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	Exclusion Criteria	Medication is being giving within 48-hours of chemotherapeutic regimen and is te full replacement for the IV doses
	Required Medical Information	Chemotherapeutic regimen including drugs, doses and schedule of administration.
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	
Abilify IM	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	Therapy greater than 3-days in length
	Required Medical Information	Documented refusal of oral anti-psychotic medications
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	3 days
	Other Criteria	

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ACTIMMUNE	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Must be a hematologist, oncologist, infectious disease specialist or pediatrician
	Coverage Duration	12 months
	Other Criteria	
ADAGEN	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Patient is not a candidate or has failed bone marrow transplant.
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	12 months
	Other Criteria	Requires Medical Director approval

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Afinitor	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Must be an oncologist
	Coverage Duration	6 months
	Other Criteria	
ALDURAZYME	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	12 months
	Other Criteria	Requires Medical Director approval

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Alferon-N	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	18 years and older
	Prescriber Restrictions	
	Coverage Duration	8 weeks
	Other Criteria	
AMEVIVE	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Minimum body surface involvement of 10%, if request is for retreatment, require CD4+ lymphocyte count
	Age Restrictions	
	Prescriber Restrictions	Dermatologist or Rheumatologist
	Coverage Duration	12 weeks, second 12 weeks approvable if 12 weeks since first course and CD4+ count is wnl
	Other Criteria	failed 2 of the the following: psoralens with PUVA, UVB with coal tar or dithranol. methotrexate or cyclosporine, topical agents (corticosteroids, retinoids, heavy moisturizers, etc), Soriatane. Failure or contraindication to preferred agents (Enbrel, Humira)

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Anadrol-50	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Hemoglobin / Hematocrit. Will require patient's updated weights for continuation of coverage showing medication is working for cachexia
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	
Antibiotics, injectable	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Documentation of appropriate diagnosis and culture and sensitivities showing effectiveness of requested medication
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	14-days for most requests, 6 weeks for osteomyelitis, 8 weeks for endocarditis
	Other Criteria	Commonly used / Nationally recognized treatment algorithms recommend agent as first-line therapy

Antifungals, injectable	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Documentation patient is unable to take oral fluconazole, diagnosis is one for which fluconazole is recognized as therapy of choice
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	candida fungemia 2 weeks, prophylaxsis 6 mo, coccidio 6 mo cryptococc 2 mo
	Other Criteria	
ANTIZOL	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	

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APOKYN	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	Patient is filling a 5-HT3 antagonist
	Required Medical Information	Apokyn is going to be used as an adjunct to other therapies
	Age Restrictions	
	Prescriber Restrictions	Neurologist, Geriatric specialist
	Coverage Duration	6 months
	Other Criteria	Patient is filling trimethobenzamide 300mg TID concurrently, will approve up to FDA max of 60ml per 30-days
Aralast	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	Requires Medical Director Approval

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ARIXTRA	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	Covered for 11 days at a time, continued coverage provided with documentation of subtherapeutic INR.
	Other Criteria	Failure or Contraindication to preferred agent (Fragmin)
Avonex	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Documentation of failure or contraindication to preferred agents, Rebif and Copaxone

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Beer's List	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Documentation patient is stable on current medication with no untoward side-effects
	Age Restrictions	65 years and younger unless required medical information provided
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Failure of at least one agent not considered inappropriate for use in the elderly
BETASERON	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Documentation of failure or contraindication to preferred agents, Rebif and Copaxone

BIDIL	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	non-Affrican American
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Patient must be on maximal ACEI, beta-blocker and diuretic therapy, failure with appropriate supporting documentation from requestor of isosorbide dinitrate and hydralazine
Bisphosphonates for Pagets	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	Contraindication to the use of bisphosphonates (i.e. abnormality of the esophagus, inability to remain upright)
	Required Medical Information	Diagnosis and Treatment history required: if member never treated with bisophosphonate before, will approve for initial time frame. If patient has history of bisphosphonate treatment, will require documentation of at least a 2 month "off" period of observation. Only a total of two treatments will be approved.
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	2 months
	Other Criteria	Alendronate is the preferred agent

Bisphosphonates, injectable	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Contraindication or significant intolerance (i.e. abnormality of esophagus or bed-ridden) oral bisphosphonates
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	
Bleomycin	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Hematologist, Oncologist
	Coverage Duration	6 months
	Other Criteria	

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BUPHENYL	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Requires Medical Director Approval
Byetta	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Require A1c drawn in previous 3 months. Failure is defined as A1c greater than 6.5.
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Documentation of failure or contraindication to two oral agents (metformin, sulfonylurea, thazolidinedione)

Drug	Criteria	Details
Campath	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Hematologist, Oncologist
	Coverage Duration	Renewable every 6 months with documentation of treatment success
	Other Criteria	
Ceredase / Cerezyme	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	One or more of the following conditions: moderate to severe anemia, thrombocytopenia with bleeding tendency, bone disease, significant hepatomegaly or splenomegaly
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Requires Medical Director approval

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CHANTIX	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Failure of bupropion SR or nicotine replacement
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	12-weeks
	Other Criteria	May approve one additional 12-week course with submission of documentation showing patient is in supportive counceling and educational materials
CHORIONIC GONADOTROPIN	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	

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Cimzia	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	failure or contraindication to formulary preferred agent (Humira or Enbrel)
COPAXONE	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	18 years and older
	Prescriber Restrictions	Neurologist
	Coverage Duration	1 year
	Other Criteria	

CYSTADANE	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Requires Medical Director approval
CYSTAGON	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Diagnosis confirmed by increased white cell cystine
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Requires Medical Director approval

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Depo-Provera	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	Will cover up to 4000mg/month
ELAPRASE	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Requires Medical Director approval

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Elitek	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Documentation patient has failed, or has contraindication to allopurinal
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	7 days
	Other Criteria	Following 3-days of therapy, provider will need to submit verbal or written documentation patient has NOT adequately responded to therapy, at which time another 2-days of treatment may be approved.
EMCYT	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Oncologist
	Coverage Duration	6 months
	Other Criteria	

EMEND	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	Being prescribed in combination with oral dexamethasone AND an oral 5HT3 antagonist, being prescribed as a single agent
	Required Medical Information	For prevention of nausea and/or vomiting secondary to chemotherapy, requires confirmation that chemotherapeutic regimen is moderately or highly emetogenic. For the prevention of postoperative nausea and vomiting, requires administration prior to the induction of anesthesia.
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	
ERAXIS	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Failure or contraindication to oral or IV fluconazole
	Age Restrictions	
	Prescriber Restrictions	Infectious Disease or HIV specialist
	Coverage Duration	30 days
	Other Criteria	

ESAs	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	Dx of any anemai due to folate deficiency, B-12 deficiency, iron deficiency, hemolysis, bleeding or bone marrow fibrosis. Anemia associated with tx of acute and chronic myelogenous leukemias or erythroid cancers, anemia of cancer not related to cancer tre
	Required Medical Information	Hemoglobin / Hematocrit within in the previous month showing Hgb less than or equal to 11gm/dL or Hct less than or equal to 33% (CHF Hgb must be less than or equal to 11.5gm/dL). If patient already on ESA, Hgb must be less than 12 gm/dL or Hct less than or equal to 36%. If diagnosis is chemo-induced anemia, Hgb must be less than 10 gm/dL or Hct less than 30%. Iron studies within the last three months must show serum ferritin greater than or equal to 100mcg/L and transferrin saturation greater than or equal to 20%
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	3 months
	Other Criteria	if request is for Procrit or Epogen, require documentation of failure or contraindication to formulary preferred agent (Aranesp)

Drug	Criteria	Details
Exjade	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	Dose greater than 30mg/kg/day
	Required Medical Information	patient has a serum ferritin level consistently over 1000
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	3 months
	Other Criteria	Failure of adequate trial of deferoxamine. Continuation of coverage requires response to therapy defined as serum ferritin level consistently below 500mcg/L
Extavia	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Documentation of failure or contraindication to preferred agents, Rebif and Copaxone

FABRAZYME	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Requires Medical Director approval
FARESTON	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	Estrogen-receptor negative breast cancer, doses greater than 60mg/day
	Required Medical Information	Estrogen-receptor status
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	

Fentanyl Transmucosal	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	any other pain diagnosis other than that directly related to cancer, dosing greater than 4 per day
	Required Medical Information	Documentation showing patient is utilizing and is tolerant to other opioid therapy
	Age Restrictions	
	Prescriber Restrictions	Oncologist or Pain Specialist
	Coverage Duration	6 months
	Other Criteria	
FORTEO	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	Increased baseline risk for osteosarcoma (Paget's disease, unexplained elevations of alkaline phosphatase, open epiphyses, prior radiation therapy involving skeleton), use for more than 2 years
	Required Medical Information	Start date of therapy, T-score, fracture history or no increase in BMD while on bisphosphonate therapy or an intolerance to bisphosphonate therapy
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	2 years
	Other Criteria	

Fosphenytoin	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Documentation of contraindication to use of oral phenytoin products
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	5 days
	Other Criteria	
FRAGMIN	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	If therapy requested not for pregnancy VTE prophylaxis, or cancer VTE prophylaxis and is longer than 14-days (or approvable time frame), will require documentation of failure to warfarin therapy despite appropriate dosage adjustment and follow-up (i.e. INRs, chart notes and dosing changes)
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	Cancer 6 mo, DVT/PE/prophylaxis14 days
	Other Criteria	

Gardasil	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	male
	Required Medical Information	
	Age Restrictions	Age 9 to 26
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	
Geodon IM	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	Recent MI, uncompensated heart failure, history of cardiac arrhythmias or on other medications that prolong the QT interval, therapy greater than 3-days in length
	Required Medical Information	Recent hospitalizations or documentation patient is at high risk for hospitalization secondary to non-compliance with oral antipsychotic, patient has a recent history of violence or self-destructive behavior to self or others
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	3 days
	Other Criteria	

GLEEVEC	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Oncologist
	Coverage Duration	6 months
	Other Criteria	
Growth Hormones	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	ADOLESCENT: GH stimulation test (if appropriate), genetic testing results, growth charts, growth velocity and weight change. ADULT: documented subnormal resonse to 2 std GH stim tests, or subnormal response to 1 stim test with documented hypothalamic or pituitary disease plus one or more additionsal pituitary hormone deficit, or documented presence of at least three other piuitary hormone deficiencies, AIDS WASTING: concurrent treatment with HIV antiviral therapy, documentation of unintentional weight loss greater than 10% of IBW or from baseline over a 1-month period, failure of sequential add on therapy with at least two agents (at least one appetite stimulant with one anabolic agent) over a 3-month period
	Age Restrictions	
	Prescriber Restrictions	For Aids Wasting: HIV/AIDS specialist
	Coverage Duration	1 year
	Other Criteria	

Hepatitis B Treatment	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	
Hepatitis C Treatment	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	failure to concomitant therapy with peginterferon and ribavirin, request for chronic maintenance therapy long-term
	Required Medical Information	Genotype, treatment history with drugs and duration used as well as response to therapy, viral load
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	initial 24-weeks followed by an additional 24-weeks if required
	Other Criteria	

HEXALEN	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	
INCRELEX	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	non-pediatric patient, secondary form of IGF-1 deficiency (i.e chronic treatment with anti-inflammatory steroids)
	Required Medical Information	Height standard deviation score (less than or equal to -3) and basal IGF-1 standard deviation score (less than or equal to -3) and normal or elevated growth hormone level
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	If patient has secondary IGF-1 deficiency due to hypothyroidism or malnutrition, these underlying conditions must be corrected prior to Increlex use

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Intron A	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	history of hepatic encephalopathy, variceal bleeding, ascites, HIV positive, undergoing liver transplantation, history of or current active autoimmune hepatitis
	Required Medical Information	Hepatitis B antigen has been present in serum for at least 6 months, serum AST greater than double the upper limit of normal, compensated liver disease
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	Renewable every six months
	Other Criteria	
ITP Treatment	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	Documentation of failure of corticosteroids, immunglobulins or splenectomy and documentation of provider and patient enrollment in Promacta Cares program

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IVIG	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	Diagnoses 279.04, 279.05, 279.06, 279.12 or 279.20 are covered under Medicare Part B
	Required Medical Information	history of treatment for diagnosis
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	
Januvia / Janumet	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	A1c drawn within the last 3 months is required, Failure is defined as A1c greater than 6.5
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	documentation of failure or contraindication to at least two oral agents (metformin, sulfonylurea or thazolidinedione)

Keppra Injectable	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Member is stabilized on oral Keppra, member has an absolute contraindication to oral therapy, member is receiving medication under direct medical supervision, member must be transitioned to oral therapy as soon as medically reasonable.
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	Renewable every six months
	Other Criteria	
KINERET	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Member not using Kineret in combination with any other TNF inhibitor
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	failure or contraindication to formulary preferred agent (Humira or Enbrel)

Kuvan	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	Doses exceeding 20mg/kg/day
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Requires Medical Director Approval
Leukotriene Receptor Antagonist	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	If member is over 18 years of age, consistant 90-day use of ICS. For 18 and younger, albuterol or ICS in last year

leuprolide	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	For prostate cancer, patient is 18 years of age or older
	Age Restrictions	
	Prescriber Restrictions	For prostate cancer, Oncologist or Urologist, For CPP, Pediatric endocrinologist
	Coverage Duration	6 months
	Other Criteria	
LOTRONEX	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	History of ischemic bowel disease
	Required Medical Information	Female age 18 or older, diarrhea plus one or more of the following: frequent and severe abdominal pain/discomfort, frequent bowel urgency or fecal incontinence, disability or restriction of daily activities because of IBS, Physician is enrolled in the GSK Lotronex Prescribing Program, will approve 0.5mg twice daily for 6 months - if member has inadequate control after 4 weeks, will approve 1mg twice daily for 6 months.
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	patient has tried, is intolerant to, or has a contraindication to at least 2 of the following: loperamide, dicyclomine, hyoscyamine, kaolin pectin, paregoric, psyllium

Lovenox	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	If therapy requested not for pregnancy VTE prophylaxis, or cancer VTE prophylaxis and is longer than 14-days (or approvable time frame), will require documentation of failure to warfarin therapy despite appropriate dosage adjustment and follow-up (i.e. INRs, chart notes and dosing changes)
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	Cancer 6 mo, DVT/PE/prophylaxis14 days
	Other Criteria	Failure or Contraindication to preferred agent (Fragmin)
Lupron Depot	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Oncologist or Urologist
	Coverage Duration	1 year
	Other Criteria	

Marinol	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	If for use within 2 hours of chemotherapy administration as full therapeutic replacement for an intravenous antiemetic drug, will be covered under Medicare Part B
	Required Medical Information	For anorexia in patients wit AIDS,: documentation of patient weights showing failure, Will approve a total of 20mg daily (divided either BID or TID) For CINV, patient is receiving chemotherapy agent considered to be level 5 or a combination of chemotherapy agents considered to be equivalent to level 5
	Age Restrictions	
	Prescriber Restrictions	Oncologist or HIV / infectious disease specialist
	Coverage Duration	3 months
	Other Criteria	For anorexia in patients wit AIDS,: trial and failure of other agents for weight gain (i.e. megestrol, Megace ES). For CINV, patient has failed other, standard antiemetic therapy (i.e.promethazine, prochlorperazine, metoclopramide, serotonin receptor antagonists)

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MATULANE	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	
MEPRON	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	For PCP Prophylaxis,patient+ has a CD4 count of less than 200 or a history of oral candidiasis, or a CD4 percentage of less that 14 or a history of an AIDS-defining illness, or when monitoring CD4 counts for more than 3 months is not possible and CD4 count is greater than 200 but less than 250. Following approval, will require updated CD4 count for continuation, if greater than 200 for 3 months or longer, prophylaxis will not be approved.
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	Babesiosis 10 days, Malaria 3 days, PCP 21 days, PCP Proph 6 months, toxoplasmosis 6 weeks
	Other Criteria	Babesiosis: must be used in combo with azithromycin or clindamycin plus quinine, will approve 750mg twice daily for up to 10-days. For Malaria, must be used in combination with other antimalarial agents. For PCP, member must have a contraindication to the use of TMP/SMZ, will approve up to 750mg BID for 21 days. For PCP Prophylaxys, member must have a contraindication to TMP/SMZ or dapsone

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Mesnex	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	drug and treatment regimen being used
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	3 months
	Other Criteria	will be approved for each day member is receiving ifosphamide or cyclophosphamide
Mycamine	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	treatment up to 47 days, prophylaxis up to 51 days
	Other Criteria	Documentation patient is unable to take oral fluconazole, failure or contraindication to fluconazole or itraconazole

MYOZYME	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Requires Medical Director Approval
NAGLAZYME	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Requires Medical Director Approval

Narcotic/Narcotic-like injectables	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	Medicatjion is administered by a patient-controlled analgesia pump (PCA), other external or implantable pump, or a nebulizer,
	Required Medical Information	documented Pain Management Treatment Plan
	Age Restrictions	
	Prescriber Restrictions	Pain Management Specialist or Oncologist
	Coverage Duration	3 months
	Other Criteria	Patient must be unable to take oral narcotic analgesics and has failed transdermal narcotic analgesics,
NEBUPENT	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D. High-risk HIV-infected patient, pneumocystis pneumonia
	Exclusion Criteria	Member does not reside in a long-term care facility
	Required Medical Information	Patient has a history of Pneumocystis carnii pneumonia, Patient does not have active PCP, CD4 count is less than or equal to 200
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	will approve 300mg monthly

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Neulasta	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	CBC and ANC, drug, dose and schedule of myelosuppressive therapy
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	Renewable every 3 months
	Other Criteria	
NEUPOGEN	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	CBC and ANC, drug, dose and schedule of myelosuppressive therapy
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	Renewable every 3 months
	Other Criteria	approval will be until ANC reaches 10,000 following expected chemotherapy nadir (should be dosed no earilier than 24-hours post chemotherapy and should not be administered in the 24-hour period before chemotherapy dose). For BMT, will approve 10mcg/kg/day until ANC reaches greater than 1000 for 3 consecutive days, then will approve 5mcg/kg/day until ANC stays above 1000 for an additional 3 consecutive days (should not be dosed sooner than 24-hours after BMT or chemotherapy dose)

Neuropathic Pain	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	for members younger than 65, failure of TCA and gabapentin. If 65 and older, failure of gabapentin
Neutrexin	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	HIV or Infectious Disease Specialist
	Coverage Duration	1 year
	Other Criteria	Contraindication to the use of two of the following: smx/tmp, pentamidine and dapsone (intolerance or refactory disease)

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NEXAVAR	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Oncologist
	Coverage Duration	6 months
	Other Criteria	
NOXAFIL	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D. Prophylaxis against invasive fungal injections, oropharyngeal candidiasis, disseminated candidiasis, infection due to
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Infectious Disease Specialist, HIV/AIDS specialist, Oncologist
	Coverage Duration	Up to 3 months at a time depending upon diagnosis.
	Other Criteria	Contraindication or failure to both fluconazole and itraconazole

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Nutrients, injectable	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 month
	Other Criteria	Patient is unable to tolerate or is unresponsive to oral nutrient replacement
Octreotide	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	For Acromegaly, patient has had surgical resection, pituitary resection and bromocriptine at maximally tolerated doses with inadequate response or medication is being used as adjunct therapy with pituitary resection, For metastatic carcinoid syndrome, patient has severe diarrhea and flushing episodes, For VIPoma, patient has profuse watery diarrhea
	Age Restrictions	
	Prescriber Restrictions	Endocrinologist, Oncologist, Gastroenterologist
	Coverage Duration	1 year
	Other Criteria	

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ONTAK	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Oncologist, Hematologist
	Coverage Duration	6 months
	Other Criteria	
ORACEA	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Documentation of failure of each of the following standard therapies: oral tetracycline product, topical cleanser product, topical anti-infective product, approval will be for maximum of 16 weeks and one capsules daily

ORFADIN	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Requires Medical Director approval
OXANDROLONE	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	4 weeks
	Other Criteria	For AIDS-related cachexia: failure to hormone replacement therapy in patients with hypogonadism.

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Oxsoralen / Oxsoralen Ultra	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Failure to respond to a 3 month trial of (or intolerant to) two of the following: UVB with coal tar or dithranol, methotrexate or cyclosporine, topical agents (corticosteroids, retinoids, heavy moisturizers if appropriate), Soriatane)
PAH Treatment	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Member has a definitive diagnosis of pulmonary hypertension from a recognized pulmonary hypertension specialist, Dx confirmed by right heart cateterization, 6 minute walk test and baseline echocardiogram, disease has progressed despite surgical and/or maximal medical treatment of underlying condition, member's symptoms are NYHA class II, III or IV
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	first line agent is sildenafil, inital approval will be for 3 months and an updated assessment with be required with new echo and 6-min walk test showing 15% improvement

PANRETIN	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	
PROLASTIN	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	Requires Medical Director Approval

Proleukin	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Oncologist, Hematologist
	Coverage Duration	Renewable every 6 months
	Other Criteria	
Protonix IV	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Patient is unable to take oral medications and appropriate documentation of cause must be submitted
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	30 days
	Other Criteria	Patient must be transitioned to oral agents as soon as clinically possible

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PROVIGIL	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Failure to stimulants such as methylphenidate and amphetamine salts for ADHD
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	
PULMOZYME	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Documented history of frequent respiratory infections, documented history of frequent IV antibiotic use for the treatment of respiratory infections
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	

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REBIF	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	18 years and older
	Prescriber Restrictions	Neurologist
	Coverage Duration	1 year
	Other Criteria	
REGRANEX	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Documentation the wound has been debrided, pressure relieved and infection has been controlled prior to use, Documentation that conservative treatment has failed, Patient must see provider once weekly for recalculation of dose, Patient has not exceeded 20 weeks of therapy
	Age Restrictions	
	Prescriber Restrictions	Podiatrist or Infectious Disease specialist
	Coverage Duration	4 weeks
	Other Criteria	

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Remicade	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Failure to Enbrel or Humira for Rhematoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis and Plaque Psoriasis. Failure to Humira for Crohn's disease. Failure to aminosalicylates OR corticosteroids OR immunomodulatory therapies for the treatment of Ulcerative Colitis.
REVLIMID	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Oncologist / Hematologist
	Coverage Duration	6 months
	Other Criteria	

RITUXAN	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	For RA, require documentation of failure to formulary preferred agent (Humira) and at least one other TNF inhibitor. Documentation member is taking methotrexate concurrently
Sancuso	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	Documented failure or contraindication to injectable ondansetron

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SOMAVERT	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Plan must receive the "Statement of Medical Necessity" from Pfizer Bridge Program, Patient has had an inadequate response to surgery and/or radiation and/or other medical therapies (or these therapy are inappropriate)
	Age Restrictions	
	Prescriber Restrictions	Endrocrinologist
	Coverage Duration	Renewable every 3 months at a time through 1 year of total therapy, then every six months
	Other Criteria	
SORIATANE	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	For psoriasis: failure to adequately respond to a 3 month trial (unless contraindicated) of at least one of the following: psoralens with UVA light, UVB with coal tar or dithranol, methotrexate or cyclosporine, topical agents (corticosteroids, retinoids, heaviy moisturizers, etc)

Drug	Criteria	Details
SPRYCEL	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Oncologist / Hematologist
	Coverage Duration	6 months
	Other Criteria	ALL: member has a medication history of prior therapies for the treatment of ALL, CML: Documentation patient has failed or has an intolerance to Gleevec
SUCRAID	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Requires Medical Director approval

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SUTENT	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Oncologist
	Coverage Duration	6 months
	Other Criteria	GIST: Patient has experienced disease progression on, or is intolerant to, Gleevec
SYNAREL	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	For endometriosis, member is at least 18 years old, For CPP, female is less than 8 and male less than 9 years old
	Prescriber Restrictions	
	Coverage Duration	For endometriosis, 6 months, 1 year for others
	Other Criteria	

Systemic Acne Antibiotics	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Patient must have failed a 2 month trial of at least two alternative systemic antibiotics (doxycycline, minocycline, tetracycline, erythromycin or Bactrin), will approve a maximum of 1 kit per month
TABLOID	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Oncologist, Hematologist, Rheumatologist
	Coverage Duration	1 year
	Other Criteria	

TARCEVA	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Oncologist
	Coverage Duration	6 months
	Other Criteria	For locally advanced, unresectable or metastatic pancreatic cancer, is being used in combination with Gemzar. For NSCLC, patient has tried and failed at least one prior chemotherapy regimen. For metastatic renal cell carcinoma, being used in combination with Avastin
TARGRETIN	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Oncologist
	Coverage Duration	6 months
	Other Criteria	Patient has refractory or persistent disease following other therapies (topical nitrogen mustard compound i.e. meclorethamine, or Oxsoralen with UVA therapy), or disease is refractory to at least one other systemic agent (i.e. Oxsoralen Ultra)

Tasigna	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	baseline ECG and regular monitoring documenting no underlying long QT syndrome, member does not have hypokalemia or hypomagnesemia
	Age Restrictions	
	Prescriber Restrictions	Oncologist
	Coverage Duration	6 months
	Other Criteria	Member is resistant or intolerant to prior therapies that include imatinib, member is not on any CYP P450 inhibitors,
Testosterone	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Total testosterone level is less than 360 or free testosterone level is less than 300
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	normal testosterone levels were not achieved with a minimum of 3 months of injectable testosterone therapy and patient has failed formulary preferred topical agent

THALOMID	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	ANC less than 750 mm3
	Required Medical Information	Require ANC documentation prior to start and with each renewal. For erythema nodosum leprosum, a tapering dose must be attempted after 4 weeks of therapy, then every 2 to 4 weeks in patients being actively treated. In patients on maintenance therapy, an attempt to taper must be made every 3 to 6 months,
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	
THYMOGLOBULIN	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	patient is on concomitant immunosuppression

TNF Inhibitors	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Plaque psoriasis: psoriasis covers at least 10% BSA
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	RA: failure of or intolerance to methotrexate, psoriatic arthritis: failure of or intolerance to methotrexate and/or leflunomide, ankylosing spondlitis: failure of or intolerance to methotrexate, JRA: failure of or intolerance to methotrexate, Plaque psoriasis: failure to adequately respond to at least 2 of the following: psoralens with UVA, UVB with coal tar or dithranol, methotrexate or cyclosporine, topical agents, Soriatane, Crohn's disease: patients disease is refractory to or has had an inadequate response to conventional therapy (i.e. sulfasalazine, mesalamine, antibiotics, corticosteroids, azathioprine, 6-mercaptopurine)

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TOBI	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	Patient does not reside in a long-term care facility
	Required Medical Information	Confirmed sputum culture showing positive for P. aeruginosa
	Age Restrictions	
	Prescriber Restrictions	Infectious Disease specialist
	Coverage Duration	28 days
	Other Criteria	
Topical Retinoids	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	

TRISENOX	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Oncologist, Hematologist
	Coverage Duration	6 months
	Other Criteria	
TYKERB	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Oncologist
	Coverage Duration	6 months
	Other Criteria	

Tysabri	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	For Crohn's, require documenation of failure of standard therapy including preferred TNF agents (Humira, Enbrel). For MS, require documentation of failure to preferred agents (Rebif and Copaxone)
VALCYTE	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Diagnosis and start of therapy
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	up to 30 days
	Other Criteria	Will approve for a total of 100 days post transplant for prophylaxis, 21 days for treatment, and 6 months for prophylaxis in patient with AIDS

Vancocin	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Patient has had a recurrence (defined as a reactivation of symptoms during the period from 7 to 21 days following initial treatment) following a course of at least 7-days therapy with metronidazole, allergy to metronidazole or contrindication to metronidazole. Documentation showing patient still has C. difficile infection, documentation of other reported treatments for multiple relapses (i.e. cholestyramine 4gm BID, probiotic agents)
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	14 days
	Other Criteria	For patients that have recurrence following both metronidazole and vancomycin, will consider coverage of a taper regimen of Vancocin

VECTIBIX	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	KRAS-gene testing results
	Age Restrictions	
	Prescriber Restrictions	Oncologist
	Coverage Duration	6 months
	Other Criteria	disease progression on or following fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy regimens, patient was unable to tolerate cetuximab plus irinotecan or patient did not have disease progression on cetuximab
VELCADE	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Oncologist, Hematologist
	Coverage Duration	6 months
	Other Criteria	Patient has received at least one prior therapy (if diagnosis is mantle cell lymphoma)

Vfend	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	14 days
	Other Criteria	Failure or contraindication to the use of oral or IV fluconazole
VIDAZA	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Oncologist, Hematolotist
	Coverage Duration	6 months
	Other Criteria	Patient has MDS refractory to other treatments. Documentation of continued benefit from therapy for extension of approvals

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Vimpat Injectable	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Member is stabilized on oral Vimpat, member has an absolute contraindication to oral therapy, member is receiving medication under direct medical supervision, member must be transitioned to oral therapy as soon as medically reasonable.
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	Renewable every six months
	Other Criteria	
Vivitrol	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Documentation patient is in a comprehensive management program for alcohol dependence
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	3 months
	Other Criteria	failure or contraindication to naltrexone oral, Antabuse or Campral OR patient is unable to take any oral medications / nutrition and requires injectable therapy

Xolair	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	Positive skin test or in vitro reactivity to a perennial aeroallergen, documented daily symptoms (i.e. coughing, wheezing, dyspnea) while on highest appropriate dose of inhaled steroids, exacerbations affecting activity or sleep AND any of the following signs of poor asthma controls: continued exacerbations requiring daily use of short-acting beta 2-actonists, diurnal vaariation in peak expiratory flow (PEF) of greater than 30%, PEF less than 80% of personal best, multiple visits to the emergency room due to acute exacerbations of asthma in the preceding 12 months, IgE levels that meet dosing guidelines
	Age Restrictions	12 years and older
	Prescriber Restrictions	pulmonologist, allergist, immunologists
	Coverage Duration	1 year
	Other Criteria	

Drug	Criteria	Details
Xopenex Nebs	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	Patient does not reside in a long-term care facility
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Failure or intolerance to albuterol nebulizers
XYREM	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	If diagnosis is fibromyalgia, require documentation of failure to other standard therapies

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ZAVESCA	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	Requires Medical Director approval
Zemaira	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	6 months
	Other Criteria	Requires Medical Director Approval

ZOLINZA	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	Oncologist, Hematologist
	Coverage Duration	6 months
	Other Criteria	tried and failed systemic therapies (i.e. antineoplastic agents, psoralens, mtx, cyclophosphamide)
Zostavax	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	60 years or older
	Prescriber Restrictions	
	Coverage Duration	1 year
	Other Criteria	

Zyprexa IM	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	Therapy greater than 3-days in length
	Required Medical Information	Recent hospitalizations or documentation patient is at high risk for hospitalization secondary to non-compliance with oral antipsychotic, patient has a recent history of violence or self-destructive behavior to self or others
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	3-days
	Other Criteria	
ZYVOX	*Covered Uses*	All FDA-approved indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.
	Exclusion Criteria	
	Required Medical Information	
	Age Restrictions	
	Prescriber Restrictions	
	Coverage Duration	Up to 28 days
	Other Criteria	Documented culture and sensistivity showing MRSA or VRE, if MRSA, documentation of failure or intolerance to vancomycin therapy ("red neck syndrome" does not qualify as intolerance). Patients should be switched from IV to PO if tolerating PO fluids. Chronic osteomyelitis will be considered on a case-by-case basis and may be apporved for up to 15 weeks of therapy