

PA_GroupNm:	Abilify
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	Members must have a diagnosis of Bipolar Disorder, or members must have a diagnosis of Schizophrenia, or members must have a diagnosis of Major Depression with Psychosis, or Members must have a diagnosis of irritability associated with Autistic disorder , or members must have a diagnosis of treatment resistant Major Depressive Disorder and failure of both mono and combination antidepressant therapy which includes: An adequate trial and failure, duration of at least 4 weeks, or intolerance to monotherapy with 2 different Antidepressant therapies AND trial and failure, duration of at least 4 weeks, or intolerance to a single trial of combination Antidepressant therapy (such as a SSRI and bupropion or SNRI and bupropion) OR trial and failure, duration of at least 4 weeks, or intolerance to a single trial of an Antidepressant with augmentation therapy (such as Lithium).

PA_GroupNm:	Acne Products
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D incl Acne, Acne vulgaris, Cystic acne, Comedones, Papul, Pustul, Precanc or canc lesions, Psoriasis, Keratosis follicularis (Darier’s Dis, Darier-White dis), Folliculitis, Molluscum contagiosum, Facial warts, Milia, Malig neopl, Rosacea, Grover’s dis, Verruca plana, or Favre-Racouchot Synd (Nodular Elastosis with Cysts and Comedones).
Coverage Excluded Reasons	Diagnoses not covered: solar elastosis, sun damage, wrinkles, actinic damage, melasma, lentigines / freckles (hyperpigmented macules, liver spots), heliodermatosis, dermatoheliosis
Information Required	Diagnosis required for initial coverage. Reauthorization will require response to therapy.
Age Restrictions	Prior authorization applies to members 35 years of age and older.
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	Will be covered for members 35 years of age and older with the following diagnoses: Acne, Acne vulgaris, Cystic acne, Comedones, Papules, Pustules, Precancerous or cancerous lesions, Psoriasis, Keratosis follicularis (Darier’s Disease, Darier-White disease), Folliculitis, Molluscum contagiosum, Facial warts, Milia, Malignant neoplasm, Rosacea, Grover’s disease, Verruca plana, or Favre-Racouchot Syndrome (Nodular Elastosis with Cysts and Comedones).

PA_GroupNm:	Actimmune
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	Diagnosis of basal cell carcinoma of the skin, breast cancer, burn infection, Chronic Myeloid Leukemia, condyloma acuminatum, graft vs. host disease, idiopathic pulmonary fibrosis, kaposi's Sarcoma, malignant mesothelioma, mycobacteriosis, ovarian cancer, rheumatoid arthritis, scleroderma, chronic hepatitis B, Whipple's disease will not be covered.
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	An immunologist, hematologist, or infectious disease physician or in consultation with these physicians must be prescribing for a diagnosis of Chronic Granulomatous Disease. An orthopedic surgeon, hematologist, or endocrinologist or in consultation with these physicians must be prescribing for a diagnosis of Severe Malignant Osteopetrosis.
Duration of Approval	365 days
Other Information we may Require:	For Chronic Granulomatous Disease, Actimmune must be prescribed by an immunologist, hematologist, infectious disease physician or in consultation with these physicians AND conventional antibiotics (SMZ-TMP, cephalexin) and/or antifungals (itraconazole) must be tried and failed. For Severe malignant osteopetrosis, Actimmune must be prescribed by an orthopedic surgeon, hematologist, or endocrinologist or in consultation with these physicians AND diagnosis confirmed by radiological evidence.

PA_GroupNm:	Actiq
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	Treatment of acute or postoperative pain.
Information Required	The member must be opioid tolerant.
Age Restrictions	16 years of age or greater.
Prescriber Restrictions	Oncologist or pain specialist must write Actiq prescriptions.
Duration of Approval	365 days
Other Information we may Require:	The member must have breakthrough cancer pain with their long-acting opioid therapy AND The member must be opioid tolerant .

PA_GroupNm:	Adagen
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	18 years of age or less.
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	Pediatric member must have a confirmed diagnosis of adenosine deaminase deficiency (ADA) with severe combined immunodeficiency disease (SCID) who have failed or are not candidates for bone marrow transplantation

PA_GroupNm:	Adcirca
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria.
Information Required	Diagnosis and confirmed diagnosis by right heart catheterization. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Cardiologist or pulmonologist
Duration of Approval	365 days
Other Information we may Require:	Member has a confirmed diagnosis of PAH with WHO functional class I-IV symptoms AND member is NOT currently taking a nitrate product.

PA_GroupNm:	Afinitor
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria.
Information Required	Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	180 days
Other Information we may Require:	Patients with advanced renal cell carcinoma after failure of treatment with sunitinib or sorafenib.

PA_GroupNm:	Aldurazyme
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	Must 5 years of age or older.
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	Must have a confirmed diagnosis of Mucopolysaccharidosis, Type I (Hurler and Hurler-Scheie forms) and Scheie form with moderate to severe symptoms.

PA_GroupNm:	Amevive 2010
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis and CD4 count.
Age Restrictions	Member is age 18 or older.
Prescriber Restrictions	Dermatologist
Duration of Approval	Initially for 12 weeks. 12 weeks off of therapy after initial 12 weeks on therapy.
Other Information we may Require:	Member must have a diagnosis of chronic moderate to severe plaque psoriasis, member must have a minimum body surface area involvement of greater than or equal to 10%, (members with plaque psoriasis of the palms, soles, head and neck, or genitalia are not required to have a minimum body surface area involvement), member must have an adequate trial of a conventional systemic therapy (e.g. methotrexate, cyclosporine, acitretin) with an inadequate response, significant side effects or toxicity, or have a contraindication to these therapies, member must have an adequate trial of a TNF-blocking agent (e.g. Enbrel, Humira, Remicade) with an inadequate response, significant side effects or toxicity, or have a contraindication to these therapies, member must have a normal CD4 lymphocyte count (250 cells/μL or greater), member cannot have HIV, as this is a contraindication for treatment with Amevive, currently not using the following in combination with Amevive such as TNF-blocking agents, other biologic agents, immunosuppressant agents or phototherapy, and have no evidence of infection. Reauthorization may be granted for an additional 12 weeks of therapy if the member has had at least 12 weeks off of therapy after the initial 12 weeks on therapy and chart documentation from the provider must indicate that that the member's disease has improved based upon the provider's assessment while on therapy and has a CD4 lymphocyte count of 250 cells/μL or greater and no evidence of infection. If the reauthorization criteria is met, the medication will be approved for an additional 12 weeks of therapy. Therapy will be limited to 2 treatment courses per year.

PA_GroupNm:	Amphetamines
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D including ADHD, adjunct to antidepressant therapy, adjunct to pain therapy, adjunct to Alzheimer’s treatment (methylphenidate), fatigue associated with chronic disease such as HIV, MS or Cancer, post traumatic brain injury or narcolepsy.
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	Prior authorization applies to members age 19 and above.
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	Amphetamines will be covered for ADHD, adjunct to antidepressant therapy, adjunct to pain therapy, adjunct to Alzheimer’s treatment (methylphenidate), fatigue associated with chronic disease such as HIV, MS or Cancer, post traumatic brain injury or narcolepsy.

PA_GroupNm:	Androgens
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis and morning serum testosterone level less than 300ng/Dl.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	Androgenic agents will be covered for Primary hypogonadism (congenital or acquired) – testicular failure due to cryptorchidism, bilateral torsions, orchitis, vanishing testis syndrome, or orchidectomy, or, Hypogonadotropic hypogonadism (congenital or acquired) – idiopathic gonadotropin or LHRH deficiency, or pituitary-hypothalamic injury from tumors, trauma or radiation.

PA_GroupNm:	Aranesp 2010
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Hemoglobin level, iron studies, and diagnosis for initial authorization. Continued authorization requires an increase in Hgb of 1gm/dl and a Hgb less than or equal to 12gm/dl.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	2 months initially then every 6 mths all pts except for those on ribavirin which is app every 2 mths .
Other Information we may Require:	Mem must have ONE of follow diag: anemia of CRF and on renal dialysis with hemoglobin (Hgb) less than or equ to 10 g/Dl or anem of CRF, not requ dialysis with Hgb less than or equ to 10g/Dl or anem (Hgb less than or equal to 10 g/Dl) in mem with non-myeloid malignancies where ane is due to effect of concomitantly adm chem or anem assoc with use of ribavirin if Hgb less than 10 g/dl or a 2g/dl decr from baseline Hgb or anem assoc with myelodysplastic syn when Hgb less than 10 g/dl and iron stat must be eval by prov for all mem before and during treat. Supp iron therapy is requ for all mem whose ferritin below 100 mcg/L (less than 300 mcg/L in mem withCKD) or transferrin sat is below 20 and memb must not have uncontrolled hypertension and mem must not have known hypersensitivity active sub or any excipients of the product and pres dose must be within the rec dosing guide. If further titration is needed to achieve a response, an additional 2-month trial will be approved.

PA_GroupNm:	Arcalyst
Covered Uses for this Drug	All FDA approved indications unless otherwise restricted from Part D coverage
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Negative Tuberculin PPD for initial authorization. For continued authorization, chart documentation must be submitted from the prescriber that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	12 years of age or older.
Prescriber Restrictions	Confirming diagnosis by a rheumatologist, dermatologist, immunologist, or genetic specialist.
Duration of Approval	365 days
Other Information we may Require:	Member must have a diagnosis of Muckle-Wells syndrome (MWS) or familial cold autoinflammatory syndrome (FCAS) and not currently using a Tumor Necrosis Factor (TNF) blocking agent or other biologic agent such as Kineret.

PA_GroupNm:	Banzel
Covered Uses for this Drug	All FDA approved indications unless otherwise restricted from Part D coverage
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Neurologist
Duration of Approval	365 days
Other Information we may Require:	Member must have a diagnosis of Lennox-Gastaut syndrome. Authorizations may be extended at one-year intervals based upon chart documentation from the prescriber that the member's disease has improved based upon the prescriber's assessment while on therapy.

PA_GroupNm:	Botox
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D incl tor dyst,blepharo,orfac dysk, spas tort,org wrir's crmp,frs of tors dyst,herd spas parapl,MS,Neuro opt,Schlder's ds,demy ds of CNS, spas hmi aff dom/nondm,InfCP, fc nv do, esotrop,exotrop,heterphor, para/mech strab, strab,do of bin eye move,do of eye move,lary sps,ds of larynx, achal, cdiosp,anl spas, anl fis, tortico, mus spasm.
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis for initial authorization. For reauthorization, chart documentation from the prescriber indicating that the member's condition has improved as a result of therapy must be submitted.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	90 days initially then 365 days per reauthorization criteria.
Other Information we may Require:	Botox will be covered for the following diagnoses: Idiopathic torsion dystonia, Symptomatic torsion dystonia, Blepharospasm, Oromaxial dyskinesia, Spasmodic torticollis, Organic writer's cramp, Fragments of torsion dystonia, other, Hereditary spastic paraplegia, Multiple sclerosis, Neuromyelitis optica, Schilder's disease, Other demyelinating disease of central nervous system, Demyelinating disease of central nervous system, unspecified, Spastic hemiplegia, affecting dominant side, Spastic hemiplegia, affecting nondominant side, Infantile cerebral palsy, Other specified infantile cerebral palsy, Infantile cerebral palsy, unspecified, Other facial nerve disorders, Esotropia, Exotropia, Intermittent Heterotropia, Other and unspecified heterotropia, Heterophoria, Paralytic strabismus, Mechanical strabismus, Other specified strabismus, Other disorder of binocular eye movements, Unspecified disorder of eye movements, Laryngeal spasm, Other diseases of larynx, not elsewhere defined, Achalasia and cardiospasm, Anal spasm, Anal fissure, Torticollis, unspecified, or Spasm of muscle.

PA_GroupNm:	Buphenyl
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	Member must have a diagnosis of urea cycle disorder AND this drug will be used as an adjunct to dietary therapy.

PA_GroupNm:	Bystolic
Covered Uses for this Drug	All FDA approved indications unless otherwise restricted from Part D coverage
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	Claims history of trial and failure of 2 beta-blockers. Chart doc can also be submitted indicating that the member has failed or had an intolerance to 2 different beta-blockers

PA_GroupNm:	Ceredase/Cerezyme 2010
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	Tay-Sachs Disease
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Prescribed by, or after consultation with, a physician that specializes in the treatment of inherited metabolic disorders or the patient was referred to a center that specializes in the treatment of Gaucher disease.
Duration of Approval	365 days
Other Information we may Require:	Member must have a diagnosis of Type I Gaucher's disease with Anemia, Thrombocytopenia, Bone Disease, Hepatomegaly, or Splenomegaly.

PA_GroupNm:

Cervarix

Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	Men
Information Required	None
Age Restrictions	Member must be between the ages of 9 to 26.
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	3 doses per 365 days
Other Information we may Require:	Female gender and 9 years of age through 26 years of age.

PA_GroupNm:

Cimzia

Covered Uses for this Drug	All FDA approved indications unless otherwise restricted from Part D coverage
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Negative Tuberculin PPD for initial authorization. For continued authorization, chart documentation must be submitted from the prescriber that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	Confirming diagnosis by a gastroenterologist or rheumatologist.
Duration of Approval	365 days
Other Information we may Require:	For a diagnosis of moderate to severe Crohn's disease members must have tried conventional therapy including aminosalicylates (i.e., sulfasalazine, mesalamine), corticosteroids or immunomodulators (i.e., azathioprine, 6-mercaptopurine) and member must currently not be using a TNF-blocking agent, such as Humira, Enbrel, or Remicade or other biologic agent, such as Kineret.

PA_GroupNm:

Elaprase

Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	5 years of age and older
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	Not Applicable

PA_GroupNm:	Elidel and Protopic
Covered Uses for this Drug	All FDA approved indications unless otherwise restricted from Part D coverage
Coverage Excluded Reasons	Weakened or compromised immune system
Information Required	Diagnosis
Age Restrictions	2 years of age or older.
Prescriber Restrictions	No Prescriber Restrictions.
Duration of Approval	Initial approval of 3 months. Retreatment for an additional 3 months within 1 year.
Other Information we may Require:	Member must have a diagnosis of atopic dermatitis (eczema), be over the age of 2, be without a weakened or compromised immune system, and had a trial and failure of a moderate to high potency topical corticosteroid unless a contraindication or intolerance to topical corticosteroid therapy, such as dermatitis on the face. Initial approval will be for 3 months. Re-treatment for an additional 3 months will be authorized upon review of chart documentation from the prescriber indicating that the member's signs and symptoms (e.g. rash, itch, and redness) have improved as a result of therapy.

PA_GroupNm:	Enbrel 2010
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Negative Tuberculin PPD test for initial authorization. For continued authorization, chart documentation must be submitted from the provider that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	18 years of age or older for psoriasis.
Prescriber Restrictions	Confirming diagnosis by a rheumatologist or dermatologist based upon diagnosis.
Duration of Approval	365 days
Other Information we may Require:	For the diagnosis of rheumatoid arthritis, and juvenile rheumatoid arthritis: member must have a diagnosis of moderate to severe rheumatoid arthritis or juvenile rheumatoid arthritis and for rheumatoid arthritis, if appropriate, member must have tried methotrexate for at least 3-6 months with an inadequate response as reported by the prescribing provider, or, member has experienced significant side effects/toxicity of methotrexate (MTX) (approvals will be granted only upon documented medical contraindications, by the prescribing provider, to methotrexate therapy) and currently not using a Tumor Necrosis Factor (TNF) blocking agent or other biologic agent such as Kineret or Humira. For the diagnosis of psoriatic arthritis: member must have a diagnosis psoriatic arthritis, defined as affecting at least five joints and member must have tried methotrexate for at least 3-6 months with an inadequate response as reported by the prescribing provider, or, member has experienced significant side effects/toxicity of methotrexate (Approvals will be granted only upon documented medical contraindications, by the prescribing provider, to methotrexate therapy.) and currently not using a TNF-blocking agent or other biologic agent such as Kineret or Humira. For the diagnosis of psoriasis: members with a diagnosis of chronic moderate to severe plaque psoriasis (greater than 10% BSA involvement), members with plaque psoriasis of the palms, soles, head and neck, or genitalia are not required to have a minimum body surface area involvement, member must have an adequate trial of one topical treatment, phototherapy, or photochemotherapy with an inadequate response, significant side effects or toxicity, or have a contraindication to these therapies, member must have an adequate trial of one conventional systemic therapy (e.g. methotrexate, cyclosporine, acitretin) with an inadequate response, significant side effects or toxicity, or have a contraindication to these therapies, member must currently not be using a TNF-blocking agent or other biologic agents in combination with Enbrel, and member must have no evidence of infection. For the diagnosis of ankylosing spondylitis: chart documentation must be submitted showing that the member has tried and failed intensive conservative treatment measures, including when indicated, a trial with one DMARD for at least 3-6 months with an inadequate response as reported by the prescribing provider, and member must currently not be using a TNF-blocking agent or other biologic agent such as Kineret or Humira.

PA_GroupNm:	Epogen/Procrit 2010
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Hemoglobin level, iron studies, and diagnosis for initial authorization. Continued authorization requires an increase in Hgb of 1gm/dl and a Hgb less than or equal to 12gm/dl.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	2 months initially then every 6 months. Every 2 months for ribavirin use.
Other Information we may Require:	Member must have a ONE of the following: CRF or ESRD and on renal dialysis and laboratory values showing Hgb less than/equal to 10 g/Dl or CRF not requiring dialysis AND lab values showing Hgb less than or equal to 10 g/dl or zidovudine treatment-induced anemia in HIV members AND lab value showing Hgb less than or equal to 10g/Dl or chemotherapy-induced anemia, not due to iron or folate deficiencies, hemolysis or GI bleed AND lab value showing Hgb less than 10 g/Dl or anemic members with lab value showing Hgb greater than 10g/dl and less than 13g/Dl, who are at high risk for perioperative transfusions secondary to significant, anticipated blood loss and are schedule to undergo elective, noncardiac, nonvascular surgery to reduce the risk for allogenic blood transfusions or anemia associated with the use of ribavirinI Hgb less than 10 g/ Dl or a 2 g/ Dl decrease from baseline or anemia associated with myelodysplastic syndrome when Hgb less than 10 g/dl. Iron status must be evaluated by the provider for all members before and during treatment. Supplemental iron therapy is required for all members whose serum ferritin is below 100 mcg/L (less than 300 mcg/L in members with chronic kidney disease) or whose serum transferrin saturation is below 20%.Member must not have uncontrolled hypertension. Member must not have a known hypersensitivity to the active substance or any of the excipients of the product. Prescribed dose must be within the recommended dosing guidelines. If further titration is needed to achieve a response, an additional 2-month trial will be approved.

PA_GroupNm:	Fabrazyme
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	Men with a diagnosis of Fabry disease based on clinical symptoms or by genetic testing. Women with presumed symptoms of Fabry disease (heterozygous carriers) based on family history and/or genetic testing.

PA_GroupNm:	Fanapt
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Prescribed by or in consultation with a psychiatrist.
Duration of Approval	365 days
Other Information we may Require:	Member must have a diagnosis of schizophrenia and member must have an adequate trial and failure or inadequate response, duration of at least 4 weeks, or intolerance to risperidone and 2 other atypical antipsychotics. For continuation, documentation required from the provider that the member's disease has improved based upon the prescriber's assessment while on therapy.

PA_GroupNm:	Gardasil
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	None
Information Required	None
Age Restrictions	Member must be between the ages of 9 and 26.
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	3 doses per 365 days
Other Information we may Require:	Female gender and 9 years of age through 26 years of age or male gender and 9 years of age through 26 years of age.

PA_GroupNm:	Gleevec
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	180 days.
Other Information we may Require:	Adult and pediatric Philadelphia positive (Ph+) chronic myeloid leukemia (CML) in chronic phase, patients in Ph+ CML in blast crisis, accelerated phase or interferon-refractory chronic phase, pediatric Ph+ CML recurrence after stem cell transplant or interferon-alpha resistant, adult relapsed or refractory Ph+ acute lymphoblastic leukemia (ALL), adult myelodysplastic disease/myeloproliferative disease (MDS/MPD) associated with PDGFR gene rearrangements, adult aggressive systemic mastocytosis (ASM) without D816V c-Kit mutation or c-Kit mutation unknown, adult hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL) with platelet derived growth factor receptor (FIP1L1-PDGFRa) fusion kinase positive, negative, or unknown, adult unresectable, recurrent and/or metastatic dermatofibrosarcoma protuberans (DFSP), or patients with Kit cancer protein (CD117) unresectable and/or metastatic malignant GI stromal tumors.

PA_GroupNm:

Growth Hormone

Covered Uses for this Drug

All FDA approved indications not otherwise excluded from Part D

Coverage Excluded Reasons

Children with constitutionally delayed growth and development (i.e., delayed skeletal maturation with normal growth velocities and rates of bone age advancement, members who are at the lowest 5% of the growth curve at age 3, steroid-induced growth failure, kidney transplant recipients, Down syndrome, Fanconi's syndrome, Bloom syndrome, chromosomal and genetic disorders. Adults with chronic fatigue syndrome, fibromyalgia, obesity, athletic performance enhancer, anti-aging treatment, sepsis, burns, trauma, surgery, ESRD, wasting associated with cancer or organ failure. No evidence of malignancy in adults.

Information Required

Diagnosis, growth charts, growth hormone levels from stimulation tests, IGF-1 level, x-rays of left hand and wrist, pituitary hormone levels. For continued authorization, one of the following cannot be true: growth velocity while on therapy is less than 2.5

Age Restrictions

No Age Restrictions

Prescriber Restrictions

Endocrinologist, pediatric endocrinologist, or pediatric nephrologist dependent upon diagnosis.

Duration of Approval

180 days for children with extreme short stature and 365 days for other indications.

Other Information we may Require:

Child and Adults with Classic GHD must: doc fail to respond to 2 GH prov tests, defined as a serum GH level (peak level) less than 10ng/ml. Unless contra, 1 test must be ITT, oths incl levo, arg, clon, propr, glucagon. 1 ab GH test is suf in child w a hx of irradi or mltpl pit hxrnone def and IGF-I levels blw nml for bone age/sex and at lst 2 of the fol: height is less than 5th perc for age/sex, pretreatment growth velocity is less than 10th percentile for bone age and gender or less than 4.5cm/yr, comp of skeletal age by x-ray of left hand and wrist is less than 2 sd below the chron age. Child w growth retardation due to CRI must: doc CRI up to time of renal transplant and at least one of: height is less than 5th percentile for age/sex, growth velocity is less than 10th perc for bone age and gender or less than 4.5cm/yr. GH therapy in child must be prescribed by a ped endocrinologist or ped nephrologists. Turner syn in females/Noonan Syn must: doc diag and at least one of fol: height is less than 5th percentile for age/sex, growth vel is less than 10th perc for bone age and gender or less than 4.5cm/yr. Child w Prader-Willi Syndrome must: doc diag of Prader-Willi Syndrome and as previously stated with Turner's syndrome. Child w extreme shxrt stature must: doc that incl spec ex of hwx basic ADLs affected, height SDS less than -2.25 cm/yr, dooc growth rates are unlikely to per attainment of adult height within target height range calc based on parental heights, doc children with shxrt stature born SGA have not shxwn catch-up growth by age 2 yrs. Adult GHD-Child Onset must: diag w GHD during child whx have GHD reconfirmed as adult, GH treatment shxuld be stopped for 2-3 months aft compl of linear growth then GH levels shxuld be reasses by stim test and mem has biochem diag of GHD det by neg resp to std GH stim test def as peak GH level less than 3ng/ml, ITT is requ unless contra. GHRH-arg stim test res may be sub for mem w doc contra to ITT and mem has NOT reach adult peak bone mass

(between 25 and 30 ys old).Ad GHD–Ad Onset must: diag w GHD, biochem diag GHD det by neg resp to std GH stim test def as pk GH level of lss thn 3ng/ml. The ITT is req unless contra. GHRH-arg stim test results may be sub for thxse w doc contr to ITT. If GHRH-arg test results nt avai, then results of 2 other stim tests, incl clon, L-Dopa, or arg, shxuld be sub OR if the cause of pit dis is known AND if 3 or more pit hxrm are def (ACTH, TSH and gonadotropins), an IGF-1 level lss thn 84 ng/MI is suf to diag GHD. Add GH stim tsts are not req in these mem OR if cause of GHD is unknown, evid of hyp-pit ds, def as doc def in at least 2 of the fol: TSH, ACTH or gonadotropins, must be provd in addition to the GH levels from stiM test and if pit adenoma, doc subm that tumor sz has remained stab one-year prior to intng GH and mem does not have poorly cont diab or diab with unstbl prol ret.GH in adlts presc by endocrinologist. GH in children presc by endricinologist or ped endocrinologist.

PA_GroupNm:

Human Chorionic Gonadotropin

Covered Uses for this Drug

All FDA approved indications not otherwise excluded from Part D

Coverage Excluded Reasons

No Exclusion Criteria

Information Required

Diagnosis

Age Restrictions

Member must be at least 4 years of age for the treatment of cryptorchidism.

Prescriber Restrictions

No Prescriber Restrictions

Duration of Approval

Up to 365 days dependent upon treatment dosage.

Other Information we may Require:

Cryptorchidism: 4000 units IM 3 times weekly for 3 weeks OR 5000 units every second day for 4 doses OR 15 injections of 500 to 1000 units over a period of 6 wks OR 500 units 3 times weekly for 4 to 6 wks repeated 1 month later using 1000 units dose if ineffective. Hypogonadotropic hypogonadism, In male patients: 500 to 1000 units IM 3 times weekly for 3 weeks followed by 500 to 1000 units 2 times weekly for 3 weeks OR 4000 units 3 times weekly for 6 to 9 months, may reduce to 2000 units 3 times weekly for an additional 3 months.

PA_GroupNm:	Humira 2010
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Negative Tuberculin PPD for initial authorization. For continued authorization, chart documentation must be submitted from the prescriber that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	18 years of or older except for the diagnosis of Juvenile Idiopathic Arthritis in which patients must be 4 years of age or older.
Prescriber Restrictions	Confirming diagnosis by a rheumatologist or a dermatologist or gastroenterologist based upon diagnosis.
Duration of Approval	365 days
Other Information we may Require:	For the diag of rheumatoid arthritis (RA): mem must have a diag of mod to sev RA, if appropriate, member must have tried methotrexate (MXT) for at least 3-6 mths with an inadequate response as reported by the presc provider, or, mem has exp sig side effects/tox of MTX, (Approvals will be granted only upon doc med contraindications, by the presc provider, to MTX therapy) and currently not using a TNF-blocking agent or other biologic agent, such as Kineret or Enbrel. For the diag of psoriatic arthritis: mem must have a diag mod to sev psoriatic arthritis, defined as affecting at least five joints and mem must have tried MXT for at least 3-6 mths with an inadequate resp as reported by the presc provider, or, mem has exp sign side effects/toxicity of MTX, (Approvals will be granted only upon doc med contraindications, by the presc provider, to MXT) and currently not using a TNF-blocking agent or other biologic ag, such as Kineret or Enbrel. For the diag of ankylosing spondylitis: chart doc must be submitted showing that the mem has tried and failed intensive conservative treatm measures, incl when ind a trial with a DMARD, such as MXT or sulfasalazine, for at least 3-6 mths with an inadequate response as reported by the prescr provider and mem must currently not be using a TNF-blocking agent or other biologic agent such as Kineret or Humira. For the diag of Crohn's Ds: mem must have diag of mod to sev active crohn's dis, mem must have: tried conventional therapy including aminosalicylates (i.e., sulfasalazine, mesalamine), corticosteroids or immunomodulators (i.e., azathioprine, 6-mercaptopurine) and mem must currently not be using a TNF-blocking agent, such as Enbrel or Remicade or other biologic agent, such as Kineret. For the diag of Juvenile Idiopathic Arthritis: mem must have a diag of mod to sev active polyarticular juvenile idiopathic arthritis, member must have: tried MXT for at least 3-6 months with an inadequate response as reported by the presc provider, or, exp sig side effects/tox of methotrexate, or, doc med contraindications, by the presc provider, to MXT therapy and currently not using a TNF-blocking agent, such as Enbrel or other biologic agent, such as Kineret, Orencia, or Rituxan. For the diag of plaque psoriasis: mem must have diag severe plaque psoriasis (greater than or equ to 10% BSA involvement), who are candidates for syst therapy (mem with plaque psoriasis of the palms, soles, head and neck, or genitalia are not requ to have a min body surface area involv), must have ad trial of topical treatments, phototherapy, or photochemotherapy with an inadequate response, sig side effects or toxicity, or

have a contra to these therapies, must have ad trial of conv systemic therapy (e.g. MTX, cyclosporine, acitretin) with inad response, sig side effects or toxicity, or have a contra to these therapies, must currently not be using a TNF-blocking agent or other biologic in combination with Humira, and no evidence of infection.

PA_GroupNm:	Immune Globulins
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis, IgG level, platelet counts.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Prescribed by immunologist or in consultation with an immunologist or transplant specialist dependent upon diagnoses.
Duration of Approval	30 to 365 days dependent upon diagnosis.
Other Information we may Require:	<p>Prim imdf by imgst or in cons w imgst.Cld w ITP ap if plt cnt is ls thn 20,000 w sg mc mem bldng or if plt cnt is ls thn 10,000 w mn prpr, if splnctmy is plnd n plat cnt is lss thn 30,000, if plt is ls thn 20,000 and incess or nncmp, or if srgr, dntal extr, or othr pre lkly to cse bld ls nded.Adlts w ITP app if pt trd crctestr d n pltlt cnt is ls thn 30,000 n there is acu bldng,ITP sxs prsist afr tx w glcrteds ad splnctmy AND pltlt cnt is lss thn 30,000 AND actv bldng, to incs pltlt cnts bfr mjr srg:dntistry lss thn qul to 10,000, extens ls thn/eq to 30,000, reg dtl blk ls thn eq to 30,000, mn surg lss thn eq 50,000 ad mj srg ls thn eq 80,000, if plt cnt lss thn eq 20,000 ad pt con risk fr intrac bld, if dfr sptmy.For prg w ITP if plt cnt is lss thn eq 100,000, if pst hx splnctmy, hv prv del infnts w autmne thcytpn. Kwski ds, one dse w asa ap in acte phse wthn 7-10 dys of illnss. Snd dse app in pts who fl to rsp to intl tx.B-cell CLL,app pts w hypogbln or w prv hx of ser bac intn.Hypgmgf df IgG ls thn 640 mg/dl.Ap 1 yr.Unquvcl CIDP AND imprd fnc by obj asnt AND trl ad fl of or contr to std tx for lst 2 mths or pls exchnng.HIV lss thn 13 yrs w CD4 cnt grtr or eql 200. Ap 1 yr for inf ad cld w 2 or more ser bac inf dng 1 yr prd dsp of HAART ad antcrbls, HIV infctd infnts, cld w hypogam (IgG ls thn 400mg/dl),fl to frm antbd to com atgns, abnce of antbdy to msls in chd who hv rec two msles imun ad who lv reg w hgh prv of msls, chnc prvrs B19 inf, adj tx for brchctass not rsp to abx ad pulm thx, pass imm for msls if IM IG contra.Glln-Brr ap if IVIG wthn 2 wks ad no lgr thn 4 wks of onst of nrpthic sxs in nnmblnt adlt pts. Ap 1 mth.Ap 6 mths drmysts incl juv ad plymyts w unquvcl dx AND trd ad fld or contr to prd 4 mths AND ad thrpy azthpne, mtx, cyclspn, or hydxychq. Mem with svr actv SLE AND trd ad fld or contra to fst ln tx of NSAIDs, strds, antmlrls AND mbr trd ad fld or contra imunspnts.Ap 1 yr.Ap 1 yr for relpsng, rem MS atr trl ad flr at lst 3 mths or contr to intrfrn or Cpxn. Ap 4 mths fr pmphigs vlgrs, pmphs folcs, bull pem, muc mem pem, ad epid bull acq AND mts one of foll crt of trl ad flr or contr to cort or imm agnts or in rap prog, ext, or deb cass givn w conv tx.Mem has unquvcl Mysthnia Grvs AND svrly impr fxn AND trd ad fld for at lst 3 mths or has contr to cholnstrse inh AND imnsp or strds.Ap 1 mth.Parvrs B19 Inf AND svre anm assoc w bn mrrw sup. Ap 1 mth.Rnl or Pncrtic Transp Des in Com w Rtxn by trsplnt spelst, 18 or ldr, awtng kdn or pnc trnspt req des def as for decd dnr w PRA grt thn 30 per OR PRA lss thn 30 perc w prev kid or pncrs trpt.Fr liv dnr tpltls w pos cross OR pos donor-spec antbdy using Lmnx assay. Ap 1 crse.Mnthrpy for Rnl Des by trsplnt spc, mem awtng kid trpl.Ap 4 mths.Rnl Trsplnt Rej if rec renl trnspt frm liv dnr w pstrpnt rej.Ap 1 mth.Allgnic BMT or HSCT w svr hypgmia (IgG lss 400),not hv to be sv due to trnspln for MM or mal mcrglobul OR HSCT W unrldt grfts w sEV hypgmia wthn frst 100 dys afr</p>

tsplnt.Ap 6 mths.

PA_GroupNm:	Increlex/Iplex
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	Member with closed epiphyses, presence of active or suspected neoplasia, or allergy to mecasecmin.
Information Required	Diagnosis, growth hormone levels from stimulation tests, IGF-1 level.
Age Restrictions	Must be at least 2 years of age.
Prescriber Restrictions	Must be prescribed by a pediatric endocrinologist and must be used with appropriate physician (pediatric endocrinologist) follow-up.
Duration of Approval	365 days
Other Information we may Require:	Two of the following must be present: present height lss than 5th percentile for age/sex, pretreatment growth velocity is lss thn 10th percentile for age and gender or lss thn 4.5 cm/yr until age 10, and lower growth rates thereafter,comparison of skeletal (bone) age by x-ray of the left hand and wrist is greater than 2 standard deviations below the chronological age. Must have basal serum IGF-1 level which is low for age (greater than 3 standard deviations below the nml level for age and gender, as measured in clinical labs where appropriate normative data are available)and normal or elevated growth hormone (GH) shown by growth stimulation tests, except for members withGH gene deletion and cannot have secondary forms of IGF-1 deficiency, such as growth hormone deficiency, malnutrition, hypothyroidism, or chronic treatment with pharmacologic doses of anti-inflammatory steroids. If thyroid or nutritional deficiencies exist, this should be corrected beforehand. For contd authorization, the member must have positive response to therapy as demonstrated through growth velocity increase, member has not reached expected final adult height and growth plates have not fused as proven through x-ray of left hand and wrist.

PA_GroupNm:	Invega
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	Member must have a diagnosis of schizophrenia and member must have failed two atypical anti-psychotics as supported by physician chart documentation.

PA_GroupNm:	Iressa
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria.
Information Required	Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	Renewable every 180 days.
Other Information we may Require:	Monotherapy for locally advanced or metastatic non-small cell lung cancer after failure of both platinum-based AND docetaxel-based chemotherapies who are benefiting or have benefited from Iressa.

PA_GroupNm:	Kuvan
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis, baseline serum phenylalanine level, and follow-up serum phenylalanine levels.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	1 month initially then annually.
Other Information we may Require:	The member must have a diagnosis of phenylketonuria (PKU) and a documented baseline serum phenylalanine level. Continuation/Discontinuation criteria: lab reassessment will be conducted after an initial one month trial to determine if authorization may be extended. Patients on the 10mg/kg/day dose whose blood phenylalanine levels have not decreased from baseline after 1 month of treatment should increase to 20mg/kg/day. These patients will be approved for another one month trial at the higher dose. Patients on the 20mg/kg/day dose whose blood phenylalanine levels have not decreased from baseline after 1 month are considered non-responders, and treatment with Kuvan should be discontinued in these patients.

PA_GroupNm:	Leflunomide Arava Kineret
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis for initial authorization. For continuation of authorization, chart documentation must be submitted by the provider stating that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Rheumatologist must be prescribing.
Duration of Approval	365 days
Other Information we may Require:	Member must have tried methotrexate for at least 3-6 months with an inadequate response as reported by the prescribing provider or, member has experienced significant side effects/toxicity of methotrexate (approvals will be granted only upon documented medical contraindications, by the prescribing provider, to methotrexate therapy) and member must currently not be using another Tumor Necrosis Factor (TNF) blocking agent or biologic agent, such as Enbrel, Kineret, Humira, or Arava.

PA_GroupNm:	Letairis
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria.
Information Required	Diagnosis and confirmed diagnosis by right heart catheterization. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Cardiologist or pulmonologist
Duration of Approval	365 days
Other Information we may Require:	Member has a confirmed diagnosis of PAH with WHO functional class II or III symptoms AND member has had baseline liver function tests (ALT, AST) prior to initiation of therapy AND if a member is a woman of childbearing potential, she has had a baseline negative pregnancy test prior to initiation of therapy.

PA_GroupNm:	Leuprolide and derivatives
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis. For continued authorization, chart documentation is required from the prescriber that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 dys f pros/bs ca,cpp, 180 dys for endosis, 90 dys for ut leiomyomata, 60 dys f endometrial thin.
Other Information we may Require:	Diagnosis of prostate cancer or diagnosis of breast cancer. Diagnosis of endometriosis confirmed by laparoscopy OR if the diagnosis is not confirmed by surgery, then chart documentation of an adequate work-up and the clinical rationale for the diagnosis must be provided, for mild endometriosis, the member must have tried oral contraceptives and/or progestins. For the diagnosis of uterine leiomyomata (fibroids), member must have a diagnosis of uterine leiomyomata (fibroids), and the use of GnRh (gonadotropin-releasing hormone) agonist can be used in the treatment for fibroid in the following contexts:it may be used preoperatively to maximize preoperative hemoglobin in patients with documented preexisting anemia (Hemoglobin lss thn 11) or it may be used preoperatively to decrease the size of the fibroid uterus so a less invasive route of hysterectomy can be attempted. (i.e. from an abdominal hysterectomy to a vaginal hysterectomy or a laparoscopic hysterectomy) and clinical rationale for other use of GnRh agonist outside of the context of preoperative adjuvant in the surgical management of leiomyoma must be provided. For the diagnosis of central precocious puberty, the member must have a diagnosis of central precocious puberty with onset of secondary sexual characteristics earlier than 8 years in females and 9 years in males. For endometrial thinning, the member must have a diagnosis of dysfunctional uterine bleeding and the member must be undergoing endometrial ablation.

PA_GroupNm:	Lexapro
Covered Uses for this Drug	All FDA approved indications unless otherwise restricted from Part D coverage
Coverage Excluded Reasons	None
Information Required	Evidence of prior use of 2 generic selective serotonin reuptake inhibitors.
Age Restrictions	None
Prescriber Restrictions	None
Duration of Approval	365 Days
Other Information we may Require:	None

PA_GroupNm:	Lidoderm Patch
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	Diagnosis of post-herpetic neuralgia.

PA_GroupNm:	Low Dose Seroquel
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	Member must be on total daily dose greater than 200mg or member with a diagnosis of schizophrenia or member with a diagnosis of bipolar I disorder or members with a diagnosis of Major Depressive Disorder who have failed both mono and combination antidepressant therapy which includes the following: an adequate trial and failure or an inadequate response, duration of at least 4 weeks, or intolerance to monotherapy with 2 different antidepressant therapies AND either of the following: Trial and failure or an inadequate response, duration of at least 4 weeks, or intolerance to a single trial of combination Antidepressant therapy OR Trial and failure or an inadequate response, duration of at least 4 weeks, or intolerance to a single trial of an Antidepressant with augmentation therapy.

PA_GroupNm:	Low-Dose Seroquel XR
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	Member must be on total daily dose greater than 200mg or member with a diagnosis of schizophrenia or member with a diagnosis of bipolar I disorder or members with a diagnosis of Major Depressive Disorder who have failed both mono and combination antidepressant therapy which includes the following: an adequate trial and failure or an inadequate response, duration of at least 4 weeks, or intolerance to monotherapy with 2 different antidepressant therapies AND either of the following: Trial and failure or an inadequate response, duration of at least 4 weeks, or intolerance to a single trial of combination Antidepressant therapy OR Trial and failure or an inadequate response, duration of at least 4 weeks, or intolerance to a single trial of an Antidepressant with augmentation therapy.

PA_GroupNm:	Lyrica
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	For fibromyalgia: chart documentation showing the diagnosis of fibromyalgia with a history of widespread pain involving the extremities for three months and localized area of tenderness and trial and failure of two agents unless documented intolerance or contraindication to the agents: gabapentin at a dose of at least 1200 mg daily which is documented in pharmacy claims or through physician chart documentation and tricyclic antidepressants (i.e., amitriptyline) OR muscle relaxants (i.e., cyclobenzaprine) and physician chart documentation showing trial of exercise or physical therapy. For Postherpetic Neuralgia: trial and failure of one of the following agents: tricyclic antidepressants (i.e., amitriptyline) or gabapentin. For Diabetic Peripheral Neuropathy: documented pharmacy claim history of prior therapy with a diabetic medication or medical claim/lab claim for the diagnosis of diabetes or physician chart documentation of diagnosis of diabetes and trial and failure of gabapentin. For seizure disorder: diagnosis.

PA_GroupNm:	Mozobil
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	18 years or older
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	4 days
Other Information we may Require:	Member must have non-Hodgkin’s lymphoma or multiple myeloma (MM) and require hematopoietic stem cell mobilization for collection and subsequent autologous transplantation, plerixafor must be used in combination with G-CSF and initiated after the member has received G-CSF once daily for four days, plerixafor will be administered approximately 11 hours prior to the initiation of apheresis for up to 4 consecutive days, plerixafor dose should not exceed maximum daily dose of 40 mg SC, and quantity limits will be for 8 vials (1.2ml single-use vial, 20mg/ml) which allows for a 4-day course at a maximum dose of 40mg SC. If all criteria are met, plerixafor will be authorized for a one time use of up to 4 days for mobilization of hematopoietic stem cells. All plerixafor therapy attempts must meet initial authorization.

PA_GroupNm:	Myobloc
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D including cervical dystonia and spasmodic torticollis.
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis. For continued authorization, chart documentation from the prescriber must be submitted indicating that the member’s condition has improved as a result of therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	90 days initially then 365 days.
Other Information we may Require:	Not Applicable

PA_GroupNm:	Naglazyme
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	Must be 5 years of age and older.
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	Not Applicable

PA_GroupNm:	Neulasta
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis for initial authorization. For continuation of authorization, documentation of improvement or ANC stabilization to maintain ANC greater than 1500 cells/ mm ³ .
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	90 days.
Other Information we may Require:	Not Applicable

PA_GroupNm:	Neupogen
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	History of hypersensitivity to E. coli-derived proteins, Filgrastim, or any component of the product.
Information Required	Diagnosis and neutrophil count. For continuation of therapy, documentation of improvement of ANC stabilization to maintain ANC greater than 1500 cells/mm ³ is required.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	90 days.
Other Information we may Require:	Neupogen will be covered for cancer members receiving conventional chemotherapy which has a significant risk of severe neutropenia, secondary prophylaxis when the following criteria are met: member is receiving a chemotherapy regimen which has a significant risk of severe neutropenia AND member has a disease for which clinical data supports maintenance of chemotherapy dose-intensity, cancer members receiving high-dose chemotherapy, Bone Marrow Transplant (BMT) to reduce the duration of neutropenia and neutropenia-related clinical sequelae in members undergoing myeloablative chemotherapy followed by marrow transplantation, members undergoing peripheral blood progenitor cell (PBPC) collection and therapy, myeloid malignancies, congenital neutropenia with neutrophil count less than 1000 cells/mm ³ , drug-induced agranulocytosis for members with a neutrophil count less than 1000 cells/mm ³ associated with fever or other evidence of serious infection, or members being treated with ganciclovir (for CMV) AND whose neutrophil counts are consistently less than 1000 cells/mm ³ .

PA_GroupNm:	Nexavar
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria.
Information Required	Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	Advanced renal cell carcinoma or unresectable hepatocellular cancer (hepatoma).

PA_GroupNm:	Noxafil
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	Members on the following medications: terfenadine, astemizole, cisapride, pimoziide, halofantrine, quinidine.
Information Required	Diagnosis.
Age Restrictions	Must be greater than 13 years of age.
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	120 days for dg of proph of Aspergillus and Candida infections,30 days for tx of oroph candidiasis
Other Information we may Require:	Member must be severly immunocompromised and must have a diagnosis of prophylaxis of Aspergillus and Candida infections, or diagnosis of treatment of oropharyngeal candidiasis.

PA_GroupNm:	Nuvigil
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D including diagnosis of chronic fatigue due to Multiple Sclerosis AND the member has had a previous trial of a amantadine.
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	6 months for the diagnosis of Shift-work sleep disorder. 365 days for other approvable indications.
Other Information we may Require:	For all indications, prior use of Provigil is required. For narcolepsy: documentation of diagnosis through sleep study and trial/failure of a CNS stimulant (i.e., methylphenidate, Dexedrine, generic Adderall) documented in pharmacy claims or through physician chart documentation. For Obstructive sleep apnea: documentation of diagnosis through sleep study and documentation/compliance report from physician that the member is using a CPAP machine on a regular basis, defined by at least 4 hours a night on at least 70% of the nights and symptoms still persist. For Shift-work sleep disorder (SWSD): must meet the International Classification of Sleep Disorders (ICSD)-10 criteria for chronic SWSD (which are consistent with the American Psychiatric Association DSM-IV criteria for Circadian Rhythm Sleep Disorder: Shift Work Type). The criteria includes either a primary complaint of excessive sleepiness or insomnia which is temporarily associated with a work period (a minimum of 5 night shifts per month) that occurs during the habitual sleep phase, OR polysomnography and the Multiple Sleep Latency Test (MSLT) demonstrate loss of a normal sleep-wake pattern and no other medical or mental disorder accounts for the symptoms and the symptoms do not meet criteria for any other sleep disorder producing insomnia or excessive sleepiness (e.g., time zone change [jet lag] syndrome). For chronic fatigue due to Multiple Sclerosis: the member has had a previous trial of a amantadine.

PA_GroupNm:	Orencia
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	6 years of age or older for Juvenile Idiopathic Arthritis
Prescriber Restrictions	Diagnosis must be confirmed by a rheumatologist.
Duration of Approval	365 days
Other Information we may Require:	Member must have a negative Tuberculin PPD (purified protein derivative) test. For a diagnosis of moderately to severely active rheumatoid arthritis, member must have tried and failed treatment with methotrexate, for at least 3 to 6 months with an inadequate response, unless the member has experienced significant side effects/toxicity to methotrexate or if the member has documented medical contraindications to methotrexate and member must have tried and failed treatment with any TNF-blocking agent for at least 3 to 6 months with an inadequate response, unless the member has experienced significant side effects/toxicity to Remicade or the member has documented medical contraindications to Remicade and the member must not be using a TNF-blocking agent such as Enbrel, Remicade, Humira, and Kineret. For Juvenile Idiopathic Arthritis, member must have tried and failed treatment with methotrexate, for at least 3 to 6 months with an inadequate response, unless the member has experienced significant side effects/toxicity to methotrexate or if the member has documented medical contraindications to methotrexate and the member must not be using a TNF-blocking agent such as Enbrel, Remicade, Humira, and Kineret.

PA_GroupNm:	Orfadin
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	The member has a confirmed diagnosis of Tyrosinemia type I and the drug is being used as an adjunct to diet therapy.

PA_GroupNm:	Peg Interferons
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	Extended or Maintenance therapy for Hepatitis C. Autoimmune hepatitis or other conditions known to be exacerbated by interferon. Known hypersensitivity to drugs used to treat hepatitis C. Patients with decompensated liver disease.
Information Required	Diagnosis, Hepatitis C genotype and baseline quantitative hepatitis C virus titer. For retreatment, liver biopsy needed.
Age Restrictions	18 years of age and older for peg alpha-2a and at least 3 years of age for peg alpha-2b.
Prescriber Restrictions	Must be prescribed by an infectious disease physician, gastroenterologist, hepatologist, or a transplant physician or in consultation with these physicians.
Duration of Approval	48 wks for all ind except for Hep C Geno 2 and 3 is 24 wks, Hep C Gento 1 is 16wks thn total 48 wks
Other Information we may Require:	For Initial Treat of Chronic Hepatitis C Genotype 1 and 4, treatment with peg alfa is authorized for up to 16 weeks (the initial auth is for 12 weeks with an additional 4 weeks granted for the prescriber to obtain the quantitative HCV RNA). After 12 weeks of therapy, a quantitative HCV RNA is required to continue therapy. If the mem has attained an early virologic resp as defined by the ach of at least a 100-fold (2 log 10) decrease in serum HCV RNA from pretreatment baseline and/or clearance of the HCV RNA, contd treat for a max of 48 wks is authorized. If the mem has not attained an early virologic response as ind by the ach of at least a 100-fold (2 log 10) decrease in serum HCV RNA from pretreatment baseline, further trmt with peg is cons not mdclly nec and shld not be auth. Cons for cont will be indiv based on sev of dseas, dem of some virologic resp, and tolerability of treatment. Patients who achieve an early virological response to int therapy, but also have a delayed virological resp may be authorized for up to 72 wks therapy. Additional chart documentation will be required showing clearance of the HCV RNA at 24 weeks of therapy. For Initial Treatment of Chronic Hepatitis C Genotypes 2 and 3 who have not been previously treated with interferon, treatment with peginterferon alfa is authorized for 24 weeks. For Treatment of HIV-Infected Member for all genotypes, treatment with peginterferon will be authorized for up to 48 weeks. For Treatment of Members with Renal Disease for all genotypes, treatment with peginterferon alfa-2A at a dose of 135mcg/week for members who are on hemodialysis will be authorized for up to 48 weeks. For Liver Transplant Members, authorization will be evaluated on a case-by-case basis using the initial treatment criteria for up to 48 weeks. Treatments will be authorized if the member has a history of treatment prior to the transplant, as this would not constitute retreatment. Upon medical review, extended treatment with peginterferon alfa beyond the treatment course of 24-48 weeks may be considered medically nec for persons with cryoglobulinemia and for liver transplant recipients with recurrent hepatitis C infections. Furthermore, retreatment with peginterferon will be approved for nonresponders or relapsers who have significant fibrosis or cirrhosis and who have undergone previous regimens of treatment using pegylated and non-pegylated interferons. A liver

biopsy will be required to determine the progression of disease. Requests for maintenance therapy will not be authorized. For indications other than hepatitis C authorization for treatment will be given for the following conditions: For interferon alfa-2b: hairy cell leukemia, malignant melanoma, follicular lymphoma, condylomata acuminata, AIDS-Related Kaposi's Sarcoma, chronic hepatitis B (1 year of age or older) For interferon alfa-2a: hairy cell leukemia or Philadelphia chromosome positive CML. For peginterferon alfa-2a: chronic hepatitis B (adult).

PA_GroupNm:

Prevacid Naprapac

Covered Uses for this Drug

All FDA-approved indications not otherwise excluded from Part D

Coverage Excluded Reasons

Member currently taking a COX-II inhibitor regardless of whether he/she meets the criteria.

Information Required

Diagnosis

Age Restrictions

No Age Restrictions

Prescriber Restrictions

No Prescriber Restrictions

Duration of Approval

365 days

Other Information we may Require:

Member must have a prior history of a gastric ulcer or be at high risk for a gastric ulcer, member must require the use of a non-steroidal anti-inflammatory drug for the treatment of rheumatoid arthritis, osteoarthritis, or ankylosing spondylitis, member must have tried and failed omeprazole and an Rx strength nonsteroidal anti-inflammatory drug (NSAID) for at least 2 weeks or have a contraindication to omeprazole.

PA_GroupNm:	Promacta
Covered Uses for this Drug	All FDA approved indications unless otherwise restricted from Part D coverage
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Platelet counts and diagnosis
Age Restrictions	18 years of age or older
Prescriber Restrictions	Hematologist or oncologist
Duration of Approval	3 months initially and then every 6 months thereafter.
Other Information we may Require:	For initial approval, diagnosis of ITP and platelet count less than $30 \times 10^9/L$. Discontinue if the platelet count does not increase to a level sufficient to avoid clinically important bleeding after 4 weeks of therapy at the maximum daily dose of 75 mg. Discontinue if ALT levels increase to greater than or equal to 3 times upper limit of normal and progressive, or persistent for greater than or equal to 4 weeks or accompanied by increased direct bilirubin or accompanied by clinical symptoms of liver injury or evidence for hepatic decompensation. Utilization of the lowest dose of eltrombopag to achieve and maintain platelet count = $50 \times 10^9/L$. Dosing adjustments to follow the prescribing information. Authorization may be extended at 6 month intervals based upon chart documentation from the provider that the member's disease has improved based upon the prescriber's assessment and documented improvement in platelet count from baseline.

PA_GroupNm:	Provigil
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D including diagnosis of chronic fatigue due to Multiple Sclerosis AND the member has had a previous trial of a amantadine.
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	6 months for the diagnosis of Shift-work sleep disorder. 365 days for other approvable indications.
Other Information we may Require:	For narcolepsy: documentation of diagnosis through sleep study and trial/failure of a CNS stimulant (i.e., methylphenidate, Dexedrine, generic Adderall) documented in pharmacy claims or through physician chart documentation. For Obstructive sleep apnea: documentation of diagnosis through sleep study and documentation/compliance report from physician that the member is using a CPAP machine on a regular basis, defined by at least 4 hours a night on at least 70% of the nights and symptoms still persist. For Shift-work sleep disorder (SWSD): must meet the International Classification of Sleep Disorders (ICSD)-10 criteria for chronic SWSD (which are consistent with the American Psychiatric Association DSM-IV criteria for Circadian Rhythm Sleep Disorder: Shift Work Type). The criteria includes either a primary complaint of excessive sleepiness or insomnia which is temporarily associated with a work period (a minimum of 5 night shifts per month) that occurs during the habitual sleep phase, OR polysomnography and the Multiple Sleep Latency Test (MSLT) demonstrate loss of a normal sleep-wake pattern and no other medical or mental disorder accounts for the symptoms and the symptoms do not meet criteria for any other sleep disorder producing insomnia or excessive sleepiness (e.g., time zone change [jet lag] syndrome). For chronic fatigue due to Multiple Sclerosis: the member has had a previous trial of a amantadine.

PA_GroupNm:	Relistor
Covered Uses for this Drug	All FDA approved indications unless otherwise restricted from Part D coverage
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis and previous agents tried and failed for constipation.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	4 months initially
Other Information we may Require:	Member must have a diagnosis of opioid-induced constipation AND member must have advanced, life-limiting illness AND trial and failure of a course of traditional laxatives for treatment of the constipation.

PA_GroupNm:	Remicade 2010
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis for initial authorization and negative PPD test. For continued authorization, chart documentation submitted from the provider showing that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	18 years of age or older for psoriasis.
Prescriber Restrictions	Confirming diagnosis by a rheumatologist or a dermatologist or gastroenterologist based upon diagnosis.
Duration of Approval	365 days
Other Information we may Require:	For the diag of rheumatoid arthritis (RA), mem must have a diagnosis of mod to sev RA and mem must have tried methotrexate (MXT) for at least 3-6 months with an inadequate response as reported by the provider unless mem has experienced sig side effects/tox of MXT or mem must have doc medical contra, by the presc provider, to MXT therapy and mem must not currently be using another Tumor Necrosis Factor (TNF) blocking agent or other biologic agent such as Enbrel, Kineret or Humira. For Chron's disease: mem must have tried one conventional therapy including corticosteroids, or 5-ASA (i.e., Sulfasalazine, Mesalamine) and mem must currently not be using a TNF-blocking agent or other biologic agent. Resp must be shown by week 14 in order to continue Remicade. For psoriatic arthritis: mem must have active psoriatic arthritis, defined as affecting at least five joints, member must have tried methotrexate for at least 3-6 months with an inadequate response as reported by prescriber, or, mem has experienced sig side effects/toxicity of methotrexate. (Approvals will be granted only upon doc medical contraindications, by the provider, to methotrexate therapy) AND member must currently not be using a TNF-blocking agent or other biologic agent. For sev ankylosing spondylitis who have had an inadequate resp to conventional treat: chart doc must be sub showing that the member has tried and failed intensive conservative treatment measures, including when indicated, a trial with one DMARD for at least 3-6 months with an inadequate response as reported by the provider and mem must currently not be using a TNF-blocking agent or other biologic agent. For ulcerative colitis: mem must have tried one adequate trial of conv therapy including corticosteroids, or at least 3 months of immunosuppressants or 5-ASA (i.e., Sulfasalazine, Mesalamine) with inadequate response and mem must currently not be using a TNF-blocking agent or other biologic agent. For psoriasis: members with a diagnosis of chronic moderate to severe plaque psoriasis (greater than 10% BSA involvement), members with plaque psoriasis of the palms, soles, head and neck, or genitalia are not required to have a minimum body surface area involvement, member must have an adequate trial of one topical treatment, phototherapy, or photochemotherapy with an inadequate response, significant side effects or toxicity, or have a contra to these therapies, mem must have an adequate trial of one conventional systemic therapy (e.g. methotrexate, cyclosporine, acitretin) with an inadequate response, sig side effects or toxicity,

or have a contra to these therapies, mem must currently not be using a TNF-blocking agent or other biologic agents in combination with Remicade, and mem must have no evidence of infection.

PA_GroupNm:

Remodulin

Covered Uses for this Drug

All FDA-approved indications not otherwise excluded from Part D

Coverage Excluded Reasons

No Exclusion Criteria

Information Required

Diagnosis and confirmed diagnosis by right heart catheterization. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.

Age Restrictions

No Age Restrictions

Prescriber Restrictions

Cardiologist or pulmonologist.

Duration of Approval

365 days

Other Information we may Require:

Member has a confirmed diagnosis of PAH with WHO functional class II-IV symptoms.

PA_GroupNm:

Revatio

Covered Uses for this Drug

All FDA-approved indications not otherwise excluded from Part D

Coverage Excluded Reasons

No Exclusion Criteria.

Information Required

Diagnosis and confirmed diagnosis by right heart catheterization. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.

Age Restrictions

No Age Restrictions

Prescriber Restrictions

Cardiologist or pulmonologist

Duration of Approval

365 days

Other Information we may Require:

Member has a confirmed diagnosis of PAH with WHO functional class I-IV symptoms AND member is NOT currently taking a nitrate product.

PA_GroupNm:	Revlimid
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria.
Information Required	Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	180 days
Other Information we may Require:	Myelodysplastic syndrome transfusion-dependent anemia due to low or intermediate-1 risk myelodysplastic syndromes associated with a deletion 5q cytogenetic abnormality with or with out other cytogenetic abnormalitie or combination therapy with dexamethasone for multiple myeloma patients who have received at least one prior therapy or combination therapy with dexamethasone for multiple myeloma patients as first-line therapy.

PA_GroupNm:	Rituxan
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	PML or history of PML
Information Required	Diagnosis. Re-treatment will be authorized upon review of chart documentation from the prescriber indicating that the member's condition has improved as a result of therapy.
Age Restrictions	Member must be 18 years of age or older.
Prescriber Restrictions	Rheumatologist or transplant specialist based on diagnosis.
Duration of Approval	1 course within 16 week period.
Other Information we may Require:	This criterion is for non-antineoplastic use only. For the treatment of cancer diagnoses, the medication will be covered under either the Part B or Part D plan in accordance with CMS regulations. Member must have a diagnosis of moderate to severe rheumatoid arthritis and member must have tried methotrexate and a Tumor Necrosis Factor (TNF) blocking agent for at least 3-6 months each with an inadequate response as reported by the prescribing provider unless member has experienced significant side effects and toxicity of TNF blocking and MTX agents or member must have documented medical contraindications, by the prescribing provider, to TNF blocking agents and member must currently be on methotrexate therapy unless documented contraindication and must currently not be using a TNF-blocking agent or other biologic agent, such as Kineret, Enbrel, or Humira. For desensitization in kidney or pancreatic transplant candidates, member must be awaiting kidney or pancreas transplant requiring desensitization as defined by for deceased donor transplants as panel reactive antibody (PRA) level greater than 30 percent or PRA less than 30 percent with a previous kidney or pancreas transplant. For living donor transplants, a positive crossmatch is required or positive donor specific antibody using Luminex assay. Additional authorization for another course of treatment for desensitization in renal or pancreatic transplant candidates will be considered in 6 months if the member has not yet received a renal or pancreatic transplant. Authorization will not be granted until 6 months have passed since the initial treatment.

PA_GroupNm:	Sabril
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	18 or older for refractory complex partial sz and 1 month to 2 years of age for infantile spasms
Prescriber Restrictions	Neurologist or pediatric neurologist.
Duration of Approval	3 mth thn annlly for ref sz. 1 mth then every 3 mths for infantile spasms.
Other Information we may Require:	For refractory complex partial seizures, must have inadequate response to at least 2 combination anticonvulsant regimens. At least one of the regimens must contain phenytoin or carbamazepine, must concurrently be on Sabril with at least one other anticonvulsant medication and must undergo vision testing prior to beginning treatment. For continuation, documentation from the prescriber that the member's disease has improved based upon the prescriber's assessment while on therapy and documentation from the prescriber that the member is undergoing vision testing at least every 3 months during treatment with Sabril. For infantile spasms, must undergo vision testing prior to beginning treatment. For continuation, documentation from the prescriber that the member's disease has improved based upon the prescriber's assessment while on therapy, documentation from the prescriber that the member is undergoing vision testing at least every 3 months during treatment with Sabril and authorizations for infantile spasms will not be extended beyond the age of 2 years.

PA_GroupNm:	Samsca
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria.
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Endocrinologist or Nephrologist
Duration of Approval	Every 3 months
Other Information we may Require:	Member must have a diagnosis of hypervolemic or euvolemic hyponatremia and either serum sodium less than 125 mEq/L or symptomatic hyponatremia with failure to fluid restriction, Samsca must be initiated and titrated in a hospital setting with close serum sodium monitoring, the member must not be anuric and the member must be able to sense and respond appropriately to thirst. For continuation, chart documentation from the prescriber is required showing the rationale for continuation of therapy and indicating that the member's condition has improved as a result of therapy.

PA_GroupNm:	Savella
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	For fibromyalgia: chart documentation showing the diagnosis of fibromyalgia with a history of widespread pain involving the extremities for three months and localized area of tenderness and trial and failure of two agents unless documented intolerance or contraindication to the agents: gabapentin at a dose of at least 1200 mg daily which is documented in pharmacy claims or through physician chart documentation and tricyclic antidepressants (i.e., amitriptyline) OR muscle relaxants (i.e., cyclobenzaprine) and physician chart documentation showing trial of exercise or physical therapy.

PA_GroupNm:	Serostim
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	Up to 48 weeks per year.
Other Information we may Require:	Member has failed at least 2 treatments with other medications used for AIDS wasting (i.e., Marinol, Megace, and Oxandrin) unless contraindications exist AND member must be compliant with his/her antiretroviral medication and follows Serostim treatment guidelines. Member will be approved for up to 48 weeks per year. Therapy continuation will be authorized with documentation from the prescriber of weight stabilization or weight gain.

PA_GroupNm:	Simponi
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Negative Tuberculin PPD test for initial authorization. For continued authorization, chart documentation must be submitted from the provider that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Confirming diagnosis by a rheumatologist or dermatologist based on diagnosis.
Duration of Approval	365 days
Other Information we may Require:	Must have a diagnosis of moderate to severely active rheumatoid arthritis and must have an adequate trial of at least 3 months of methotrexate with an inadequate response and must be on concurrent methotrexate therapy and must currently not be using a TNF-blocking agent or other biologic agents in combination with Simponi and have no evidence of infection OR must have a diagnosis of active ankylosing spondylitis and if dominant axial disease, member must have an adequate trial of at least 3 months with at least 2 NSAIDs at anti-inflammatory target dose, with an inadequate response, sig side effects or toxicity, or have a contraindication to these therapies. If dominant peripheral disease, member must have an adequate trial of at least 3 months with at least one NSAID at anti-inflammatory target dose, with an inadequate response, significant side effects or toxicity, or have a contraindication to these therapies AND member must have an adequate trial of one DMARD conventional systemic therapy with an inadequate response, sig side effects or toxicity, or have a contraindication to this therapy and must currently not be using a TNF-blocking agent or other biologic agents in combination with Simponi and have no evidence of infection OR must have a diagnosis of active ankylosing spondylitis and if dominant axial disease, member must have an adequate trial of at least 3 months with at least 2 NSAIDs at anti-inflammatory target dose, with an inadequate response, significant side effects and toxicity, or have a contraindication to these therapies. If dominant peripheral disease, member must have an adequate trial of at least 3 months with at least one NSAID at anti-inflammatory target dose, with an inadequate response, significant side effects and toxicity, or have a contraindication to these therapies AND member must have an adequate trial of one DMARD conventional systemic therapy with an inadequate response, significant side effects /toxicity, or have a contraindication to this therapy and member must currently not be using a TNF-blocking agent or other biologic agents in combination with Simponi and have no evidence of infection.

PA_GroupNm:

Sporanox

Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	90 days/year for onychomycosis. For other diagnoses, dependent upon recommended duration of therapy
Other Information we may Require:	Sporanox will be approved for onychomycosis in a diabetic, transplant, or immunocompromised member, or, onychomycosis causing severe debilitating foot pain (supported by chart documentation), or fungal infections on trunk of body such as tinea that are too large to treat with topical cream, or, diagnosis of oral thrush that has not responded to oral nystatin, or diagnosis of esophageal candidiasis.

PA_GroupNm:

Sprycel

Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria.
Information Required	Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	180 days
Other Information we may Require:	Adults with chronic, accelerated, or myeloid or lymphoid blast phase Chronic Myeloid Leukemia (CML) resistant or intolerant to prior therapy including imatinib (Gleevec) or Ph+ chromosome-positive ALL resistant or intolerant to prior therapy.

PA_GroupNm:	Stelara
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No exclusion criteria
Information Required	Diagnosis
Age Restrictions	Member must be 18 years of age or older
Prescriber Restrictions	Dermatologist
Duration of Approval	365 days
Other Information we may Require:	Member must have a negative Tuberculin PPD (purified protein derivative) test, and have a diagnosis of moderate to severe plaque psoriasis that involves a minimum body surface area involvement of greater than or equal to 10% (mbrs w plaque psoriasis of palms, soles, head and neck or genitalia are not required to have a minimum body surface area involvement). Mbr must have an adequate trial of topical treatment, phototherapy, or pheotochemoherapy with an inadequate response, significant side effects or toxicity, or have a contraindication to these therapies. Member must have an adequate trial of at least 3 months of a conventional systemic therapy (mtx,cyclosporine, or acitretin) w an inadequate response, significant side effects or toxicity, or have a contraindication to these therapies, and no evidence of infection, and not currently be using a TNF-blocking agent, other biologic agent, immunosuppressant, or phototherapy in combination with Stelara. Requests for increased dosing frequency will be approved if a partial response was observed after a 24 week trial at the recommended every 12 week dosing frequency. All prior authorization renewals will be reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. Authorization may be extended at one-year intervals based upon documentation from the provider that the member’s disease has improved based upon the prescriber’s assessment while on therapy and no evidence of infection.

PA_GroupNm:	Suboxone and Subutex
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria.
Information Required	Diagnosis. For continuation therapy, recent drug-free urine testing required.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Prescriber must have DATA 2000 waiver and Unique Identification Number and DEA number.
Duration of Approval	90 days initially then annually.
Other Information we may Require:	Covered initially for 90 days. For continuation, member must be compliant with therapy for the previous 3 months, member must have a recent drug-free urine testing, member be enrolled and consistently participating in formal behavioral health counseling and member must not have attempted to fill any opioid prescriptions during this initial period as indicated by their drug claim history.

PA_GroupNm:	Sucraid 2010
Covered Uses for this Drug	All FDA approved indications unless otherwise restricted from Part D coverage
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	5 months or older.
Prescriber Restrictions	Gastroenterologist, Endocrinologist, or Genetic Specialists
Duration of Approval	1 month initially then annually.
Other Information we may Require:	Must have a diagnosis of congenital sucrase-isomaltase deficiency characterized by stool pH less than 6, an increase in breath hydrogen of greater than 10ppm when challenged w sucrose after fasting, and negative lactose breath test OR diagnosis of congenital sucrase-isomaltase deficiency characterized by low sucrase activity on duodenal biopsy and other disaccharidases normal on same duodenal biopsy.

PA_GroupNm:	Sutent
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	180 days.
Other Information we may Require:	Gastrointestinal (GI) stromal tumors refractory to imatinib (Gleevec) or in patients intolerant to imatinib (Gleevec) or advanced renal cell carcinoma.

PA_GroupNm:	Synagis
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis.
Age Restrictions	Under 24 months at the start of RSV season.
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	Maximum of 6 doses per RSV season.
Other Information we may Require:	Synagis will be covered for children under the age of 24 months at the beginning of Respiratory Syncytial Virus (RSV) season with Chronic Lung Disease (CLD) who have required medical treatment such as oxygen, bronchodilator, diuretic or corticosteroid therapy, for CLD within 6 months before the start of RSV season or children under the age of 24 months at the beginning of RSV season with Congenital Heart Disease, Congestive Heart Failure (CHF), severe pulmonary hypertension, cyanotic heart disease) or premature infants recommendations are based upon gestational age a) less than 28 weeks, 0 days gestational age and 12 months of age or less at the start of RSV season OR b) 28 weeks, 1 day –32 weeks, 0 days gestational age and 6 months of age or less at the start of RSV season OR c) 32 weeks, 1 day –35 weeks, 0 days gestational age and 6 months of age or less at the start of RSV season with TWO or more of the following risk factors: day care attendance, exposure to tobacco smoke/environmental pollutants at home, school aged siblings, diagnosis of neuromuscular disease, or diagnosis of congenital abnormality of airways.

PA_GroupNm:	Tarceva
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria.
Information Required	Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member’s disease has improved based upon the prescriber’s assessment while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	180 days.
Other Information we may Require:	Locally advanced or metastatic non-small cell lung cancer after failure of at least one prior chemotherapy regimen or first-line treatment in combination with gemcitabine (Gemzar) in patients with locally advanced, unresectable or metastatic pancreatic cancer.

PA_GroupNm:	Targretin
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria.
Information Required	Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	180 days
Other Information we may Require:	Cutaneous manifestations of T-cell lymphoma in patients who are refractory to at least one prior systemic therapy.

PA_GroupNm:	Tasigna
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria.
Information Required	Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	180 days
Other Information we may Require:	Adult Ph+ CML in chronic phase or accelerated phase resistant to or intolerant to prior therapy including imatinib (Gleevec).

PA_GroupNm:	Tracleer
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria.
Information Required	Diagnosis and confirmed diagnosis by right heart catheterization. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	Cardiologist or pulmonologist.
Duration of Approval	365 days
Other Information we may Require:	Member has a confirmed diagnosis of PAH with WHO functional class II, III or IV symptoms AND member is NOT currently taking glyburide or cyclosporine AND member has had baseline liver function tests (ALT, AST) prior to initiation of therapy AND if a member is a woman of childbearing potential, she has had a baseline negative pregnancy test prior to initiation of therapy.

PA_GroupNm:	Tykerb
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria.
Information Required	Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member’s disease has improved based upon the prescriber’s assessment while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	180 days
Other Information we may Require:	Combination therapy with capecitabine (Xeloda) for treatment of advanced or metastatic breast cancer whose tumors overexpress (HER2) AND who have had prior therapy with: anthracycline, taxane, or trastuzumab (Herceptin).

PA_GroupNm:	Tysabri
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	Member must not have or have had progressive multifocal leukoencephalopathy (PML).
Information Required	Diagnosis.
Age Restrictions	Must be greater than 18 years of age.
Prescriber Restrictions	Must be prescribed by a neurologist or gastroenterologist dependent upon the diagnosis who is registered with the TOUCH Prescribing program.
Duration of Approval	90 days initially for Crohn's disease and 365 days for MS.
Other Information we may Require:	For MS, member must have a diagnosis of relapsing forms of multiple sclerosis, member must have previously had an inadequate response or cannot tolerate other multiple sclerosis therapies, including interferon beta-1a, interferon beta-1b, and glatiramer acetate, member must not have or have had progressive multifocal leukoencephalopathy (PML), member should not be receiving chronic immunosuppressant or immunomodulatory therapy (including interferon beta-1a, interferon beta-1b, and glatiramer acetate since natalizumab is indicated as monotherapy) or have systemic medical conditions resulting in significant compromised immune system function. For Chron's disease, member must have a diagnosis of moderately to severely active Crohn’s disease with evidence of inflammation, member must have previously had an inadequate response or cannot tolerate conventional therapies such as aminosalicylates (i.e., sulfasalazine, mesalamine), corticosteroids or immunomodulators (i.e., azathioprine, 6-mercaptopurine) AND TNF-alpha inhibitors, member must not have or have had progressive multifocal leukoencephalopathy (PML), member should not be receiving chronic immunosuppressant or immunomodulatory therapy (including 6-mercaptopurine, azathioprine, cyclosporine, methotrexate, or inhibitors of TNF-alpha) or have systemic medical conditions resulting in significant compromised immune system function.

PA_GroupNm:	Vimpat
Covered Uses for this Drug	All FDA approved indications unless otherwise restricted from Part D coverage
Coverage Excluded Reasons	No Exclusion Criteria.
Information Required	Diagnosis of partial-onset seizures.
Age Restrictions	17 years of age or older.
Prescriber Restrictions	Neurologist or in consultation with a neurologist.
Duration of Approval	365 days
Other Information we may Require:	Vimpat (lacosamide) must be prescribed by or in consultation with a neurologist AND member must be 17 years of age or older AND member must have a diagnosis of partial-onset seizures AND member must be using Vimpat (lacosamide) as adjunctive therapy to other anti-epileptic drugs (AEDs).

PA_GroupNm:	Votrient
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria.
Information Required	Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	180 days
Other Information we may Require:	Must have a diagnosis of advanced renal cell carcinoma.

PA_GroupNm:	Xenazine
Covered Uses for this Drug	All FDA approved indications unless otherwise restricted from Part D coverage
Coverage Excluded Reasons	Member must not be actively suicidal or have uncontrolled depression or currently using a monoamine oxidase inhibitor or reserpine.
Information Required	Diagnosis
Age Restrictions	18 years of age or older
Prescriber Restrictions	Neurologist
Duration of Approval	365 days
Other Information we may Require:	Member must have a diagnosis of chorea associated with Huntington’s Disease. Authorizations may be extended at one-year intervals based upon chart documentation from the prescriber that the member’s disease has improved based upon the prescriber’s assessment while on therapy and documentation that the member is being monitored for depression and suicidal ideation. Requests for doses above 50mg/day will also require documentation from the prescriber showing inadequate efficacy of lower doses and slow titration of tetrabenazine dose with close monitoring of side effects.

PA_GroupNm:	Xolair
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis, IgE level, positive skin or RAST test to a perennial aeroallergen for initial authorization. For continued authorization, chart documentation from the provider must be submitted to indicate that that the member’s disease has improved based upo
Age Restrictions	12 years of age or older
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	Xolair will approved for adults and adolescents (12 years of age and older) with moderate to severe persistent asthma on concomitant asthma therapy within the past year, and have a positive skin or RAST test to a perennial aeroallergen. An IgE (greater than 30 IU/ml or more) level must be provided.

PA_GroupNm:	Xyrem
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis and sleep studies for initial authorization. For continued authorization, chart documentation from the provider must be submitted to indicate that the member's disease has improved based upon the provider's assessment while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	Xyrem will be covered for a diagnosis of cataplexy associated with narcolepsy demonstrated by supporting chart documentation or sleep studies OR a diagnosis of excessive daytime sleepiness (EDS) associated with narcolepsy demonstrated by polysomnographic evaluation or chart documentation supporting clinical history of narcolepsy.

PA_GroupNm:	Xyzal
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	For the diagnosis of allergic rhinitis, the member must have had an inadequate response as documented in pharmacy claims or physician chart documentation of 1 of the following non-sedating antihistamines: loratadine, fexofenadine, cetirizine AND an intranasal corticosteroid. For the diagnosis of urticaria, the member must have tried at least 2 of the following medications with an inadequate response as documented in pharmacy claims or physician chart documentation: loratadine, fexofenadine, and cetirizine.

PA_GroupNm:	Zavesca
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	365 days
Other Information we may Require:	Zavesca will be approved for a diagnosis of mild to moderate non-neuronopathic Gaucher's disease when enzyme replacement is not an option.

PA_GroupNm:	Zolinza
Covered Uses for this Drug	All FDA-approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	Diagnosis. For continued authorization, chart documentation from the provider must be submitted to show that the member's disease has improved based upon the prescriber's assessment while on therapy.
Age Restrictions	No Age Restrictions
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	180 days
Other Information we may Require:	Cutaneous T-cell lymphoma (CTCL) in patients who have progressive, persistent or recurrent disease on or following 2 systemic therapies.

PA_GroupNm:	Zorbitive
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	Members with active malignancy.
Information Required	Diagnosis
Age Restrictions	Must be at least 18 year of age.
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	4 weeks.
Other Information we may Require:	Member must be at least 18 years of age. However, members under the age of 18 with a confirmed diagnosis of short bowel syndrome will be considered on a case-by-case basis in consultation with the Medical Director. Chart documentation must be submitted indicating that the member has a diagnosis of short bowel syndrome, defined as follows: member must have documented malabsorption from the small intestine that is marked by diarrhea, malnutrition, and steatorrhea and that results from resection of the small intestine and member must have a small intestine less than 200 cm in length and member must have an intact stomach and duodenum as well as greater than or equal to 30% of functioning colon with at least 15 cm of intact jejunum and/or ileum or member must have an intact stomach and duodenum as well as less than 30% functioning colon with at least 90 cm intact jejunum and/or ileum. Member should also be receiving adequate nutritional support as determined by their Provider.

PA_GroupNm:	Zostavax
Covered Uses for this Drug	All FDA approved indications not otherwise excluded from Part D
Coverage Excluded Reasons	No Exclusion Criteria
Information Required	None
Age Restrictions	Must be 60 years of age or older.
Prescriber Restrictions	No Prescriber Restrictions
Duration of Approval	1 dose per 365 days
Other Information we may Require:	Not Applicable