

Drug Name	Criteria	Additional Criteria
8-MOP	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
ABELCET	Verification of FDA approved indications	Coverage determination requires submission of labs including culture and sensitivity results
ABILIFY	Verification of FDA approved indications	Coverage is excluded for diagnosis of dementia related psychosis. Prescription must be written by a psychiatrist. Patients must have had trial/failure of preferred atypical antipsychotics Seroquel and Risperidone.
ABILIFY DISCMELT	Verification of FDA approved indications	Coverage is excluded for diagnosis of dementia related psychosis. Prescription must be written by a psychiatrist. Patients must have had trial/failure of preferred atypical antipsychotics Seroquel and Risperidone.
ABRAXANE	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
ACETADOTE	Verification of FDA approved indications	
ACETYLCYSTEINE	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
ACTIMMUNE	Verification of FDA approved indications	
ADAGEN	Verification of FDA approved indications	
ADCIRCA	Verification of FDA approved indications	Coverage determination requires appropriate diagnosis
ADVAIR DISKUS	Verification of FDA approved indications	Coverage is excluded for diagnosis of COPD if requested strength is 500/50. For diagnosis of asthma patients must have previous trial and failure of lower strengths (100/50; 250/50) first.
AFINITOR 10	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
AFINITOR 5	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
ALBUTEROL SULFATE NEBULIZER	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
ALDARA	Verification of FDA approved indications	Previous trial and failure of podofilox for treatment of genital/perianal warts. Previous trial and failure of topical fluouracil for treatment of actinic keratosis and treatment of basal cell carcinoma.
ALDURAZYME	Verification of FDA approved indications	
ALFERON N	Verification of FDA approved indications	
ALIMTA	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
ALKERAN	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
ALOXI	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
AMBISOME	Verification of FDA approved indications	Coverage determination requires submission of labs including culture and sensitivity results
AMEVIVE	Verification of FDA approved indications	Coverage determination requires clinical notes and labs (including CD4-T count within 1 week of initiating therapy)
AMINOSYN	Verification of FDA approved indications	
AMINOSYN II	Verification of FDA approved indications	
AMINOSYN II 3.5%/DEXTROSE	Verification of FDA approved indications	
AMINOSYN II 4.25%/DEXTROSE	Verification of FDA approved indications	
AMINOSYN II 5%/DEXTROSE 25	Verification of FDA approved indications	
AMINOSYN II 8.5%/ELECTROL	Verification of FDA approved indications	

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AMINOSYN II M 3.5%/DEXTRO	Verification of FDA approved indications	
AMINOSYN-HF	Verification of FDA approved indications	
AMINOSYN-PF	Verification of FDA approved indications	
AMITIZA	Verification of FDA approved indications	Patient must be 18 years of age and older. Previous trial and failure of PEG 3350 or lactulose for treatment of constipation.
AMNESTEEM	Verification of FDA approved indications	Previous trial and failure of 2 oral antibiotics
AMPHOTEC	Verification of FDA approved indications	Coverage determination requires submission of labs including culture and sensitivity results
AMPHOTERICIN B	Verification of FDA approved indications	Coverage determination requires submission of labs including culture and sensitivity results
ANADROL-50	Verification of FDA approved indications	Coverage excluded for patients with severe liver dysfunction, kidney dysfunction, pregnancy, high calcium blood levels and/or patients diagnosed with breast or prostate cancer. Coverage determination requires submission of labs including CBC and liver function tests.
ANAGRELIDE HYDROCHLORIDE	Verification of FDA approved indications	Coverage determination requires submission of labs including platelet counts within 30 days of request.
ANDRODERM	Verification of FDA approved indications	Coverage determination requires submission of labs including testosterone levels prior to treatment for diagnosis of testosterone deficiency. Coverage determination requires submission of labs including LH (luteinizing hormone) and Testosterone levels for diagnosis of hypogonadism.
ANDROGEL	Verification of FDA approved indications	Coverage determination requires submission of labs including testosterone levels prior to treatment for diagnosis of testosterone deficiency. Coverage determination requires submission of labs including LH (luteinizing hormone) and Testosterone levels for diagnosis of hypogonadism.
ANDROXY	Verification of FDA approved indications	Coverage is excluded for patients with hypercalcemia. Coverage determination requires submission of labs including calcium levels and liver function tests.
ANZEMET	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
APLENZIN	Verification of FDA approved indications	Previous trial and failure of preferred generic long acting bupropion
ARANESP ALBUMIN FREE	Verification of FDA approved indications	Coverage determination requires submission of labs including Hemoglobin and Hematocrit within 30 days of requesting therapy. Coverage will only be approved at 3 month intervals. Diagnosis submitted must be FDA approved or Medicare allowable.
ARIXTRA	Verification of FDA approved indications	
AROMASIN	Verification of FDA approved indications	Coverage determination requires previous trial of tamoxifen
ARRANON	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
ATGAM	Verification of FDA approved indications	
AVITA	Verification of FDA approved indications	
AVONEX	Verification of FDA approved indications	
AZACTAM	Verification of FDA approved indications	
AZACTAM IN DEXTROSE	Verification of FDA approved indications	
AZASAN	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	

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AZATHIOPRINE	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
BACTOCILL IN DEXTROSE	Verification of FDA approved indications	
BARACLUDE	Verification of FDA approved indications	Coverage determination requires submission of labs including viral load and ALT/AST levels.
BETASERON	Verification of FDA approved indications	
BICNU W/DILUENT ABSOLUTE	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
BLEOMYCIN SULFATE	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
BOTOX	Verification of FDA approved indications	Coverage limited to FDA and Medicare approved diagnoses only. Coverage excluded for cosmetic uses.
BUSULFEX	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
BYETTA	Verification of FDA approved indications	Previous trial and failure of at least 3 months with metformin (unless contraindications) and TZD (Actos/Avandia) or sulfonylurea concurrently. Must provide documentation of uncontrolled glucose with HbA1C greater than 7 while on preferred therapy.
CAMPATH	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
CAMPTOSAR	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
CARIMUNE NANOFILTERED	Verification of FDA approved indications	
CEENU	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
CELLCEPT	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
CEREDASE	Verification of FDA approved indications	
CEREZYME	Verification of FDA approved indications	
CHANTIX	Verification of FDA approved indications	Patient must be enrolled in smoking cessation program. Coverage duration if approved will be limited to 12 weeks - additional 12 weeks therapy approved upon receipt of documentation that initial treatment was successful
CICLOPIROX NAIL LACQUER	Verification of FDA approved indications	Coverage determination requires submission of positive fungal culture or KOH stain and evidence of pain
CLAFORAN	Verification of FDA approved indications	
CLAFORAN/D5W	Verification of FDA approved indications	
CLARAVIS	Verification of FDA approved indications	Previous trial and failure of 2 oral antibiotics
CLEOCIN	Verification of FDA approved indications	
CLOLAR	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
COMVAX	Verification of FDA approved indications	
COPAXONE	Verification of FDA approved indications	
COSMEGEN	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
CUBICIN	Verification of FDA approved indications	
CYCLOPHOSPHAMIDE	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
CYCLOPHOSPHAMIDE	Verification of FDA approved indications	
CYCLOSPORINE	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	

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Drug Name	Criteria	Additional Criteria
CYCLOSPORINE MODIFIED	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
CYMBALTA	Verification of FDA approved indications	Previous trial and failure of 2 preferred generics for diagnosis of depression
CYTARABINE	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
CYTOVENE	Verification of FDA approved indications	
CYTOXAN	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
DAUNOXOME	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
DEMEROL INJ	Verification of FDA approved indications	
DEPO-MEDROL	Verification of FDA approved indications	Coverage determination requires submission of evidence that both oral formulation is not feasible and generic injectable formulation is not acceptable
DESMOPRESSIN ACETATE	Verification of FDA approved indications	
DEXRAZOXANE	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
DIURIL IV	Verification of FDA approved indications	
DOXIL	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
DRONABINOL	Verification of FDA approved indications	
DURAMORPH INJ	Verification of FDA approved indications	
ELAPRASE	Verification of FDA approved indications	
ELIDEL	Verification of FDA approved indications	Previous trial and failure of 2 topical steroids
ELIGARD	Verification of FDA approved indications	Coverage determination requires submission of labs including prostate specific antigen for prostate cancer or CBC for anemia associated with fibroids.
ELITEK	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
ELOXATIN	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
ELSPAR	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
EMCYT	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
EMEND	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
EMSAM	Verification of FDA approved indications	Previous trial and failure of 2 generic antidepressant medications at least one being formulary MAO-I (monoamine oxidase inhibitor)
ENBREL	Verification of FDA approved indications	Coverage excluded for use with another TNF blocker. Coverage determination requires appropriate diagnosis and failed at least one DMARD for following indications: psoriatic arthritis, rheumatoid arthritis, polyarticular juvenile idiopathic arthritis. Appropriate diagnosis and failed methotrexate for plaque psoriasis. Coverage determination also requires submission of labs including TB (tuberculosis) test results.
ENBREL SURECLICK	Verification of FDA approved indications	Coverage excluded for use with another TNF blocker. Coverage determination requires appropriate diagnosis and failed at least one DMARD for following indications: psoriatic arthritis, rheumatoid arthritis, polyarticular juvenile idiopathic arthritis. Appropriate diagnosis and failed methotrexate for plaque psoriasis. Coverage determination also requires submission of labs including TB (tuberculosis) test results.
ENGERIX-B	Verification of FDA approved indications	
ENGERIX-B	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
EPIRUBICIN HCL	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis

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Drug Name	Criteria	Additional Criteria
ERBITUX	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
ETHYOL	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
ETOPOPHOS	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
EXJADE	Verification of FDA approved indications	
FABRAZYME	Verification of FDA approved indications	
FASLODEX	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
FENTANYL CITRATE INJ	Verification of FDA approved indications	
FENTANYL CITRATE ORAL TRA	Verification of FDA approved indications	
FLUCONAZOLE IN DEXTROSE	Verification of FDA approved indications	Coverage determination requires submission of labs including culture and sensitivity results
FLUDARABINE PHOSPHATE	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
FORTEO	Verification of FDA approved indications	Previous trial and failure or contraindication of 2 preferred oral bisphosphonates. Coverage determination requires submission of labs including T-score and calcium levels.
FRAGMIN	Verification of FDA approved indications	
GAMASTAN S/D	Verification of FDA approved indications	
GAMMAGARD LIQUID	Verification of FDA approved indications	
GAMUNEX	Verification of FDA approved indications	
GARDASIL	Verification of FDA approved indications	
GEMZAR	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
GENGRAF	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
GENOTROPIN	Verification of FDA approved indications	Coverage determination requires diagnosis, clinical notes and monitoring parameters (including growth hormone levels and height and weight)
GENOTROPIN MINIQUICK	Verification of FDA approved indications	Coverage determination requires diagnosis, clinical notes and monitoring parameters (including growth hormone levels and height and weight)
GEODON	Verification of FDA approved indications	Coverage is excluded for diagnosis of dementia related psychosis. Prescription must be written by a psychiatrist. Patients must have had trial/failure of preferred atypical antipsychotics (Seroquel and Risperidone).
GEODON INJ	Verification of FDA approved indications	
GLEEVEC	Verification of FDA approved indications	
GRANISETRON HCL	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
HEPARIN SODIUM	Verification of FDA approved indications	
HEPARIN SODIUM/D5W	Verification of FDA approved indications	
HEPSERA	Verification of FDA approved indications	
HERCEPTIN	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
HUMATROPE	Verification of FDA approved indications	Coverage determination requires diagnosis, clinical notes and monitoring parameters (including growth hormone levels and height and weight)
HUMATROPE COMBO PACK	Verification of FDA approved indications	Coverage determination requires diagnosis, clinical notes and monitoring parameters (including growth hormone levels and height and weight)

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Drug Name	Criteria	Additional Criteria
HUMIRA	Verification of FDA approved indications	For the diagnosis of psoriatic arthritis must have trial and failure to one of the following sulfasalazine, leflunomide, methotrexate or cyclosporine. For the diagnosis of rheumatoid arthritis must have trial and failure to one of the following leflunomide, methotrexate, hydroxychloroquine or sulfasalazine. For the diagnoses of juvenile idiopathic arthritis or plaque psoriasis must have trial and failure of methotrexate.
HYCANTIN	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
IDARUBICIN	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
IFOSFAMIDE/MESNA	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
IMOVAX RABIES (H.D.C.V.)	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
INCRELEX	Verification of FDA approved indications	Coverage determination requires submission of labs including growth hormone levels, height, thyroid stimulating hormone, insulin-like growth factor.
INFERGEN	Verification of FDA approved indications	Coverage determination requires submission of labs including viral load and ALT/AST levels.
INFUMORPH 200 INJ	Verification of FDA approved indications	
INTRALIPID	Verification of FDA approved indications	
INTRON-A	Verification of FDA approved indications	
INTRON-A W/DILUENT	Verification of FDA approved indications	
INVANZ	Verification of FDA approved indications	
INVEGA	Verification of FDA approved indications	Coverage is excluded for diagnosis of dementia related psychosis. Prescription must be written by a psychiatrist. Patients must have had trial/failure of preferred atypical antipsychotics (Seroquel and Risperidone).
IPRATROPIUM BROMIDE NEBULIZER	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
IRESSA	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
ISONIAZID	Verification of FDA approved indications	
JANUMET	Verification of FDA approved indications	Previous trial and failure of at least 3 months with metformin (unless contraindications) and TZD or sulfonylurea concurrently. Must provide documentation of uncontrolled glucose with HbA1C greater than 7 while on preferred therapy.
JANUVIA	Verification of FDA approved indications	Previous trial and failure of at least 3 months with metformin (unless contraindications) and TZD or sulfonylurea concurrently. Must provide documentation of uncontrolled glucose with HbA1C greater than 7 while on preferred therapy.
KEPPRA	Verification of FDA approved indications	
KETEK	Verification of FDA approved indications	Previous trial and failure of azithromycin and clarithromycin
KINERET	Verification of FDA approved indications	Coverage determination requires submission of appropriate diagnosis and evidence of failure of at least one DMARD and labs including absolute neutrophil count (ANC). Coverage is excluded for use with another biologic agent.
LETAIRIS	Verification of FDA approved indications	Coverage determination requires evidence patient with WHO Class II or III symptoms.
LEUCOVORIN CALCIUM	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
LEUKERAN	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
LEUKINE	Verification of FDA approved indications	
LEUPROLIDE ACETATE	Verification of FDA approved indications	Coverage determination requires submission of labs including prostate specific antigen for prostate cancer or CBC for anemia associated with fibroids.
LEVAQUIN PREMIX	Verification of FDA approved indications	

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LEVO DROMORAN INJ	Verification of FDA approved indications	
LEVOCARNITINE	Verification of FDA approved indications	
LIDODERM	Verification of FDA approved indications	Coverage determination requires evidence of diagnosis of post herpetic neuralgia
LOTRONEX	Verification of FDA approved indications	Coverage excludes male patients
LUPRON DEPOT	Verification of FDA approved indications	Coverage determination requires submission of labs including prostate specific antigen for prostate cancer or CBC for anemia associated with fibroids.
LUPRON DEPOT-PED	Verification of FDA approved indications	Coverage determination requires submission of labs including prostate specific antigen for prostate cancer or CBC for anemia associated with fibroids.
LYRICA	Verification of FDA approved indications	Previous trial and failure of Cymbalta for diagnosis of fibromyalgia
MATULANE	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
MAXIPIME	Verification of FDA approved indications	
MEGACE ES	Verification of FDA approved indications	
MEGESTROL ACETATE	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
MEGESTROL ACETATE	Verification of FDA approved indications	
MERREM	Verification of FDA approved indications	
MESNEX	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
METHOTREXATE	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
MITOXANTRONE HCL	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
MORPHINE SULFATE INJ	Verification of FDA approved indications	
MUSTARGEN	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
MYCOPHENOLATE MOFETIL	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
MYLOTARG	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
MYOBLOC	Verification of FDA approved indications	Coverage limited to FDA and Medicare approved diagnoses only. Coverage excluded for cosmetic uses.
NAGLAZYME	Verification of FDA approved indications	
NALBUPHINE HCL INJ	Verification of FDA approved indications	
NALLPEN/DEXTROSE	Verification of FDA approved indications	
NEULASTA	Verification of FDA approved indications	
NEUMEGA	Verification of FDA approved indications	Coverage determination requires submission of labs including platelet count.
NEUPOGEN	Verification of FDA approved indications	Coverage determination requires submission of labs including absolute neutrophil count.
NEUTREXIN	Verification of FDA approved indications	
NICOTROL NS	Verification of FDA approved indications	Patient must be enrolled in smoking cessation program. Coverage duration if approved will be limited to 12 weeks - additional 12 weeks therapy approved upon receipt of documentation that initial treatment was successful
NILANDRON	Verification of FDA approved indications	Coverage is excluded for patients with severe hepatic dysfunction.
NORDITROPIN NORDIFLEX PEN	Verification of FDA approved indications	Coverage determination requires diagnosis, clinical notes and monitoring parameters (including growth hormone levels and height and weight)
NUTROPIN	Verification of FDA approved indications	Coverage determination requires diagnosis, clinical notes and monitoring parameters (including growth hormone levels and height and weight)
NUTROPIN AQ	Verification of FDA approved indications	Coverage determination requires diagnosis, clinical notes and monitoring parameters (including growth hormone levels and height and weight)

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Drug Name	Criteria	Additional Criteria
OCTREOTIDE ACETATE	Verification of FDA approved indications	Coverage determination requires submission of labs including growth hormone levels for diagnosis of acromegaly.
ONCASPAR	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
ONDANSETRON HCL	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
ONDANSETRON ODT	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
ONGLYZA	Verification of FDA approved indications	Previous trial and failure of at least 3 months with metformin (unless contraindications) and TZD or sulfonylurea concurrently. Must provide documentation of uncontrolled glucose with HbA1C greater than 7 while on preferred therapy.
ONTAK	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
ORENCIA	Verification of FDA approved indications	
ORPHENADRINE CITRATE	Verification of FDA approved indications	
OXANDROLONE	Verification of FDA approved indications	Coverage is excluded for patients with hypercalcemia.
PACLITAXEL	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
PAMIDRONATE DISODIUM	Verification of FDA approved indications	Coverage determination requires submission of labs including calcium levels for diagnosis of hypercalcemia, T-score for diagnosis of osteoporosis, iPTH and GFR for hyperparathyroidism.
PEDIARIX	Verification of FDA approved indications	
PEDVAX HIB	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
PEGASYS	Verification of FDA approved indications	
PEG-INTRON	Verification of FDA approved indications	
PEG-INTRON REDIPEN	Verification of FDA approved indications	
PEG-INTRON REDIPEN PAK 4	Verification of FDA approved indications	
PENTOSTATIN	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
PHOTOFRIN	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
PRIMAXIN IV	Verification of FDA approved indications	
PROCRIT	Verification of FDA approved indications	Coverage determination requires submission of labs including Hemoglobin and Hematocrit within 30 days of requesting therapy. Coverage will only be approved at 3 month intervals. Diagnosis submitted must be FDA approved or Medicare allowable.
PROGRAF	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
PROLASTIN	Verification of FDA approved indications	
PROLEUKIN	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
PROMACTA	Verification of FDA approved indications	Previous trial and failure of corticosteroid and immunoglobulin. Initial coverage duration if approved will be limited to 4 weeks. Continuation of therapy beyond initial approval will require submission of resulting platelet count (i.e. less than 400 x 109/L). Initial coverage determination requires submission of labs including platelet counts.
PROTOPIC	Verification of FDA approved indications	Previous trial and failure of 2 topical steroids

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Drug Name	Criteria	Additional Criteria
PROVIGIL	Verification of FDA approved indications	For diagnosis of narcolepsy trial/failure of 2 of the following stimulants dextroamphetamine, dexamethylphenidate, methylphenidate, amphetamine salt combo. For diagnosis of OSAHS – obstructive sleep apnea/hypopnea syndrome trial and failure or contraindication of 12 weeks of CPAP.
PULMOZYME	Verification of FDA approved indications	
QUALAQUIN	Verification of FDA approved indications	Coverage determination requires evidence of treatment of malaria
RANEXA	Verification of FDA approved indications	Previous trial and failure of one drug from each of the following drug classes used concurrently for at least 2 months - Beta blocker, Calcium channel blocker, and Nitrate
RAPAMUNE	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
REBETOL	Verification of FDA approved indications	Coverage determination requires submission of labs including viral load and ALT/AST levels.
REBIF	Verification of FDA approved indications	
REBIF TITRATION PACK	Verification of FDA approved indications	
RECOMBIVAX HB	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
REMICADE	Verification of FDA approved indications	Coverage determination requires appropriate diagnosis and failed at least one DMARD for following indications: psoriatic arthritis, rheumatoid arthritis. Appropriate diagnosis and failed at least one DMARD (methotrexate) for plaque psoriasis. Coverage is excluded for use with another biological agent. Coverage requires submission of TB (tuberculosis) test results.
RETIN-A MICRO	Verification of FDA approved indications	
REVATIO	Verification of FDA approved indications	Coverage determination requires appropriate diagnosis
REVLIMID	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
RHEUMATREX	Verification of FDA approved indications	
RIBAPAK	Verification of FDA approved indications	Coverage determination requires submission of labs including viral load and ALT/AST levels.
RIBASPHERE	Verification of FDA approved indications	Coverage determination requires submission of labs including viral load and ALT/AST levels.
RIBAVIRIN	Verification of FDA approved indications	Coverage determination requires submission of labs including viral load and ALT/AST levels.
RIFAMPIN INJ	Verification of FDA approved indications	Coverage requires submission of clinical notes including positive TB or susceptible N. meningitidis strain and documentation indicating oral formulation is not feasible
RISPERDAL CONSTA	Verification of FDA approved indications	Previous trial and failure or contraindication of oral formulation of risperidone. Coverage determination requires that therapy was prescribed by psychiatrist.
RISPERDAL CONSTA	Verification of FDA approved indications	
RITUXAN	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
ROBAXIN	Verification of FDA approved indications	
ROTATEQ	Verification of FDA approved indications	
SABRIL	Verification of FDA approved indications	Coverage determination requires confirmation prescriber has enrolled into SHARE program the approved REMS (risk evaluation mitigation strategy)
SAIZEN CLICK.EASY	Verification of FDA approved indications	Coverage determination requires diagnosis, clinical notes and monitoring parameters (including growth hormone levels and height and weight)

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Drug Name	Criteria	Additional Criteria
SANCUSO	Verification of FDA approved indications	Coverage determination requires trial and failure or contraindication to oral granisetron and ondansetron
SANDOSTATIN LAR DEPOT	Verification of FDA approved indications	Coverage determination requires submission of labs including growth hormone levels for diagnosis of acromegaly.
SAVELLA	Verification of FDA approved indications	Coverage is excluded for diagnosis of depression.
SEROSTIM	Verification of FDA approved indications	
SEROSTIM	Verification of FDA approved indications	
SIMULECT	Verification of FDA approved indications	
SINGULAIR	Verification of FDA approved indications	Previous trial and failure of nasal corticosteroid and oral non-sedating antihistamine for diagnosis of allergy. Previous trial and failure of inhaled corticosteroid for asthma. Coverage is excluded for diagnosis of COPD (chronic obstructive pulmonary disease).
SOLU-MEDROL	Verification of FDA approved indications	Coverage determination requires submission of evidence that both oral formulation is not feasible and generic injectable formulation is not acceptable
SOMATULINE DEPOT	Verification of FDA approved indications	Coverage determination requires evidence of an inadequate response to or cannot be treated with surgery and/or radiotherapy
SOMAVERT	Verification of FDA approved indications	Coverage determination requires evidence of inadequate response to surgery and/or radiation therapy and/or other medical therapies, or for whom these therapies are not appropriate
SOTRET	Verification of FDA approved indications	
SPORANOX	Verification of FDA approved indications	Coverage determination requires submission of labs including positive fungal culture or KOH stain. Coverage duration, if approved, is generally limited to 12 weeks.
SPRYCEL	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
SPRYCEL	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
STRIANT	Verification of FDA approved indications	Coverage determination requires submission of labs including testosterone levels prior to treatment for diagnosis of testosterone deficiency. Coverage determination requires submission of labs including LH (luteinizing hormone) and Testosterone levels for diagnosis of hypogonadism.
SUBOXONE	Verification of FDA approved indications	
SUBUTEX	Verification of FDA approved indications	
SUTENT	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
SYMLIN	Verification of FDA approved indications	
SYNERCID	Verification of FDA approved indications	
TARCEVA	Verification of FDA approved indications	
TASIGNA	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
TAXOTERE	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
TEKTURNA	Verification of FDA approved indications	Previous trial and failure or contraindication of ACE - inhibitor (angiotensin-converting enzyme inhibitor) and ARB (angiotensin receptor blockers)
TEKTURNA HCT	Verification of FDA approved indications	Previous trial and failure or contraindication of ACE - inhibitor (angiotensin-converting enzyme inhibitor) and ARB (angiotensin receptor blockers)
TESTIM	Verification of FDA approved indications	Coverage determination requires submission of labs including testosterone levels prior to treatment for diagnosis of testosterone deficiency. Coverage determination requires submission of labs including LH (luteinizing hormone) and Testosterone levels for diagnosis of hypogonadism.
TESTOSTERONE CYPIONATE	Verification of FDA approved indications	Coverage determination requires submission of labs including testosterone levels prior to treatment for diagnosis of testosterone deficiency. Coverage determination requires submission of labs including LH (luteinizing hormone) and Testosterone levels for diagnosis of hypogonadism.

*Criteria includes all FDA approved indications not otherwise excluded from Part D coverage.

**All prior authorization requests require submission of clinical notes and/or evidence supporting submitted diagnosis.

Drug Name	Criteria	Additional Criteria
TESTOSTERONE ENANTHATE	Verification of FDA approved indications	Coverage determination requires submission of labs including testosterone levels prior to treatment for diagnosis of testosterone deficiency. Coverage determination requires submission of labs including LH (luteinizing hormone) and Testosterone levels for diagnosis of hypogonadism.
TEV-TROPIN	Verification of FDA approved indications	Coverage determination requires diagnosis, clinical notes and monitoring parameters (including growth hormone levels and height and weight)
THALOMID	Verification of FDA approved indications	Coverage determination requires evidence of negative pregnancy test for female patients.
THIOTEPA	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
THYMOGLOBULIN	Verification of FDA approved indications	
TIKOSYN	Verification of FDA approved indications	Coverage is excluded for patients with a baseline QT interval greater then 440 (greater then 500 in pts with ventricular conduction abnormalities) and/or a CrCl less then 20.
TIKOSYN	Verification of FDA approved indications	Coverage is excluded for patients with a baseline QT interval greater then 440 (greater then 500 in pts with ventricular conduction abnormalities) and/or a CrCl less then 20.
TIMENTIN	Verification of FDA approved indications	
TOBI	Verification of FDA approved indications	
TRACLEER	Verification of FDA approved indications	Coverage determination requires evidence of a diagnosis of WHO Group I pulmonary hypertension with WHO class II to IV symptoms. Coverage is excluded for patients that are pregnant and/or on cyclosporine or glyburide. Coverage determination requires submission of labs including liver function tests.
TRELSTAR DEPOT	Verification of FDA approved indications	Coverage determination requires submission of labs including prostate specific antigen for prostate cancer or CBC for anemia associated with fibroids.
TRELSTAR LA	Verification of FDA approved indications	Coverage determination requires submission of labs including prostate specific antigen for prostate cancer or CBC for anemia associated with fibroids.
TRETINOIN	Verification of FDA approved indications	
TREXALL	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
TRISENOX	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
TWINRIX	Verification of FDA approved indications	
TYGACIL	Verification of FDA approved indications	
TYKERB	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
UVADEX	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
VANCOICIN HCL	Verification of FDA approved indications	
VANCOMYCIN HCL	Verification of FDA approved indications	
VANTAS	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
VELCADE	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
VFEND	Verification of FDA approved indications	Coverage determination requires submission of labs including culture and sensitivity results
VFEND IV	Verification of FDA approved indications	Coverage determination requires submission of labs including culture and sensitivity results
VIDAZA	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
VINBLASTINE SULFATE	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
VIRAZOLE	Verification of FDA approved indications	
VISTIDE	Verification of FDA approved indications	

*Criteria includes all FDA approved indications not otherwise excluded from Part D coverage.

**All prior authorization requests require submission of clinical notes and/or evidence supporting submitted diagnosis.

Drug Name	Criteria	Additional Criteria
VIVAGLOBIN	Verification of FDA approved indications	
XIFAXAN	Verification of FDA approved indications	Coverage is excluded for patients with fever or blood in stool.
XOLAIR	Verification of FDA approved indications	
XYREM	Verification of FDA approved indications	Coverage duration, if approved, is limited to 6 months. Evidence of reevaluation and improvement on therapy is required prior to extension of initial authorization.
ZANOSAR	Verification of FDA approved indications	Diagnosis submitted must be for FDA approved or Medicare allowable diagnosis
ZAVESCA	Verification of FDA approved indications	
ZEMPLAR	Verification of FDA approved indications	Coverage determination requires submission of labs including calcium levels for diagnosis of hypercalcemia, T-score for diagnosis of osteoporosis, iPTH and GFR for hyperparathyroidism.
ZENAPAX	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.	
ZINACEF	Verification of FDA approved indications	
ZOMETA	Verification of FDA approved indications	Coverage determination requires submission of labs including calcium levels for diagnosis of hypercalcemia, T-score for diagnosis of osteoporosis, iPTH and GFR for hyperparathyroidism.
ZORBTIVE	Verification of FDA approved indications	Coverage determination requires diagnosis, clinical notes and monitoring parameters (including growth hormone levels and height and weight)
ZOSYN	Verification of FDA approved indications	
ZYPREXA	Verification of FDA approved indications	Coverage is excluded for diagnosis of dementia related psychosis. Prescription must be written by a psychiatrist. Patients must have had trial/failure of preferred atypical antipsychotics (Seroquel and Risperidone).
ZYPREXA INJ	Verification of FDA approved indications	
ZYPREXA ZYDIS	Verification of FDA approved indications	Coverage is excluded for diagnosis of dementia related psychosis. Prescription must be written by a psychiatrist. Patients must have had trial/failure of preferred atypical antipsychotics (Seroquel and Risperidone).
ZYVOX	Verification of FDA approved indications	
ZYVOX	Verification of FDA approved indications	Coverage determination requires culture and sensitivity. Coverage authorized up to 28 days.

*Criteria includes all FDA approved indications not otherwise excluded from Part D coverage.

**All prior authorization requests require submission of clinical notes and/or evidence supporting submitted diagnosis.