting for a second treatment course for endometriosis. Coverage duration: 2 yrs(advanced prostate cancer) 6 mo(endometriosis) 3 mo(uterine leiomyoma), 1 yr(central precocious puberty)

Prior_Authorization_Group_Desc	Enbrel
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Patients with sepsis or active infection
Required_Medical_Information	Diagnosis, Prior drug and/or non-drug therapy tried and failed, Confirmation if patient is currently using a Tumor Necrosis Factor (TNF) blocking agent such as Humira or Kineret. For psoriasis diagnosis, percent of body area affected.
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 year
Other_Criteria	

Prior_Authorization_Group_Desc	Epogen
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Pre-treatment Hct greater than 36%, patients not receiving iron supplementation if iron stores are inadequate, unspecified diagnosis of "anemia", uncontrolled hypertension
Required_Medical_Information	FOR INITIAL AUTHORIZATION ALL FOUR MAJOR CRITERIA MUST BE MET. 1.) Anemia associated with one of the following: Chronic renal failure patients on dialysis, Chronic renal failure patients NOT on dialysis AND with hematocrit less than 30% or transfusion dependant and serum ferritin greater than100ng/ml transferrin sat.greater than20%. Endogenous Erythropoietin less than500mU/ml. Zidovudine-treated HIV-infected patients with endogenous erythropoietin level less than 500 mUnits/mL AND zidovudine dose is less than 4,200 mg/week. Serum ferritin greater than100ng/ml transferrin sat.greater than20%. Endogenous Erythropoietin less than500mU/ml. Concomitant chemotherapy treatment of non-myeloid malignancies (where anemia is not caused by other factors). Serum ferritin greater than100ng/ml transferrin sat.greater than20%. Endogenous Erythropoietin less than500mU/ml. Patients schedule to undergo elective, non-cardiac, non-vascular surgery with hemoglobin greater than10 g/dL but less than 13 g/dL 2.) Patients do not have uncontrolled hypertension 3.) Patients do not have allergy to any component of epoetin or allergy to mammalian cel-derived products. 4.) Patients do not have allergy to Albumin
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	3 months
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage. Must send to PROF for review by a clinical pharmacist if diagnosis is chemo d/t Hep C, or anemia d/t Hep C, or Peg-Intron/Pegasys use. PROF SVS: medical justification will be required for doses that exceed 10,000 IU 3 times weekly (30,000 total per week)

Prior_Authorization_Group_Desc	Ethyol
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	APPROVE for nephrotoxicity prophylaxis in patients receiving cisplatin for advanced ovarian cancer or non-small cell lung carcinoma: APPROVE for xerostomia prophylaxis in patients undergoing post-operative radiation treatment of head and neck cancer, where the radiation port includes a substantial portion of the parotid glands: APPROVE for bone marrow suppression prophylaxis, nephrotoxicity prophylaxis, or neurotoxicity prophylaxis in patients receiving antineoplastic agents and/or fractionated radiation therapy.

Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 year
Other_Criteria	

Prior_Authorization_Group_Desc	Fabrazyme
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	Diagnosis
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 year
Other_Criteria	

Prior_Authorization_Group_Desc	Gleevec
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Pregnancy
Required_Medical_Information	DX: acute lymphocytic leukemia (ALL), chronic myelogenous leukemia (CML), desmoid tumor, gastrointestinal stromal tumors (GIST). APPROVE AS REQUESTED for Hematology/Oncology or consult with Hem/Onc
Age_Restrictions	
Prescriber_Restrictions	Prescribing physician must be a hematology/oncology specialist or have consulted with one
Coverage_Duration	1 year (maximum treatment duration 5 years)
Other_Criteria	ONLY APPLIES to NEW STARTS

Prior_Authorization_Group_Desc	Humira
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Patients with mild rheumatoid arthritis, patients with mild Crohn's disease, patients with an active, serious infection, patients with a latent tuberculosis infection, concurrent use of anakinra
Required_Medical_Information	Dx: Rheumatoid, Psoriatic and Juvenile rheumatoid arthritis: 1. MD is a rheumatologist, AND2. Patient has had an inadequate response to one or more disease modifying antirheumatic drugs (DMARDS): Methotrexate, Sulfasalazine, Cyclosporine, hydroxychloroquine, injectable gold, azathioprine, or penicillamine. (Humira can be used in combination with methotrexate for patients

	who do not respond adequately to methotrexate alone.) 3. Patient is not currently using a Tumor Necrosis Factor (TNF) blocking agent or other biological agent such as Enbrel or Kineret. Dx: Moderate to Severe Active Crohn's disease: 1. MD is GI AND 2. Pt has had inadequate response to one or more of the following: DMARDs (Methotrexate, Sulfasalazine or azathioprine only), oral 5-ASA products (mesalamine, Asacol, Pentasa, Lialda, etc.), corticosteroids (Entocort EC, prednisone, etc.) or Remicade. Dx: Ankylosing Spondylitis: 1. MD is rheumatologist, AND 2. Pt has had inadequate response to UV light therapy AND a DMARD such as methotrexate or sulfasalazine for atleast 3 months prior. Dx: Plaque Psoriasis:1. MD is Dermatologist or Rheumatologist, AND 2. Condition is stable AND 3. At least 10% of body surface affected 4. Mbr is a candidate for phototherapy or systemic therapy.
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 year
Other_Criteria	

Prior_Authorization_Group_Desc	Increlex
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Insulin-like growth factor therapy is considered NOT medically necessary when any of the following criteria are met: Final adult height has been reached as determined by the 5th percentile of adult height OR the bone epiphyses are closed OR the patient is older than 18 years of age.
Required_Medical_Information	Diagnosis, Labs (IGF-1, GH)
Age_Restrictions	The patient is between 2 years -18 years old for Increlex therapy
Prescriber_Restrictions	Licensed Practioner
Coverage_Duration	1 year
Other_Criteria	

Prior_Authorization_Group_Desc	Infergen
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Not approvable for Hepatitis A or B
Required_Medical_Information	For Hepatitis C: positive hepatitis C viral load.
Age_Restrictions	
Prescriber_Restrictions	Prescribing physician must be gastroenterologist, hepatologist or infectious disease specialist
Coverage_Duration	1 yr chronic Hep C, 6 mo-1yr Hep B
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage. Coverage duration equal to 1 year with diagnosis of chronic Hep C, 6 months with Hepatitis B if: patient is less than 60 years old, MD is a gastroenterologist, infectious disease specialist or hepatologist, persistently elevated ALT (greater than 6 months) (normal 0 -45), positive HCV RNA, liver biopsy showing either portal or bridging fibrosis, and at least moderate degrees of inflammation and necrosis, 1 year with Hepatitis B if: all above criteria is met (for 6 month approval) and very high HCV RNA level (greater than 2million copies/ml), HCV genotype 1, or cirrhosis on biopsy (with otherwise high likelihood of response)

Prior_Authorization_Group_Desc	Intron-A
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Not approvable for Hepatitis A - not indicated for this. Autoimmune hepatitis, decompensated liver disease, prior hypersensitivity to any interferon alfa preparations or components
Required_Medical_Information	For Hepatitis C: positive hepatitis C viral load.
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 yr chronic Hep C, 6 mo-1yr Hep B
Other_Criteria	

Prior_Authorization_Group_Desc	Iressa
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Members currently taking this medication at time of enrollment will not be required to meet prerequisites for prior authorization
Required_Medical_Information	Liver function tests. Need to have diagnosis of locally advanced/metastatic Non-Small Cell Lung

	Cancer And, patients who have failed both platinum-based and docetaxel chemotherapies who are benefiting or have benefited from IRESSA. Or who are either part of a clinical study approved by an investigational drug review board prior to June 17, 2005, Or who are part of a clinical study approved by an investigational drug review board after June 17,2005 that is conducted under an investigational new drug application
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 year
Other_Criteria	

Prior_Authorization_Group_Desc	Itraconazole
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Coadministration with cisapride, dofetilide, oral midazolam, pimozide, levacetylmethadol, quinidine, lovastatin, simvastatin, triazolam, ergot alkaloids metabolized by CYP3A4 (such as dihydroergotamine, ergometrine, ergotamine and methylethergometrine), congestive heart failure or history of (capsules for treatment of onychomycosis), pregnant women or women contemplating pregnancy (capsules for treatment of onychomycosis), hypersensitivity to itraconazole
Required_Medical_Information	IF Dx equal to Onychomycosis member must have infection documented by a positive KOH or other lab test PLUS one of the following, be a diabetic OR immunocomprised, OR have repeated ingrown nails requiring surgery, OR have pain severe enough that limits activities of daily living or interferes with work.
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	7 days - 1 yr (diagnosis dependent)
Other_Criteria	Although no PA is required for the preferred alternative, please provide dosing limits for educational purposes. Edits are not required. Approval duration: 7 days (superficial mycoses), 2 weeks (oropharyngeal candidiasis), 5 weeks (fingernail and esophageal candidiasis), 12 weeks (toenail with or without fingernail in adults or mild disseminated histoplasmosis in AIDS), 5 months (toenail with or without fingernail in adolescents and children), 12 months (chronic pulmonary or progressive disseminated histoplasmosis in AIDS), 18 months (cutaneous or systemic sporotrichosis), 1 year (prophylaxis of indicated fungal infections in HIV patients)

Prior_Authorization_Group_Desc	Kineret
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	6 mo (refractory chronic infantile neurological, cutaneous and articular syndrome), 1 yr(all others)
Other_Criteria	

Prior_Authorization_Group_Desc	Kuvan
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	Diagnosis
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	First- 2 months to determine response to therapy, if response is positive, for 10 months.
Other_Criteria	Response is defined as a 20% or greater reduction of blood Phe level from baseline during treatment for 1 – 2 months

Prior_Authorization_Group_Desc	Leukine
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Chemotherapy or radiotherapy within 24 hours or concomitantly, excess leukemic myeloid blasts in the bone marrow or blood (10% or greater), hypersensitivity to granulocyte-macrophage colony-stimulating factor (GM-CSF) or yeast-derived products, allergic or anaphylactoid reactions to the medication in the past , severe preexisting cardiac disease
Required_Medical_Information	APPROVE for patients with low WBC counts for the following uses: 1) Acceleration of myeloid recovery in patients with Non-Hodgkin's lymphoma (NHL), Acute lymphoblastic leukemia (ALL) and Hodgkin's disease undergoing autologous bone marrow transplantation (BMT), 2) BMT failure or engraftment delay. 3) Induction chemotherapy in acute myelogenous leukemia (AML)

	(Chemotherapy for AML cancer treatment, patients receiving myelosuppressive chemotherapy agents), 4) Mobilization and following transplantation of autologous PBPC (Peripheral Blood Progenitor Cell (PBPC) Collection). After myeloablative chemotherapy, transplantation of an increased number of progenitor cells leads to a more rapid engraftment, decreasing need for supportive care, 5) Myeloid reconstitution after Allogeneic Bone Marrow Transplantation. Unlabeled (but approvable) Uses: 1) To increase White Blood Cell Counts in patients with myelodysplastic syndromes and in AIDS patients receiving zidovudine, 2) For myelosuppressive chemotherapy treated patient and preleukemic patients, 3) Aplastic Anemia, 4) To decrease transplantation-associated organ system damage, particularly in the liver and kidney.
Age_Restrictions	Patients requiring prophylaxis of febrile neutropenia in acute myelogenous leukemia following induction chemotherapy must be at least 55 years of age, other diagnoses do not specify an age restriction
Prescriber_Restrictions	
Coverage_Duration	1 year
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage.

Prior_Authorization_Group_Desc	Myobloc
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Use for cosmetic purposes such as wrinkles
Required_Medical_Information	APPROVE AS REQUESTED if the Dx is any FDA-approved indication not otherwise exclude for Part D, such as Achalasia, Blepharospasm, Cervical Dystonia, hyperhidrosis, Muscle Spasm for Patients w/Cerebral Palsy, Strabismus. For Dx of Migraine HA, approve if: 1) Prescriber is a Neurologist OR Pain Management specialist, 2) Dx is moderate to severe migraine (with or without aura), chronic daily headache, or chronic tension-type headache 3) and patient has a least 2 headaches a month 4) abortive medication is contraindicated or ineffective 5) patient has tried/failed at least 1 preventative therapy within last 6 months (i.e. beta-blocker, antiepileptic, calcium channel blockers, etc.), 6) rebound headaches from medication overuse has been ruled out.
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 year

Other_Criteria	
-----------------------	--

Prior_Authorization_Group_Desc	Neulasta
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Patients with hypersensitivity to E coli-derived proteins, filgrastim, or pegfilgrastim, or any component of the product
Required_Medical_Information	Diagnosis, chemo regimen, patient history when applicable.
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 year
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage. Forward to clinical pharmacist to review.

Prior_Authorization_Group_Desc	Neumega
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	Approve if: Dx: Chemo-induced thrombocytopenia AND Platelet count less than 100,000.
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	21 days per treatment cycle
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage. Platelet count must be less than 100,000 and must be submitted with PA request. Once platelets reach 100,000 or greater, it will no longer be approved.

Prior_Authorization_Group_Desc	Neupogen
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Diagnosis of any of the above indications without current weight, recent CBC with diff. or ANC, documented chemotherapy induced neutropenia, dose, duration, and target ANC/WBC for therapy, ANC of greater than 10,000/mm ³
Required_Medical_Information	Diagnosis of any of the indications and the following information must be obtained before approval is authorized: patient's weight, most recent (within the past week) CBC with differential or absolute neutrophil count (ANC) (for chemotherapeutic regimens where patient has had history of significant neutropenia while on chemotherapy, provide CBC with diff. or ANC of last chemo cycle where patient experienced neutropenia), dose to administer, duration of therapy, target ANC or target WBC. Clinical trial data shows no clinical benefit seen once an ANC is greater than 10,000/mm ³ .
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	7 days maximum (bone marrow ablation), 14 days maximum per cycle (all other diagnoses)
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage.

Prior_Authorization_Group_Desc	Octreotide, Sandostatin, Zorbtive
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	Labs, IGF-1, Glucose
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 year
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage.

Prior_Authorization_Group_Desc	Orencia
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	Diagnosis. The patient must have had an inadequate response to conventional treatment including methotrexate with or without one or more disease modifying anti- rheumatic drugs (DMARDs) +/- NSAIDs for at least 3 consecutive months within the last 12 months, unless contraindicated or intolerant. The patient has had an inadequate response to one the TNF antagonist therapy Remicade, Humira, or Enbrel. An inadequate response can be defined as therapy was ineffective, not tolerated, or other clinical circumstance exists that precludes use.
Age_Restrictions	
Prescriber_Restrictions	Licensed Practioner highly familiar with the use and monitoring of special biologic response modifiers
Coverage_Duration	Plan year
Other_Criteria	

Prior_Authorization_Group_Desc	Pegasys
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	For Hepatitis C: positive hepatitis C viral load. For HBeAg positive and HBeAg negative chronic Hepatitis B: evidence of viral replication
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 yr chronic Hep C, 6 mo-1yr Hep B
Other_Criteria	

Prior_Authorization_Group_Desc	Peg-Intron
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	Approved for the following diagnoses and duration of therapy: 1) Hepatitis C infection ff MD is any of the following specialist: Gastroenterologist, Hepatologist, Transplant specialist, Infectious Disease specialist) AND the following labs are provided: HCV RNA levels, AST/ALT levels, Viral genotype, with or without results of liver biopsy.
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 yr chronic Hep C, 6 mo-1yr Hep B
Other_Criteria	

Prior_Authorization_Group_Desc	Promacta
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	Diagnosis
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	3 months
Other_Criteria	Patient has a diagnosis of relapsed/refractory chronic (greater than 6 months) immune/idiopathic thrombocytopenic purpura (ITP) AND Patient and Prescriber have been enrolled in Promacta FDA REMS long term safety monitoring program (Promacta Cares1-877-9-PROMACTA) AND Patient has a baseline platelet count of less than 50 (x 10 ⁹ /L) Patient is intolerant to splenectomy, and has had an insufficient response or is intolerant to corticosteroids AND immunoglobulins (IVIG) OR Patient has had a splenectomy with an inadequate response AND had an insufficient response or is intolerant to postsplenectomy corticosteroids. Reauthorizations Patient has a baseline platelet count of less than 200 (x 10 ⁹ /L) AND Patient remains at risk for bleeding complications. Promacta should not be utilized to normalize platelet counts AND Patient is responding to therapy as evidenced by increased platelet counts. Promacta® should be discontinued in patients that have failed to respond after 4 weeks of therapy at maximum dose.

Prior_Authorization_Group_Desc	Remicade
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	Diagnosis, Prior drug and/or non-drug therapy tried and failed and length of therapy, For psoriasis diagnosis, percent of body area affected.
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 year
Other_Criteria	

Prior_Authorization_Group_Desc	Remodulin, Revatio, Tracleer, Ventavis
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Requests for uses other than each medications' specific indications, requests for titration schedules other than those proven to be safe and effective without documentation of failures at lower doses, quantities, or time schedules. Letairis: known or suspected pregnancy, Tracleer: concomitant therapy with cyclosporine or glyburide, hypersensitivity to bosentan or any component of the film-coated tablet, pregnancy, Flolan: chronic use in congestive heart failure due to severe left ventricular systolic dysfunction, hypersensitivity to epoprostenol sodium or to any of its components, chronic use in patients who may develop pulmonary edema during initiation, Remodulin: hypersensitivity to treprostinil or any of its components
Required_Medical_Information	Diagnosis of PAH, as well as FDA approved indication for individual medications. The dose/quantity requested must be supported by one of the three CMS accepted compendia (DrugDex, USP or AHFS) or a published, peer reviewed article found on Medline with the supporting documentation in such literature being specific to that indication.
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	Lifetime
Other_Criteria	

Prior_Authorization_Group_Desc	Revlimid
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	LABS, Platelet count, ANC, pregnancy test if female.
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	6 months
Other_Criteria	ONLY APPLIES to NEW STARTS

Prior_Authorization_Group_Desc	Somatropin
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Growth promotion in pediatric patients with closed epiphyses, progression of any underlying intracranial lesion or actively growing intracranial tumor, acute critical illness due to complications following open heart or abdominal surgery, multiple accidental trauma or acute respiratory failure, evidence of active malignancy, active proliferative or severe nonproliferative diabetic retinopathy, use in patients with Prader-Willi syndrome without growth hormone deficiency (except Genotropin®) or in patients with Prader-Willi syndrome with growth hormone deficiency who are severely obese or have severe respiratory impairment, children with: constitutionally delayed growth and development (i.e., delayed skeletal maturation with normal growth velocities and rates of bone age advancement, members who are at the lowest 5% of the growth curve at age 3), steroid-induced growth failure, kidney transplant recipients, down syndrome, Fanconi's syndrome, Bloom syndrome, chromosomal and genetic disorders, adults with: chronic fatigue syndrome, fibromyalgia, obesity, athletic performance enhancer, anti-aging treatment, sepsis, burns, trauma, surgery, end stage renal disease, or wasting associated with: cancer or organ failure.
Required_Medical_Information	NEW THERAPY: Children: Criteria 1, 2 or 3 are required PLUS one below for approval x 1 year. 1. Child has hypopituitarism and hypoglycemia. 2. Child has failed two provocative growth hormone tests. 3. Child is to be treated for short stature associated with Turner Syndrome. PLUS ONE OF THESE A) A height of greater than 2.5 standard deviations below the median for age. B) A yearly growth rate of less than 4.5 cm/yr. C) A bone age of 2 standard deviations below chronological age. D) For Turner's Syndrome only - must supply height information- 1. Present height below 5th percentile 2. A height of greater than 2.0 standard deviations below the median for age. If none of the information above is provided send to Clinical Pharmacist. Adults (new therapy) MD must provide one of the following diagnosis: 1. Adult growth hormone deficiency 2. Cachexia or 3. HIV / AIDS wasting, or 4. Short bowel syndrome. If diagnosis is growth hormone deficiency, MD must document failure of two growth hormone tests. If diagnosis is cachexia or HIV / AIDS wasting, must answer YES to patient receiving concomitant antiretroviral therapy. If

	answer is yes approve for Serostim only. If diagnosis is short bowel syndrome, must answer YES to patient receiving specialized nutritional support. If answer is yes approve for Zorbitive 8mg/day x 4 weeks only.
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	4 weeks (adults with short bowel syndrome), 1 year (all other diagnoses)
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage.

Prior_Authorization_Group_Desc	Somavert
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Hypersensitivity to pegvisomant, polyethylene glycol, latex or any component of the formulation
Required_Medical_Information	Acromegaly who have had inadequate responses to or are not candidates for surgical resection, pituitary irradiation, and/or other medical therapies because considered second line therapy
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 year
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage.

Prior_Authorization_Group_Desc	Tarceva
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Concurrent use of platinum-based chemotherapy
Required_Medical_Information	Dosing or Quantity Limit Exception Approval Criteria: The prescribing physician must document that the patient has failed or is unresponsive to the lower dose or that the length of therapy dose limit is not meeting the clinical needs or the patient AND the dose/quantity requested is supported by one of the three CMS accepted compendia (DrugDex, USP or AHFS). The supporting documentation in such literature must be specific to that indication.
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 year
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare

setting administration, redirect for Medicare Part B coverage. ONLY APPLIES to NEW STARTS

Prior_Authorization_Group_Desc	Testosterone
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Male patients with normal or above normal testosterone levels (normal equal to 270-1070 ng/dl or 9.3-37 mmol), breast cancer in males, hypersensitivity to testosterone or any component of the product, pregnancy, known or suspected prostate cancer, use of the gel or patch in women
Required_Medical_Information	No form of this medication should be used recreationally, can also be approved for AIDS wasting
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 year (AIDS wasting), as requested for hypogonadism
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage.

Prior_Authorization_Group_Desc	Trelstar
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Hypersensitivity to triptorelin or any other component of the product, hypersensitivity to any other luteinizing hormone-releasing hormone (LHRH) or LHRH agonist, existing or potential pregnancy
Required_Medical_Information	Dx: Breast cancer, Prostate cancer AND prescriber is Hematology/Oncology or consult with Hem/Onc specialist. Non-cancer Diagnosis: Endometriosis, Precocious puberty, Uterine leiomyomata.
Age_Restrictions	
Prescriber_Restrictions	Prescribing physician must be a hematology/oncology specialist or have consulted with one
Coverage_Duration	1 year
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage. Can be reviewed and approved by a clinical pharmacist if therapy exceeds maximum allowable cost. Diagnosis of infertility requires confirmation and must be forwarded to a clinical pharmacist.

Prior_Authorization_Group_Desc	Tretinoin (topical)
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Diagnosis of acne vulgaris without trying and failing at least 1 preferred alternatives (such as generic acne products - erythromycin/benzoyl peroxide, clindamycin, etc), use for cosmetic purposes (hyperpigmentation/age spots, wrinkles, tactile roughness of the skin, sun damage, etc.)
Required_Medical_Information	Patients diagnosed with ACNE or other non-cosmetic diagnosis
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	1 month (warts/actinic keratosis), open-ended (acne vulgaris)
Other_Criteria	

Prior_Authorization_Group_Desc	Xolair
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	All criteria from 1, 2, AND 3 MUST be met for approval: (1) MD must be allergic asthma specialist. Age must be greater than 12, Weight must be less than 150 kg. Dx must be BOTH Allergic Asthma (evidence of atopy) AND moderate/severe persistent asthma. Must show evidence of reversibility (greater than 12% FEV1 OR greater than 20% PEF improvement). AND IgE level greater than 30 (usual range 30-700) IU/ml. (2) Patient must be high-risk: Either uncontrolled on med-high dose ICS for 3 months, OR controlled on high dose inhaled or oral CS, OR Contraindication to high dose ICS AND long acting beta agonists.... AND documentation of hospital stays, missed days, night symptoms, etc. (3) Documentation of: Attempted meds in last year (w/date), presence/management of confounding morbidities, environmental control issues addressed, Pt compliance/method used.
Age_Restrictions	
Prescriber_Restrictions	
Coverage_Duration	6 months
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage.

Prior_Authorization_Group_Desc	Zometa
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	
Required_Medical_Information	Diagnosis
Age_Restrictions	
Prescriber_Restrictions	Licensed Practioner
Coverage_Duration	Plan year
Other_Criteria	

Prior_Authorization_Group_Desc	Zyvox
Covered_Uses	All FDA-approved indications not otherwise excluded for Part D
Exclusion_Criteria	Patients that are currently myelosuppressed due to any cause
Required_Medical_Information	Diagnosis including micro-organism causing the infection
Age_Restrictions	
Prescriber_Restrictions	Presribing physician must be an infectious disease specialist
Coverage_Duration	14 days. Addnl 14 days if confirmed vancomycin-resistant Enterococcus faecium infection
Other_Criteria	Home or LTC administration covered under Medicare Part D. Physician office or healthcare setting administration, redirect for Medicare Part B coverage. IV therapy is only approved in instances where oral therapy is neither appropriate or tolerable.