

Prior Authorization Group Description	Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ACTIQ	FENTANYL CITRATE	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		CANCER PAIN			3 MONTHS	TREATMENT FOR THE MANAGEMENT OF BREAK-THROUGH CANCER PAIN IN MEMBERS WITH MALIGNANCIES WHO ARE ALREADY RECEIVING AND WHO ARE TOLERANT TO OPIOID THERAPY FOR THEIR UNDERLYING CANCER PAIN. LIMIT OF 4 DOSES PER DAY. REQUESTS MUST BE ACCOMPANIED BY DOCUMENTATION OF AN APPROPRIATE EVALUATION AND MANAGEMENT PLAN IN THE MEDICAL RECORD. CONSULTATION WITH PAIN MANAGEMENT MAY BE REQUIRED.
ADDERALL	ADDERALL XR AMPHETAMINE SALT COMBO	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		ADHD AND NARCOLEPSY DIAGNOSIS	USE LIMITED TO MEMBERS BETWEEN 3 AND 16 YEARS OF AGE.		6 MONTHS	
AMPHOTEC	AMPHOTEC	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					1 MONTH	
ARAVA	LEFLUNOMIDE	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
ARICEPT	ARICEPT ARICEPT ODT	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		MMSE SCORE			12 MONTHS	
ATYPICALS	ABILIFY ABILIFY DISCMELT FANAPT GEODON INVEGA SEROQUEL SEROQUEL XR ZYPREXA ZYPREXA ZYDIS	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D					12 MONTHS	TRIAL AND FAILURE OR CONTRA-INDICATIONS TO USE OF RISPERIDONE WHEN USED FOR TREATMENT OF SCHIZOPHRENIA AND BIPOLAR DISORDERS.
AVONEX	AVONEX AVONEX ADMINISTRATION PACK	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		ANNUAL SPECIALIST PROGRESS UPDATE			12 MONTHS	
BARACLUDE	BARACLUDE	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		ANNUAL SPECIALIST PROGRESS UPDATE			6 MONTHS	
BETASERON	BETASERON EXTAVIA	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		ANNUAL SPECIALIST PROGRESS UPDATE			12 MONTHS	
BUPRENEX/BUPRENORPHINE	BUPRENORPHINE HCL SUBOXONE SUBUTEX	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					3 MONTHS	

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BVD	ACYCLOVIR SODIUM ADRIAMYCIN AMINOSYN AMINOSYN II AMINOSYN II 3.5% M-DEXTROSE 5% AMINOSYN II 3.5%-DEXTROSE 25% AMINOSYN II 3.5%-DEXTROSE 5% AMINOSYN II 4.25% M-DEXT 10% AMINOSYN II 4.25%-DEXTROSE 25% AMINOSYN II 5% IN 25% DEXTROSE AMINOSYN II IN DEXTROSE AMINOSYN II W/ELEC IN DEX W/CA AMINOSYN M AMINOSYN W/ELECTROLYTES AMINOSYN-HBC AMINOSYN-HF AMINOSYN-PF AMPHOTERICIN B ATTENUVAX VACCINE WITH DILUENT AZASAN AZATHIOPRINE AZATHIOPRINE SODIUM BLEOMYCIN SULFATE CARIMUNE NF NANOFILTERED CLADRIBINE CLINIMIX CLINIMIX E CLINISOL CYCLOSPORINE CYTARABINE CYTOVENE DEXTROSE 10%-1/4NS DEXTROSE IN LACTATED RINGERS DEXTROSE IN WATER DEXTROSE WITH SODIUM CHLORIDE DOXIL DOXORUBICIN HCL ENGERIX-B FLEBOGAMMA DIF FLUOROURACIL FOSCARNET SODIUM FREAMINE HBC FREAMINE III FREAMINE III WITH ELECTROLYTES GAMASTAN S-D GAMMAGARD LIQUID GAMUNEX HAVRIX HEPATAMINE HEPATASOL HERCEPTIN IFOSFAMIDE-MESNA IMOVAX RABIES VACCINE INTRALIPID LIPOSYN II LIPOSYN III MYFORTIC NAGLAZYME NEPHRAMINE NOVAMINE OCTAGAM POLYGAM S-D PREMASOL PRIVIGEN PROCALAMINE PROSOL QUICK MIX WITH LYTRES RABAVERT RECOMBIVAX HB REMODULIN RENAMIN TETANUS TOXOID ADSORBED TRAVASOL TRAVASOL W/ELECTROLYTES TRAVASOL WITH DEXTROSE TRAVASOL WITH ELECTROLYTES TROPHAMINE TWINRIX VAQTA VINCRISTINE SULFATE VINORELBINE TARTRATE VIVAGLOBIN	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
BYETTA	BYETTA	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		HA1C			12 MONTHS	
CELEBREX	CELEBREX	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					6 MONTHS	
CELLCEPT	CELLCEPT MYCOPHENOLATE MOFETIL	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
COPAXONE	COPAXONE	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
COZAAR-HCT	COZAAR HYZAAR LOSARTAN POTASSIUM LOSARTAN-HYDROCHLOROTHIAZIDE	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
CYCLOSPORINE	CYCLOSPORINE CYCLOSPORINE MODIFIED GENGRAF	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
CYMBALTA	CYMBALTA	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
DARBEOETIN	ARANESP	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					4 MONTHS	
DARVOCET-N	DARVON-N PROPOXYPHENE NAP-ACETAMINOPHEN	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					4 MONTHS	
DAYTRANA	DAYTRANA	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	

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DDAVP	DESMOPRESSIN ACETATE	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					6 MONTHS	
DESVENLAFAXINE	PRISTIQ	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
DEXEDRINE	DEXTROAMPHETAMINE SULFATE	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			PATIENTS 16 YEARS AND GREATER MUST SHOW TRIAL AND FAILURE OF ATOMOXETINE		6 MONTHS	
DIOVAN	DIOVAN	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
DURAGESIC PATCH	FENTANYL	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					6 MONTHS	TREATMENT OF SEVERE PAIN FOR MEMBERS WITH CANCER OR THOSE MEMBERS WITH A DEMONSTRATED NEED FOR A NON-ORAL ROUTE OF ADMINISTRATION. OTHER CONDITIONS REQUIRE PRESCRIBING BY A PAIN MANAGEMENT SPECIALIST. REQUESTS MUST BE ACCOMPANIED BY DOCUMENTATION OF AN APPROPRIATE EVALUATION AND MANAGEMENT PLAN IN THE MEDICAL RECORD. CONSULTATION WITH PAIN MANAGEMENT MAY BE REQUIRED.
EMEND	EMEND	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		NAUSEA AND VOMITING ASSOCIATED WITH EMETOGENIC CANCER CHEMOTHERAPY, PREVENTION OF POST OPERATIVE NAUSEA AND VOMITING.			3 MONTHS	
EMSAM	EMSAM	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
ENBREL	ENBREL	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
EPOGEN	EPOGEN PROCRT	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		HGB/HCT RESULTS			4 MONTHS	
EXELON	EXELON	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		MMSE SCORE			12 MONTHS	
FORTEO	FORTEO	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
GEODON	GEODON	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
GRANISETRON	GRANISETRON HCL	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					RENEWABLE EVERY 6 MONTHS	
GROWTH HORMONE	GENOTROPIN HUMATROPE NORDITROPIN NORDIFLEX NUTROPIN NUTROPIN AQ OMNITROPE SAIZEN SEROSTIM TEV-TROPIN ZORBTIVE	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIMINISHED PEAK SERUM GH RESPONSE			12 MONTHS	
HUMIRA	HUMIRA	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
INCRELEX	INCRELEX	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			FOR PATIENTS LESS THAN 18 YEARS OLD		12 MONTHS	
INSPIRA	EPLERENONE	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
KINERET	KINERET	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			LIMITED TO 18 YEARS AND OLDER		12 MONTHS	
LAMISIL	TERBINAFINE HCL	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		LAB CONFIRMATION OF DIAGNOSIS, BASELINE LFT			3 MONTHS	
LEXAPRO	LEXAPRO	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
LIDODERM PATCH	LIDODERM	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DX OF POST HERPETIC NEURALGIA		PRESCRIPTION OR RECOMMENDATION FROM PAIN SPECIALIST/CLINIC	12 MONTHS	
LOTRONEX	LOTRONEX	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
LUNESTA	LUNESTA	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					6 MONTHS	

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LYRICA	LYRICA	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
MARINOL	DRONABINOL	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					3 MONTHS	
METHYLPHENIDATE	METADATE ER METHYLIN METHYLIN ER METHYLPHENIDATE HCL METHYLPHENIDATE SR RITALIN-SR	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			USE LIMITED TO MEMBERS BETWEEN 6 AND 16 YEARS OF AGE. 16 YEARS AND OLDER MUST SHOW TRIAL AND FAILURE WITH ATOMOXETINE		6 MONTHS	
METHYLTESTOTERONE	METHITEST	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
NAMENDA	NAMENDA	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		MMSE SCORES			12 MONTHS	
NEUPOGEN	NEULASTA NEUPOGEN	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		HX OF NEUTROPENIA, HIGH RISK OF FEBRILE NEUTROPENIA AS DEFINED BY NCCN PRACTICE GUIDLEINES IN ONCOLOGY V.2007			4 MONTHS	
NICOTINE, SPRAY/CART RIGE	NICOTROL NICOTROL NS	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					3 MONTHS	
OMEGA-3 ACID ETHYL ESTERS	LOVAZA	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
ORFADIN	ORFADIN	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
ORTHOCLONE	ORTHOCLONE OKT-3	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
OXANDRIN	OXANDROLONE	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
OXYCONTIN	OXYCODONE HCL	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					6 MONTHS	TREATMENT OF MODERATE-TO-SEVERE CHRONIC PAIN FOR MEMBERS WHO HAVE A DEMONSTRATED INEFFECTIVENESS TO MAXIMUM DOSES OF LA MORPHINE AND METHADONE OR FOR MEMBERS WHO HAVE A DEMONSTRATED INTOLERANCE (DEFINED AS HALLUCINATIONS, DELIRIUM, NAUSEA/VOMITING OR EXCESSIVE SEDATION) TO LA MORPHINE OR METHADONE. REQUESTS MUST BE ACCOMPANIED BY DOCUMENTATION OF AN APPROPRIATE EVALUATION AND MANAGEMENT PLAN IN THE MEDICAL RECORD. CONSULTATION WITH PAIN MANAGEMENT MAY BE REQUIRED.
PEGASYS	PEGASYS	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		VIRAL LOAD (HCV/RNA), EARLY VIRAL RESPONSE (EVR) BASELINE LABS			4 MONTHS	
PEG-INTRON	PEGINTRON	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		VIRAL LOAD (HCV/RNA), EARLY VIRAL RESPONSE (EVR) BASELINE LABS			4 MONTHS	
PENLAC NAIL LACQUER	CICLOPIROX	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					6 MONTHS	
PRENATAL VITAMINS	PRENATAL PLUS	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
PREVACID	LANSOPRAZOLE PREVACID	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
PRILOSEC RX	OMEPRAZOLE ZEGERID	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
PROGRAF	PROGRAF TACROLIMUS	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
PROTONIX	PANTOPRAZOLE SODIUM PROTONIX	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
PROTOPIC	PROTOPIC	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
PROVIGIL	PROVIGIL	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					6 MONTHS	

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RAPAMUNE	RAPAMUNE	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
REBETROL	REBETOL RIBAPAK RIBASPHERE RIBAVIRIN	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		BASELINE LABS/REPORTS. VIRAL LOAD (HCV/RNA) AND EARLY VIRAL RESPONSE (EVR)			4 MONTHS	
REBETRON	RIBASPHERE RIBAVIRIN	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		VIRAL LOAD (HCV/RNA), EARLY VIRAL RESPONSE (EVR) BASELINE LABS			4 MONTHS	
REGRANEX	REGRANEX	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					4 MONTHS	
REMICADE	REMICADE	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
RESTASIS	RESTASIS	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					6 MONTHS	
REVATIO	REVATIO	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
RISPERDAL	RISPERDAL CONSTA	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
ROZEREM	ROZEREM	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					3 MONTHS	
SARGRAMOSTIN	LEUKINE	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
SENSIPAR	SENSIPAR	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		CALCIUM AND PHOSPHATE LEVELS			RENEWABLE EVERY 6 MONTHS	
SYMLIN	SYMLIN SYMLINPEN 120 SYMLINPEN 60	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
SYNAGIS	SYNAGIS	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			SEE OTHER CRITERIA SECTION FOR AGE LIMITS		6 MONTHS	
TEKTRUNA	TEKTRUNA	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
TESTOSTERONE	ANADROL-50 TESTOSTERONE TESTOSTERONE CYPIONATE	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		LAB RESULT FOR TESTOSTERONE LEVEL DRAWN BEFORE 9AM	LIMITED TO MALE PATIENT 12 YEARS OF AGE OR OLDER		6 MONTHS	
TNF INHIBITORS	CIMZIA	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
TRACLEER	TRACLEER	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
TYZEKA	TYZEKA	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					6 MONTHS	
VANCOMYCIN ORAL	VANCOCIN HCL	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					1 MONTH	
XOLAIR	XOLAIR	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		POSITIVE SKIN PRICK OR RAST	MEMBERS 12 YEARS OF AGE AND OLDER WITH MODERATE TO SEVERE ALLERGY OR RELATED ASTHMA INADEQUATELY CONTROLLED		6 MONTHS	
XOPENEX	XOPENEX HFA	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					6 MONTHS	
ZAVESCA	ZAVESCA	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
ZOFRAN	ONDANSETRON HCL	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					3 MONTHS	
ZYBAN	ZYBAN	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					3 MONTHS	
ZYVOX	ZYVOX	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					1 MONTH	