L. A. Care Health Plan Medicare Advantage HMO
Drugs Requiring Prior Authorization Effective 07/01/2014
Updated 06/2014

Medicare Part D

Prior Authorization Group Description	Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
5HT3 ANTI-NAUSEA AGENT BVD DETERMINATION	GRANISETRON HCL | GRANISOL | ONDANSETRON HCL | ONDANSETRON ODT	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
ABATACEPT	ORENCIA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		RENEWAL: RHEUMATOID ARTHRITIS/JUVENILE IDIOPATHIC ARTHRITIS: EXPERIENCED OR MAINTAINED 20% OR GREATER IMPROVEMENT IN TENDER AND SWOLLEN JOINT COUNT.		PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST.	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS	INITIAL: FOR RHEUMATOID ARTHRITIS : TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE) AND TRIAL OF HUMIRA OR CIMZIA. FOR JUVENILE IDIOPATHIC ARTHRITIS: TRIAL OF AT LEAST ONE OF THE FOLLOWING: TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE) AND HUMIRA.
ABATACEPT SQ	ORENCIA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		RENEWAL: RHEUMATOID ARTHRITIS: EXPERIENCED OR MAINTAINED 20% OR GREATER IMPROVEMENT IN TENDER AND SWOLLEN JOINT COUNT.	18 YEARS OR OLDER.	PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST.	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS	INITIAL: RHEUMATOID ARTHRITIS: TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE) AND TRIAL OF HUMIRA OR CIMZIA.
ABIRATERONE	ZYTIGA	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
ADALIMUMAB	HUMIRA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECT THE HANDS, FEET, OR GENITAL AREA. RENEWAL: RHEUMATOID ARTHRITIS/JUVENILE IDOPATHIC ARTHRITIS/PSORIATIC ARTHRITIS: EXPERIENCED OR MAINTAINED 20 PERCENT IMPROVEMENT IN TENDER OR SWOLLEN JOINT COUNT WHILE ON THERAPY. ANKYLOSING SPONDYLITIS: EXPERIENCED OR MAINTAINED IMPROVEMENT OF AT LEAST 50 PERCENT OR 2 UNITS IN THE BATH ANKYLOSING SPONDYLITIS DISEASE ACTIVITY INDEX (BASDAI). PLAQUE PSORIASIS: ACHIEVED OR MAINTAINED CLEAR OR MINIMAL DISEASE OR A DECREASE IN PSORIASIS AREA AND SEVERITY INDEX (PASI) OF AT LEAST 50% OR MORE.		PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST, DERMATOLOGIST, GASTROENTEROLOGIST .	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.	INITIAL: RHEUMATOID ARTHRITIS/JUVENILE IDIOPATHIC ARTHRITIS: TRIAL/FAILURE OF A DMARD (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE). PSORIATIC ARTHRITIS: TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE). PLAQUE PSORIASIS: TRIAL/FAILURE OF ONE OR MORE FORMS OF PREFERRED THERAPY (PUVA, UVB, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE). CROHN'S DISEASE: TRIAL/FAILURE OF ONE OR MORE CONVENTIONAL THERAPIES SUCH AS CORTICOSTEROIDS (BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. ULCERATIVE COLITIS: TRIAL/FAILURE OF AT LEAST ONE OF THE FOLLOWING SULFASALAZINE, CORTICOSTEROIDS, METHOTREXATE, AZATHIOPRINE, OLSALAZINE, MESALAMINE, CYCLOSPORINE, OR MERCAPTOPURINE. RENEWAL: RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS/ ANKYLOSING SPONDYLITIS: FOR HUMIRA 40 MG EVERY WEEK: TRY/FAIL AT LEAST A 3 MONTH TRIAL OF HUMIRA 40MG EVERY OTHER WEEK AND CURRENTLY
ADO-TRASTUZUMAB EMTANSINE	KADCYLA	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
AFATINIB DIMALEATE	GILOTRIF	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
AFLIBERCEPT	ZALTRAP	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
ANAKINRA	KINERET	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		RENEWAL: RHEUMATOID ARTHRITIS: EXPERIENCED OR MAINTAINED 20% OR GREATER IMPROVEMENT IN TENDER AND SWOLLEN JOINT COUNT.	RA: 18 YEARS OR OLDER	PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST.	RA: INITIAL: 3 MONTHS RENEWAL: 12 MONTHS. NOMID: 12 MONTHS.	INITIAL: RHEUMATOID ARTHRITIS: TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE) AND HUMIRA OR CIMZIA.
APREMILAST	OTEZLA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			18 YEARS OF AGE OR OLDER.	PRESCRIBED BY OR IN CONSULATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.	STARTER PACK: 14 DAYS. TABLETS (NON-STARTER PACK): 12 MONTHS	TRIAL OF OR CONTRAINDICATION TO HUMIRA (ADALIMUMAB) AND CIMZIA (CERTOLIZUMAB PEGOL).
APREPITANT BVD DETERMINATION	EMEND	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
AROMATASE INHIBITORS	ANASTROZOLE | EXEMESTANE | LETROZOLE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
ASPARAGINASE	ERWINAZE	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					3 MONTHS	HYPERSENSITIVITY TO E.COLI-DERIVED ASPARAGINASE (ELSPAR OR ONCASPAR).

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AXITINIB	INLYTA	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	TRIAL OF AT LEAST ONE SYSTEMIC THERAPY FOR THE TREATMENT OF RCC SUCH AS NEXAVAR (SORAFENIB), TORISEL (TEMSIROLIMUS), SUTENT (SUNITINIB), VOTRIENT (PAZOPANIB), OR AVASTIN (BEVACIZUMAB) IN COMBINATION WITH INTERFERON.
BACILLUS OF CALMETTE AND GUERIN VACCINE BVD DETERMINATION	BCG VACCINE (TICE STRAIN)	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.						
BEDAQUILINE FUMARATE	SIRTURO	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					24 WEEKS	
BELIMUMAB	BENLYSTA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		AUTOANTIBODY POSITIVE LUPUS TEST.			12 MONTHS	INITIAL: SELENA-SELDAI SCORE GREATER THAN OR EQUAL TO 6. RENEWAL: MAINTAIN AT LEAST A 4 POINT REDUCTION IN SELENA-SELDAI SCORE FROM BASELINE. MEMBER IS CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. NO APPROVAL FOR DIAGNOSIS OF SEVERE ACTIVE LUPUS NEPHRITIS OR SEVERE CENTRAL NERVOUS SYSTEM LUPUS OR CONCURRENT USE OF BIOLOGIC AGENTS, OR INTRAVENOUS CYCLOPHOSAMIDE.
BEVACIZUMAB	AVASTIN	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
BEXAROTENE	TARGRETIN	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
BOCEPREVIR	VICTRELIS	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	TREATMENT WITH BOCEPREVIR WILL NOT BE APPROVED FOR A PATIENT WHO HAS FAILED SHORT TRIAL OR HAS CONTRAINDICATION TO TELAPREVIR (INCIVEK) OR HAS PREVIOUS FAILURE OF FULL COURSE OF TRIPLE THERAPY WITH TELAPREVIR (INCIVEK) OR BOCEPREVIR (VICTRELIS) OR CURRENTLY TAKING CARBAMAZEPINE, PHENOBARBITAL, PHENYTOIN, OR RIFAMPIN OR HAS A CO-INFECTION WITH HEPATITIS B. DETECTABLE HCV RNA LEVEL/VIRAL LOAD OR HCV RNA LEVEL/VIRAL LOAD GREATER THAN OR EQUAL TO 100 IU/ML AFTER TRIPLE THERAPY.	CHRONIC HEPATITIS C, GENOTYPE 1. NATIVE PATIENT: HCV RNA LEVEL/VIRAL LOAD AT TRIPLE THERAPY TREATMENT WEEK 4, 8, 12, AND 24 OF BOCEPREVIR THERAPY. PARTIAL RESPONDER, NULL RESPONDER, OR RELAPSER: HCV RNA LEVEL/VIRAL LOAD AT WEEK 8 AND 20 OF BOCEPREVIR THERAPY. RENEWAL HCV RNA LEVELS TO DETERMINE LENGTH OF TREATMENT.	PATIENT 18 YEARS OF AGE OR OLDER.	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST) OR SPECIALLY TRAINED GROUP (E.G. EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES). HEP C AND ORGAN TRANSPLANT: TRANSPLANT CENTER AND TRANSPLANT PHYSICIAN.	INITIAL: UP TO 12 WKS. RENEWAL: W/ CIRRHOSIS UP TO 32 WKS, W/O CIRRHOSIS UP TO 20 WKS.	CONCURRENT USE OF RIBAVIRIN AND PEGINTERFERON ALFA.
BORTEZOMIB	VELCADE	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
BOSUTINIB	BOSULIF	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	CML: BCR-ABL MUTATIONAL ANALYSIS CONFIRMING THAT BOTH T315I AND V299L MUTATIONS ARE NOT PRESENT.
C1 ESTERASE INHIBITOR	CINRYZE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.				HEMATOLOGIST, IMMUNOLOGIST	12 MONTHS	TRIAL OF OR INTOLERABLE SIDE EFFECTS TO DANAZOL.
CABOZANTINIB	COMETRIQ	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
CALCINEURIN INHIBITORS	ELIDEL | PROTOPIC	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	NOT TRIED/FAILED OR INTOLERABLE ADVERSE EFFECTS TO TOPICAL CORTICOSTEROIDS		ELIDEL 1% AND PROTOPIC 0.03%: 2 YEARS OR OLDER. PROTOPIC 0.1%: OVER 14 YEARS.		12 MONTHS	
CANAKINUMAB	ILARIS	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			CAPS: 4 YEARS AND OLDER. SJIA: 2 YEARS AND OLDER.	PRESCRIBED OR SUPERVISED BY RHEUMATOLOGIST	12 MONTHS	
CERTOLIZUMAB PEGOL	CIMZIA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		RENEWAL: RHEUMATOID ARTHRITIS: EXPERIENCED OR MAINTAINED 20% OR GREATER IMPROVEMENT IN TENDER AND SWOLLEN JOINT COUNT.		PRESCRIBED BY OR SUPERVISED BY A GASTROENTEROLOGIST OR RHEUMATOLOGIST.	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS	FOR MODERATE TO SEVERE CROHN'S DISEASE: TRIAL/FAILURE OF ONE OR MORE CONVENTIONAL THERAPIES FOR CROHN'S DISEASE SUCH AS CORTICOSTEROIDS, AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. FOR MODERATE TO SEVERE RHEUMATOID ARTHRITIS: TRIAL/FAILURE OF AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE).
CETUXIMAB	ERBITUX	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		METASTATIC COLORECTAL CANCER : WILD TYPE KRAS (WITHOUT MUTATION)			12 MONTHS	
CHENODIOL	CHENODAL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CEREBROTENDINOUS XANTHOMATOSIS.	RADIOLUCENT GALLSTONES: NO FAILED TREATMENT WITH URSODIOL				12 MONTHS	
CLOBAZAM	ONFI	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			2 YEARS OF AGE OR OLDER		12 MONTHS	TRIAL OF LAMOTRIGINE OR TOPIRAMATE.
CORTICOSTEROID BVD DETERMINATION	A-HYDROCORT | CORTISONE ACETATE | DEXAMETHASONE | DEXAMETHASONE SODIUM PHOSPHATE | HYDROCORTISONE | METHYLPREDNISOLONE | METHYLPREDNISOLONE ACETATE | METHYLPREDNISOLONE SOD SUCC | PREDNISOLONE SODIUM PHOSPHATE | PREDNISONE | PREDNISONE INTENSOL | SOLU-CORTEF | SOLU-MEDROL	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.						
CORTICOTROPIN	H.P. ACTHAR	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	USED FOR DIAGNOSTIC PURPOSES. ACUTE EXACERBATION OF MULTIPLE SCLEROSIS: IV ACCESS OR IV ACCESS CAN BE OBTAINED.		INFANTILE SPASMS: LESS THAN 2 YEARS OF AGE.		INFANTILE SPASMS: 28 DAYS. MULTIPLE SCLEROSIS: 21 DAYS.	

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CRIZOTINIB	XALKORI	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		LOCALLY ADVANCED OR METASTATIC NON SMALL CELL LUNG CANCER IS ANAPLASTIC LYMPHOMA KINASE POSITIVE.			12 MONTHS	
CYCLOPHOSPHAMIDE BVD DETERMINATION	CYCLOPHOSPHAMIDE	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.						
CYCLOSPORINE OPHTHALMIC	RESTASIS	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		KERATOCONJUNCTIVITIS SICCA (KCS) OR DRY EYE DISEASE.		PRESCRIBED BY OR SUPERVISED BY A OPHTHALMOLOGIST, OPTOMETRIST, OR RHEUMATOLOGIST.	12 MONTHS	
DABIGATRAN	PRADAXA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	TRIAL OF OR CONTRAINDICATION TO XARELTO OR ELIQUIS.
DABRAFENIB MESYLATE	TAFINLAR	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
DALFAMPRIDINE	AMPYRA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		WALKING DISABILITY SUCH AS MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS OR UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA.		NEUROLOGIST	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS	RENEWAL: PATIENT HAS EXPERIENCED OR MAINTAINED AT LEAST 15% IMPROVEMENT IN WALKING ABILITY.
DASATINIB	SPRYCEL	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	PREVIOUSLY TREATED CML REQUIRES MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS FOLLOWING BCR-ABL MUTATIONAL ANALYSIS - T315I, V299L, T315A, F317L/V/I/C.
DENOSUMAB	PROLIA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		A PATIENT WITH EITHER A HISTORY OF OSTEOPORTIC FRACTURE(S) OR GREATER THAN OR EQUAL TO TWO FACTORS FOR FRACTURE (E.G. HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS), OR FAILED AN ADEQUATE TRIAL OF BISPHOSPHONATES, IS INTOLERANT, OR HAS A CONTRAINDICATION TO BISPHOSPHONATES.			12 MONTHS	
DENOSUMAB-XGEVA	XGEVA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	DIAGNOSIS OF MULTIPLE MYELOMA				12 MONTHS	
DIMETHYL FUMARATE	TECFIDERA	ALL FDA APPROVED INDICATIONS NOT			18 YEARS AND OLDER		12 MONTHS	TRIAL OF OR CONTRAINDICATION TO INTERFERON
ELTROMBOPAG	PROMACTA	ALL FDA APPROVED INDICATIONS NOT					INITIAL:1 MOS.	CHRONIC IMMUNE (IDIOPATHIC)
ENDOTHELIN RECEPTOR ANTAGONISTS	LETAIRIS | OPSUMIT | TRACLEER	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIAGNOSIS OF PULMONARY ARTIERAL HYPERTENTION GREATER OR EQUAL TO NYHA/WHO FUNCTIONAL CLASS II.		CARDIOLOGIST OR PULMONOLOGIST.	12 MONTHS	
ENZALUTAMIDE	XTANDI	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	TRIAL OF OR CONTRAINDICATION TO DOCETAXEL.
EPIDERMAL GROWTH FACTOR RECEPTOR INHIBITORS - ERLOTNIB	TARCEVA	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
ERIBULIN	HALAVEN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	PREVIOUS TREATMENT WITH AN ANTHRACYCLINE (DAUNORUBICIN, DOXORUBICIN, IDARUBICIN, EPIRUBICIN, OR MITOXANTRONE) AND A TAXANE (DOCETAXEL OR PACLITAXEL).
ERYTHROPOIESIS STIMULATING AGENTS - EPOETIN ALFA	EPOGEN | PROCRIT	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL OFF LABEL ANEMIA IN HEPATITIS C BEING TREATED IN COMBINATION WITH RIBAVIRIN AND AN INERFERON ALFA OR PEGINTERFERON ALFA.		CHRONIC RENAL FAILURE HEMAGLOBIN LEVELS LESS THAN 10 G/DL IF NOT ON DIALYSIS AND LESS THAN 11 G/DL IF ON DIALYSIS OR HEMOGLOBIN HAS REACHED 11 G/DL IF ON DIALYSIS AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS OR HEMOGLOBIN HAS REACHED 10 G/DL IF NOT ON DIALYSIS AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CANCER CHEMOTHERAPY: HEMOGLOBIN LEVELS BETWEEN 10 AND 12 G/DL OR HEMOGLOBIN LEVEL LESS THAN 11 G/DL OR HEMOGLOBIN LEVEL DECREASED AT LEAST 2 G/DL BELOW THEIR BASELINE. ZIDOVUDINE THERAPY: HEMOGLOBIN LEVEL BETWEEN 10 AND 12 G/DL OR HEMOGLOBIN LESS THAN 10 G/DL. ELECTIVE, NONCARDIAC, NONVASCULAR SURGERY: HEMOGLOBIN LESS THAN 13 G/DL. CONCURRENT HEPATITIS C TREATMENT: HEMOGLOBIN LESS BETWEEN 10 AND 12 G/DL FOR PATIENTS CURRENTLY TAKING REQUESTED MEDICATION OR CONTRAINDICATION TO RIBAVIRIN DOSE REDUCTION AND HEMOGLOBIN LESS THAN 10 G/DL FOR NEW STARTS.			ANEMIA FROM MYELOSUPPRESSIVE CHEMO/CKD W/O DIALYSIS/ZIDOVUDINE: 12 MOS. SURGERY:1 MO. HEP C:6 MOS.	ALL INDICATIONS: TRIAL OF PROCRIT. PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.
ESRD BVD DETERMINATION	BONIVA | CALCITRIOL | CUBICIN | DOXERCALCIFEROL | HECTOROL | HEPARIN SODIUM | IBANDRONATE SODIUM | LEVOCARNITINE | LIDOCAINE | LIDOCAINE HCL | LIDOCAINE-PRILOCAINE | MIACALCIN | PAMIDRONATE DISODIUM | PARICALCITOL | VANCOMYCIN HCL | ZEMPLAR	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						

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ETANERCEPT	ENBREL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECT THE HANDS, FEET, OR GENITAL AREA. RENEWAL: RHEUMATOID ARTHRITIS/JUVENILE IDIOPATHIC ARTHRITIS/PSORIATIC ARTHRITIS: EXPERIENCED OR MAINTAINED 20 PERCENT OR GREATER IMPROVEMENT IN TENDER OR SWOLLEN JOINT COUNT WHILE ON THERAPY. ANKYLOSING SPONDYLITIS: EXPERIENCED OR MAINTAINED IMPROVEMENT OF AT LEAST 50 PERCENT OR 2 UNITS IN THE BATH ANKYLOSING SPONDYLITIS DISEASE ACTIVITY INDEX (BASDAI). PLAQUE PSORIASIS: ACHIEVED OR MAINTAINED CLEAR OR MINIMAL DISEASE OR A DECREASE IN PSORIASIS AREA AND SEVERITY INDEX (PASI) OF AT LEAST 50% OR MORE.		PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST OR DERMATOLOGIST.	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS	INITIAL: FOR RHEUMATOID ARTHRITIS: TRIAL OF HUMIRA OR CIMIZIA AND TRIAL/FAILURE OF AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE). FOR JUVENILE IDOPATHIC ARTHRITIS: TRIAL OF HUMIRA AND TRIAL/FAILURE TO AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE). FOR ANKYLOSING SPONDYLITIS: TRIAL OF HUMIRA. FOR PSORIATIC ARTHRITIS: TRIAL OF HUMIRA AND TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE). FOR MODERATE TO SEVERE PLAQUE PSORIASIS: TRIAL OF HUMIRA AND TRIAL/FAILURE OF ONE OR MORE FORMS OF PREFERRED THERAPY (PUVA, UVG, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE).
EVEROLIMUS	AFINITOR | AFINITOR DISPERZ	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	ADVANCED RENAL CELL CARCINOMA (RCC): TRIAL OF OR CONTRAINDICATION TO SUTENT OR NEXAVAR.
FENTANYL NASAL SPRAY	LAZANDA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					6 MONTHS	CANCER: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION (SUCH AS MORPHINE SULFATE SR, OXYCODONE SR, OR FENTANYL). EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE (1) IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT (SUCH AS MORPHINE SULFATE IR, OXYCODONE/ASPIRIN, OXYCODONE/ACETAMINOPHEN, CODEINE/ACETAMINOPHEN, HYDROMORPHONE, OR MEPERIDINE) OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES AND TRIAL OR CONTRAINDICATION TO GENERIC FENTANYL CITRATE LOZENGE.
FENTANYL TRANSDERMAL PATCH	FENTANYL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE SUSTAINED-RELEASE MORPHINE PRODUCT. EVERY 48 HOUR DOSING CONSIDERED FOR PATIENTS WHO FAIL EVERY 72 HOUR DOSING. NO APPROVAL WHEN PRESCRIBED FOR AS NEEDED DOSAGE FREQEUNCY.
FENTANYL TRANSMUCOSAL AGENTS - FENTANYL CITRATE	FENTANYL CITRATE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					6 MONTHS	CANCER: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION (SUCH AS MORPHINE SULFATE SR, OXYCODONE SR, OR FENTANYL). EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE (1) IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT (SUCH AS MORPHINE SULFATE IR, OXYCODONE/ASPIRIN, OXYCODONE/ACETAMINOPHEN, CODEINE/ACETAMINOPHEN, HYDROMORPHONE, OR MEPERIDINE) OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES.
FINGOLIMOD	GILENYA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	TRIAL OR CONTRAINDICATION TO INTERFERON THERAPY (AVONEX, BETASERON, EXTAVIA, OR REBIF) AND COPAXONE, OR RAPIDLY PROGRESSING DISEASE WHILE ON INTERFERON THERAPY OR COPAXONE.
GLP-1 ANALOGS	VICTOZA 3-PAK	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	FAILURE TO REACH TREATMENT GOALS WITH METFORMIN, METFORMIN ER, GLYBURIDE/METFORMIN, GLIPIZIDE/METFORMIN, A FORMULARY SULFONYLUREA (GLYBURIDE, GLIPIZIDE), PIOGLITAZONE (ACTOS), PIOGLITAZONE/METFORMIN (ACTOSPLUS MET), OR PIOGLITAZONE/GLIMEPIRIDE (DUETACT) AND EXENATIDE EXTENDED RELEASE (BYDUREON).
GLYCEROL PHENYLBUTYRATE	RAVICTI	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	TRIAL OF OR CONTRAINDICATION TO SODIUM PHENYLBUTYRATE (BUPHENYL).
GOLIMUMAB	SIMPONI	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		RENEWAL: ACTIVE RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS: MAINTAINED OR EXPERIENCED GREATER THAN 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT. ANKYLOSING SPONDYLITIS: MAINTAINED OR EXPERIENCED GREATER THAN 20% IMPROVEMENT IN ANKYLOSING SPONDYLITIS (ASAS20) CRITERIA.	18 YEARS OR OLDER	PRESCRIBED BY OR SUPERVISED BY A RHEUMATOLOGIST, DERMATOLOGIST, OR GASTROENTEROLOGIST .	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS. UC: 12 MONTHS.	ACTIVE RHEUMATOID ARTHRITIS INITIAL: TRIAL OF HUMIRA OR CIMZIA AND TRIAL/FAILURE OF AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE). PSORIATIC ARTHRITIS: TRIAL OF HUMIRA AND TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE) AND HUMIRA. ANKYLOSING SPONDYLITIS: TRIAL OF HUMIRA. ULCERATIVE COLITIS: TRIAL OF OR CONTRAINDICATION TO SULFASALAZINE, CORTICOSTEROIDS, METHOTREXATE, AZATHIOPRINE, OLSALAZINE, MESALAMINE, CYCLOSPORINE, OR MERCAPTOPURINE.
GOLIMUMAB - SIMPONI ARIA	SIMPONI ARIA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		RHEUMATOID ARTHRITIS. RENEWAL: AT LEAST 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT.	18 YEARS OF AGE AND OLDER	PRESCRIBED OR SUPERVISED BY A RHEUMATOLOGIST	12 MONTHS	RHEUMATOID ARTHRITIS: INITIAL: TRIAL/FAILURE OF AT LEAST ONE OF THE FOLLOWING DMARD AGENTS: METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.

Prior Authorization Group Description	Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
HEPATITIS A VACCINE (INACTIVATED) BVD DETERMINATION	HAVRIX | VAQTA	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.						
HEPATITIS B VACCINE BVD DETERMINATION	ENGERIX-B ADULT | ENGERIX-B PEDIATRIC-ADOLESCENT | RECOMBIVAX HB	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
HIGH RISK DRUGS IN THE ELDERLY - ANTI-INFECTIVE	NITROFURANTOIN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.		12 MONTHS	MEMBERS 65 YEARS OR OLDER WILL BE EVALUATED FOR LIMITED PRESCRIPTION USE TO NO MORE THAN 90 DAYS (TOTAL) OF CUMULATIVE USE. REQUESTS FOR GREATER THAN 90 DAYS OF CUMULATIVE USE WILL REQUIRE TRIAL OF OR CONTRAINDICATION TO SULFAMETHOXAZOLE/TRIMETHOPRIM (TMP-SMX) OR TRIMETHOPRIM.
HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS	CARBINOXAMINE MALEATE | CLEMASTINE FUMARATE | CYPROHEPTADINE HCL | PALGIC	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.		12 MONTHS	PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: TRIAL OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE. ANXIETY: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - BUSPIRONE, PAROXETINE, DULOXETINE, OR VENLAFAXINE. MOTION SICKNESS: TRIAL OR CONTRAINDICATION TO MECLIZINE. INSOMNIA: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.
HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - BENZTROPINE TRIHEXYPHENIDYL	BENZTROPINE MESYLATE | TRIHEXYPHENIDYL HCL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.		12 MONTHS	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.
HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - HYDROXYZINE	HYDROXYZINE HCL | HYDROXYZINE PAMOATE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.		12 MONTHS	PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: TRIAL OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE. ANXIETY: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - BUSPIRONE, PAROXETINE, DULOXETINE, OR VENLAFAXINE.
HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - PROMETHAZINE	PHENADOZ | PROMETHAZINE HCL | PROMETHEGAN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.		12 MONTHS	PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: TRIAL OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE. ANXIETY: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - BUSPIRONE, PAROXETINE, DULOXETINE, OR VENLAFAXINE. MOTION SICKNESS: TRIAL OR CONTRAINDICATION TO MECLIZINE.
HIGH RISK DRUGS IN THE ELDERLY - BARBITURATE COMBINATIONS	ACETAMINOPHEN-BUTALBITAL | ALAGESIC LQ | ASCOMP WITH CODEINE | BUTALB-CAFF-ACETAMINOPH-CODEIN | BUTALBITAL-ACETAMINOPHEN-CAFFE | BUTALBITAL-ASPIRIN-CAFFEINE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.		6 MONTHS	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.
HIGH RISK DRUGS IN THE ELDERLY - CARDIOVASCULAR	GUANFACINE HCL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.		12 MONTHS	HYPERTENSION: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - BENAZEPRIL, BENAZEPRIL/HYDROCHLOROTHIAZIDE, CAPTOPRIL, CAPTOPRIL/HYDROCHLOROTHIAZIDE, ENALAPRIL, ENALAPRIL/HYDROCHLOROTHIAZIDE, FOSINOPRIL, FOSINOPRIL/HYDROCHLOROTHIAZIDE, LISINOPRIL, LISINOPRIL/HYDROCHLOROTHIAZIDE, QUINAPRIL, QUINALPRIL/HYDROCHLOROTHIAZIDE, RAMIPRIL, MOEXIPRIL, MOEXIPRIL/HYDROCHLOROTHIAZIDE, PERINDOPRIL ERBUMINE, QUNINAPRIL, QUINAPRIL/HYDROCHLOROTHIAZIDE, TRANDOLAPRIL, TRANDOLAPRIL/VERAPAMIL, LOSARTAN, LOSARTAN/HYDROCHLOROTHIAZIDE, IRBESARTAN, IRBESARTAN/HYDROCHLOROTHIAZIDE, OLMESARTAN, OLMESARTAN/HYDROCHLOROTHIAZIDE, OLEMSARTAN/AMILODIPINE/HYDROCHLOROTHIAZIDE, VALSARTAN, VALSARTAN/HYDROCLOROTHIAZIDE, DILTIAZEM HCL, DILTIAZEM SUSTAINED RELEASE, VERAPAMIL, VERAPAMIL SUSTAINED RELEASE, ATENOLOL, ATENOLOL/HCLORTHALIDONE, BISOPROLOL, BISOPROLOL/HYDROCHLOROTHIAZIDE, PROPRANOLOL/HYDROCHLOROTHIAZIDE, SOTALOL, TIMOLOL MALEATE.
HIGH RISK DRUGS IN THE ELDERLY - CENTRAL NERVOUS SYSTEM - THIORIDAZINE	THIORIDAZINE HCL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	65 YEARS AND OLDER: SCHIZOPHRENIA - PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.

Prior Authorization Group Description	Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
HIGH RISK DRUGS IN THE ELDERLY - DIGOXIN	DIGOX | DIGOXIN | LANOXIN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIGOXIN LEVEL	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.		12 MONTHS	APPROVAL FOR MEMBERS STABLE ON 250 MCG WITH DOCUMENTED THERAPEUTIC DIGOXIN LEVEL TAKEN WITHIN THE PAST YEAR.
HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - ESTROGEN	COMBIPATCH | DUAVEE | ESTRADIOL | ESTRADIOL-NORETHINDRONE ACETAT | ESTRASORB | ESTROPIPATE | JINTELI | MENEST | PREMARIN | PREMPHASE | PREMPRO | VIVELLE-DOT	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.		12 MONTHS	VULVAR/VAGINAL ATROPHY: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - ESTRACE VAGINAL CREAM, PREMARIN VAGINAL CREAM, OR VAGIFEM. OSTEOPOROSIS: TRIAL OR CONTRAINDICATION TO ONE OF THE FOLLOWING - ALENDRONATE, IBANDRONATE, OR RALOXIFENE. VASOMOTOR SYMPTOMS OF MENOPAUSE: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER. ALL OTHER FDA APPROVED INDICATIONS, SUCH AS PALLIATION TREATMENT, NOT PREVIOUSLY MENTIONED IN THIS SECTION, ARE TO BE APPROVED WITHOUT A TRIAL OF FORMULARY ALTERNATIVES.
HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - GLYBURIDE	GLYBURIDE | GLYBURIDE MICRONIZED | GLYBURIDE-METFORMIN HCL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.		12 MONTHS	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.
HIGH RISK DRUGS IN THE ELDERLY - INDOMETHACIN	INDOMETHACIN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.		12 MONTHS	TRIAL OF OR CONTRAINDICATION TO CELECOXIB OR A TOPICAL NON-STEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) SUCH AS VOLTAREN GEL OR FLECTOR. PRESCRIPTIONS WRITTEN BY A RHEUMATOLOGIST DO NOT REQUIRE TRIAL OF FORMULARY ALTERNATIVES.
HIGH RISK DRUGS IN THE ELDERLY - NON-BENZODIAZEPINE	ZALEPLON | ZOLPIDEM TARTRATE | ZOLPIDEM TARTRATE ER	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.		12 MONTHS	MEMBERS 65 YEARS OR OLDER WILL BE EVALUATED FOR LIMITED PRESCRIPTION USE TO NO MORE THAN 90 DAYS (TOTAL) OF CUMULATIVE USE WITHIN THE CURRENT PLAN YEAR. REQUESTS GREATER THAN 90 DAYS OF CUMULATIVE USE REQUIRES PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.
HIGH RISK DRUGS IN THE ELDERLY - SKELETAL MUSCLE RELAXANTS	CARISOPRODOL | CHLORZOXAZONE | CYCLOBENZAPRINE HCL | METAXALONE | METHOCARBAMOL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.		12 MONTHS	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.
HIGH RISK DRUGS IN THE ELDERLY - TCA	AMITRIPTYLINE HCL | CLOMIPRAMINE HCL | DOXEPIN HCL | IMIPRAMINE HCL | IMIPRAMINE PAMOATE | PERPHENAZINE-AMITRIPTYLINE | TRIMIPRAMINE MALEATE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	APPLIES TO MEMBERS 65 YEARS AND OLDER FOR THE FOLLOWING: MIGRAINE PROPHYLAXIS: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - PROPRANOLOL, TIMOLOL, TOPIRAMATE, VALPROIC ACID, OR DIVALPROEX. DEPRESSION: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - PAROXETINE, SERTRALINE, VENLAFAXINE, DULOXETINE, CITALOPRAM, ESCITALOPRAM, FLUOXETINE, OR TRAZODONE. POSTHERPERTIC NEURALGIA: TRIAL OR CONTRAINDICATION TO GABAPENTIN OR PREGABALIN.
IBRUTINIB	IMBRUVICA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
IMATINIB MESYLATE	GLEEVEC	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					ALL DIAGNOSIS: 12 MONTHS. GIST (TWICE DAILY DOSE): 36 MONTHS.	GASTROINTESTINAL STROMAL TUMOR (GIST) KIT (CD117) POSITIVE USE FOR GLEEVEC 400MG TWICE DAILY: TRIAL OF GLEEVEC 400MG ONCE DAILY OR GIST TUMOR EXPRESSING A KIT EXON 9 MUTATION. PREVIOUSLY TREATED CML REQUIRES MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS FOLLOWING BCR-ABL MUTATIONAL ANALYSIS - T315I, V299L, F317L/V/I/C, Y253H, E255K/V, F359V/C/I.
IMIQUIMOD - ALDARA	IMIQUIMOD	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL OFF LABEL COVERAGE FOR ACTINIC KERATOSIS NOT LIMITED TO THE FACE AND SCALP IN NON-IMMUNOCOMPETENT PATIENTS, MOLLUSCUM CONTAGIOSUM, AND LETIGO MALIGNA.			EXTERNAL GENITAL OR PERIANAL WARTS: GREATER THAN OR EQUAL TO 12 YEARS OF AGE. ACTINIC KERATOSIS: GREATER THAN OR EQUAL TO 18 YEARS OF AGE.	ACTINIC KERATOSIS: DERMATOLOGIST ONLY. SUPERFICIAL BASAL CELL CARCINOMA/LETIGO MALIGNA: DERMATOLOGIST OR ONCOLOGIST ONLY.	4 MONTHS	CRITERIA APPLIES TO NEW STARTS ONLY. ACTINIC KERATOSIS: TRIAL OF TOPICAL 5-FLUOROURACIL. ACTINIC KERATOSIS BRAND DRUG REQUEST: TRIAL/FAILURE OF GENERIC IMIQUIMOD 5%. SUPERFICIAL BASAL CELL CARCINOMA: LESS THAN 2CM IN SIZE AND NOT ON THE FACE. MOLLUSCUM CONTAGISOUM LIMITED TO THE FACE.
IMMUNE GLOBULIN BVD DETERMINATION	CARIMUNE NF NANOFILTERED | GAMMAGARD LIQUID | GAMMAPLEX | GAMUNEX-C | PRIVIGEN	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.						
IMMUNOSUPPRESSANT BVD DETERMINATION	ASTAGRAF XL | AZATHIOPRINE | CELLCEPT | CYCLOSPORINE | CYCLOSPORINE MODIFIED | GENGRAF | MYCOPHENOLATE MOFETIL | MYCOPHENOLIC ACID | NULOJIX | PROGRAF | RAPAMUNE | SIMULECT | SIROLIMUS | TACROLIMUS | ZORTRESS	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.						

Prior Authorization Group Description	Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
INFLIXIMAB	REMICADE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 10 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECT THE HANDS, FEET, OR GENITAL AREA. RENEWAL: RHEUMATOID/PSORIATIC ARTHRITIS: MAINTAINED OR EXPERIENCED GREATER THAN 20% IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT. PLAQUE PSORIASIS: MAINTAINED OR EXPERIENCED PASI OF GREATER THAN 50% OR SIGNIFCANT IMPROVEMENT IN QUALITY OF LIFE OBSERVED BY PHYSICIAN AND PATIENT. ANKYLOSING SPONDYLITIS: MAINTAINED OR EXPERIENCED IMPROVEMENT OF AT LEAST 50%, OR 2 UNITS (SCALE OF 1-10), IN THE BATH ANKYLOSING SPONDYLITIS DISEASE ACTIVITY INDEX (BASDAI) OR IMPROVEMENT OF AT LEAST 20% IN THE ASSESSMENT IN ANKYLOSING SPONDYLITIS (ASAS20) CRITERIA.		PRESCRIBED BY OR SUPERVISED BY A GASTROENTEROLOGIST , RHEUMATOLOGIST OR DERMATOLOGIST.	UC: 12 MO. OTHER INDICATIONS INITIAL: 4 MO RENEWAL: 12 MO	INITIAL: MODERATE TO SEVERE CROHN'S DISEASE/ULCERATIVE COLITIS/ACUTE ENTEROCUTANEOUS FISTULA: TRIAL/FAILURE OF ONE OR MORE OF THE FOLLOWING PREFERRED THERAPY AGENTS SUCH AS SULFASALAZINE, CORTICOSTEROIDS, AZATHIOPRINE, METHOTREXATE, OLSALAZINE, MESALAMINE, CYCLOSPORINE,OR MERCAPTOPURINE. FOR MODERATE TO SEVERE RHEUMATOID ARTHRITIS: TRIAL OF HUMIRA OR CIMZIA AND TRIAL/FAILURE TO AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE). FOR PSORIATIC ARTHRITIS: TRIAL OF HUMIRA AND TRIAL/FAILURE TO AT LEAST ONE DMARD AGENT (METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. FOR SEVERE PLAQUE PSORIASIS COVERING 10% BSA: TRIAL/FAILURE/INTOLERABLE SIDE AFFECTS TO AT LEAST ONE PREFERRED THERAPY (PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE). RENEWAL: FOR RHEUMATOID ARTHRITIS: CONCOMITANT METHOTREXATE USE.
INFUSIBLE DRUG BVD DETERMINATION	ABELCET | ACYCLOVIR SODIUM | AMPHOTERICIN B | BLEOMYCIN SULFATE | CLADRIBINE | CYTARABINE | FLUOROURACIL | FOSCARNET SODIUM | GANCICLOVIR SODIUM | IFOSFAMIDE | METHOTREXATE | MITOMYCIN | REMODULIN | TORISEL | VINBLASTINE SULFATE | VINCRISTINE SULFATE	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.						
INTERFERON AGENTS - INTERFERON ALFA-2B	INTRON A	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		HEP C: PRETREATMENT HCV RNA LEVEL GREATER THAN OR EQUAL TO 50 IU/ML.	HEP C: 3 YEARS OR OLDER.	HEP C: GASTROENTEROLOGIST , INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST).	INITIAL HEP C: 2 TO 6 MOS. ALL OTHERS: 4 MOS. RENEWAL HEP C AND ALL OTHERS: 6 MOS.	HEP C: DRUG MUST BE USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED.
INTERFERON AGENTS - PEG-INTERFERON ALFA-2A	PEGASYS | PEGASYS PROCLICK	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		INITIAL: HEP C: PRETREATMENT HCV RNA LEVEL GREATER THAN OR EQUAL TO 50 IU/ML. HEP C WITH HIV: CD4 COUNT GREATER THAN 100 CELLS/MM3, HCV RNA LEVELS/VIRAL LOAD GREATER THAN OR EQUAL TO 50 IU/ML. RENEWAL: HCV RNA LEVELS TO DETERMINE LENGTH OF TREATMENT.	5 YEARS OR OLDER.	GASTROENTEROLOGIST , INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST).	INITIAL HEP B: 6 MOS HEP C 2 TO 6 MOS. RENEWAL HEP B: 6 MOS. HEP C: 1 TO 12 MOS.	HEP C: TRIAL OR CONTRAINDICATION TO PEGINTRON. DRUG MUST BE USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED. RENEWAL: HEP C: USED IN COMBINATION OR CONTRAINDICATION WITH RIBAVIRIN. GENOTYPE 2 OR 3: NO RENEWAL.
INTERFERON AGENTS - PEG-INTERFERON ALFA-2B	PEGINTRON | PEGINTRON REDIPEN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		INITIAL: HEP C: PRETREATMENT HCV RNA LEVEL GREATER THAN OR EQUAL TO 50 IU/ML. RENEWAL: HCV RNA LEVELS TO DETERMINE LENGTH OF TREATMENT.	3 YEARS OR OLDER.	GASTROENTEROLOGIST , INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST).	INITIAL HEP C: 2 TO 6 MOS. RENEWAL HEP C: 1 TO 12 MOS.	HEP C: DRUG MUST BE USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED. RENEWAL HEP C: USED IN COMBINATION OR CONTRAINDICATION WITH RIBAVIRIN. GENOTYPE 2 OR 3: NO RENEWAL.
IPILIMUMAB	YERVOY	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					3 MONTHS	
IVACAFTOR	KALYDECO	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		G551D MUTATION	6 YEARS OF AGE OR OLDER.		12 MONTHS	
LENALIDOMIDE	REVLIMID	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
METHOTREXATE BVD DETERMINATION	METHOTREXATE | TREXALL	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
METHYLNALTREXONE	RELISTOR	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		CONSTIPATION DUE TO OPIOIDS			UP TO 6 MONTHS	PATIENT IS RECEIVING PALLIATIVE CARE.
MIFEPRISTONE	KORLYM	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
MIPOMERSEN	KYNAMRO	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	PATIENT IS CONCURRENTLY RECEIVING LDL APHERESIS.				12 MONTHS	USE IN COMBINATION WITH A STATIN (EXAMPLE: SIMVASTATIN, ATORVASTATIN), BILE ACID SEQUESTRANT FENOFIBRATE OR NIACIN.
MODAFINIL AND ARMODAFINIL - PROVIGIL	MODAFINIL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL COVERAGE CONSIDERATION FOR CHRONIC FATIGUE SYNDROME RELATED TO MULTIPLE SCLEROSIS.					12 MONTHS	NARCOLEPSY: TRIAL OF OR CONTRAINDICATION TO AMPHETAMINE, DEXTROAMPHETAMINE, OR METHYLPHENDATE.
NATALIZUMAB	TYSABRI	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					MULTIPLE SCLEROSIS:12 MONTHS. CROHN'S DISEASE: 6 MONTHS. RENEWAL: CROHN'S: 12 MONTHS.	MULTIPLE SCLEROSIS: TRIAL OF AN INTERFERON OR COPAXONE. CROHN'S DISEASE: TRIAL OF A TNF-ALPHA INHIBITOR. RENEWAL: CROHNS: PATIENT IS NOT ON CONCOMITANT CORTICOSTEROID TREATMENT AFTER 6 MONTHS ON NATALIZUMAB, OR HAS NOT RECEIVED MORE THAN 3 MONTHS OF A CORTICOSTEROID WITHIN THE PAST 12 MONTHS.
NEBULIZER BVD DETERMINATION	ACETYLCYSTEINE | ALBUTEROL SULFATE | BETHKIS | CROMOLYN SODIUM | NEBUPENT | PULMOZYME | TOBRAMYCIN | TYVASO | VENTAVIS	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.						

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NILOTINIB	TASIGNA	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	PREVIOUSLY TREATED CML REQUIRES MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS FOLLOWING BCR-ABL MUTATIONAL ANALYSIS - T315I, Y253H, E255K/V, F359V/C/I.
OFATUMUMAB	ARZERRA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	CHRONIC LYMPHOCYTIC LEUKEMIA: NO FAILED TREATMENT WITH FLUDARABINE AND ALEMTUZUMAB				6 MONTHS	
OMACETAXINE	SYNRIBO	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					INDUCTION: 3 MONTHS. POST INDUCTION/RENEWAL: 3 TO 12 MONTHS	CML INDUCTION THERAPY: TRIAL OF OR CONTRAINDICATION TO AT LEAST TWO OF THE FOLLOWING GLEEVEC, SPRYCEL, TASIGNA, BOSULIF, OR ICLUSIG. DETERMINATION FOR THERAPY LENGTH OF APPROVAL THAT IS NOT INDUCTION THERAPY WILL DEPEND ON THE PATIENTS HEMATOLOGIC RESPONSE (DEFINED AS ABSOLUTE NEUTROPHIL COUNT (ANC) GREATER THAN OR EQUAL TO 1.5 X 10^9/L AND PLATELETS GREATER THAN OR EQUAL TO 100 X 10^9/L AND NO BLOOD BLASTS OR BONE MARROW BLASTS LESS THAN 5%). IF MEETS HEMATOLOGIC RESPONSE CRITERIA APPROVAL WILL BE 12 MONTHS. IF HEMATOLOGIC RESPONSE CRITERIA IS NOT MET APPROVAL WILL BE FOR 3 MONTHS.
OMALIZUMAB	XOLAIR	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		INITIAL: PATIENT MEETS THE CRITERIA OF MODERATE TO SEVERE ASTHMA, POSITIVE SKIN PRICK OR RAST TEST, FEV1 LESS THAN 80%, DEMONSTRATED INADEQUATELY CONTROLLED SYMPTOMS ON INHALED CORTICOSTEROIDS AND SECOND ASTHMA CONTROLLER, BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30 IU/ML. RENEWAL: PATIENT REDUCED EXACERBATIONS BY AT LEAST 25% FROM BASELINE, REDUCTION IN ORAL OR INHALED CORTICOSTEROID USE FROM BASELINE.	PATIENT 12 YEARS OF AGE OR OLDER	SPECIALIST IN ALLERGY OR PULMONARY MEDICINE ONLY	12 MONTHS	
OPIOID DEPENDENCY AGENTS	BUPRENORPHINE HCL | BUPRENORPHINE-NALOXONE | SUBOXONE | ZUBSOLV	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		PSYCHOSOCIAL COUNSELING		PRESCRIBING PHYSICIAN MUST BE CERTIFIED TO PRESCRIBE BUPRENORPHINE FOR OPIOID DEPENDENCE.	BUPRENORPHINE: 1 WEEK. RENEWAL: 6 MOS. BUPRENOR/NALOX: 6 MOS	PATIENT CANNOT BE CURRENTLY TAKING OPIOID ANALGESICS. CONTINUATION OF THERAPY WITH BUPRENORPHINE: CONTRAINDICATION OR UNABLE TO TOLERATE NALOXONE IN COMBINATION WITH BUPRENORPHINE.
PANITUMUMAB	VECTIBIX	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
PAZOPANIB	VOTRIENT	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION	ADCIRCA | REVATIO | SILDENAFIL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.				CARDIOLOGIST OR PULMONOLOGIST	12 MONTHS	REQUEST FOR ADCIRCA REQUIRE TRIAL OR CONTRAINDICATION TO REVATIO.
PEG-INTERFERON ALFA-2B-SYLATRON	SYLATRON 4-PACK	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	CRITERIA APPLIES TO NEW STARTS ONLY. DURATION LIMITATION OF 5 YEARS OF THERAPY.
PERTUZUMAB	PERJETA	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS	
PLERIXAFOR	MOZOBIL	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		USE IN COMBINATION WITH GRANULOCYTE-COLONY STIMULATING FACTOR (G-CSF) TO MOBILIZE HEMATOPOIETIC STEM CELLS TO THE PERIPHERAL BLOOD FOR COLLECTION AND SUBSEQUENT AUTOLOGOUS TRANSPLANTATION IN PATIENTS WITH NON-HODGKIN'S LYMPHOMA AND MULTIPLE MYELOMA		HEMATOLOGIST OR ONCOLOGIST	4 DOSES (UP TO 8 VIALS) FOR ONE FILL PER DAY.	
POMALIDOMIDE	POMALYST	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
PRAMLINTIDE	SYMLINPEN 120 | SYMLINPEN 60	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		TYPE I OR TYPE II DIABETES: REQUIRING INSULIN OR CONTINUOUS INSULIN INFUSION (INSULIN PUMP) FOR GLYCEMIC CONTROL			12 MONTHS	
QUININE SULFATE	QUININE SULFATE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
RABIES VACCINE BVD DETERMINATION	IMOVAX RABIES VACCINE | RABAVERT	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.						
REGORAFENIB	STIVARGA	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	TRIAL OR CONTRAINDICATION TO ANTI-EGFR THERAPY SUCH AS ERBITUX OR VECTIBIX. TRIAL OR CONTRAINDICATION TO ANTI-VEGF THERAPY SUCH AS AVASTIN OR ZALTRAP AND A FLUOROPYRMIDE-, OXAPLATIN- AND IRINOTECAN-BASED CHEMOTHERAPY SUCH AS FOLFOX, FOLFIRI,CAPEOX, INFUSIONAL 5-FU/LV OR CAPECITABINE, AND FOLFOXIRI.
RIFAXIMIN	XIFAXAN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.			TRAVELERS' DIARRHEA: 12 YEARS OR OLDER. HEPATIC ENCEPHALOPATHY: 18 YEARS OR OLDER.		TRAVELERS' DIARRHEA: 1 FILL IN 1 MONTH. HEPATIC ENCEPHALOPATHY: 12 MONTHS.	TRAVELERS' DIARRHEA: TRIAL OF CIPROFLOXACIN OR AZITHROMYCIN. HEPATIC ENCEPHALOPATHY: TRIAL OF LACTULOSE MONOTHERAPY.
RIOCIGUAT	ADEMPAS	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.				PRESCRIBED BY A CARDIOLOGIST OR PULMONOLOGIST.	12 MONTHS	

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RITUXIMAB	RITUXAN	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		RENEWAL: ACTIVE RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS: GREATER THAN 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT.		PRESCRIBED BY OR SUPERVISED BY: FOR RHEUMATOID ARTHRITIS A RHEUMATOLOGIST. FOR NHL OR CLL AN ONCOLOGIST.	RA: INITIAL AND RENEWAL 4 MO. HNL: 1 YEAR. CLL: 6 MO. WG, MPA: 1 MO.	INITIAL: RHEUMATOID ARTHRITIS: CURRENTLY TAKING OR HAVE A CONTRAINDICATION TO THE USE OF METHOTREXATE AND TRIAL/FAILURE OF ONE TNF BLOCKER (ENBREL, HUMIRA, SIMPONI, CIMZIA). NON HODGKIN'S LYMPHOMA/CHRONIC LYMPHOCYTIC LEUKEMIA: USED IN COMBINATION WITH CHEMOTHERAPY. WEGNER'S GRANULOMATOSIS/MICROSCOPIC POLYANGIITIS: CONCURRENT GLUCOCORTICOID USE.
ROMIDEPSIN	ISTODAX	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	TRIAL OF OR CONTRAINDICATION TO VORINOSTAT (ZOLINZA) AND NOT ABLE TO TOLERATE ORAL MEDICATIONS, OR IS ABLE TO TOLERATE ORAL MEDICATIONS AND HAS TRIED AT LEAST ONE SYSTEMIC THERAPY (RETINOID, INTERFERON, EXTRACORPOREAL PHOTOPHERESIS, DENILEUKIN DIFTITOX, METHOTREXATE, LIPOSOMAL DOXORUBICIN, GEMCITABINE, CHLORAMBUCIL, PENTOSTATIN, ETOPOSIDE, CYCLOPHOSPHAMIDE, TEMOZOLOMIDE, BORTEZOMIB).
RUXOLITINIB	JAKAFI	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		RENEWAL: IMPROVEMENT OR MAINTENANCE OF SYMPTOM IMPROVEMENT SUCH AS A 50% OR GREATER REDUCTION IN TOTAL SYMPTOM SCORE ON THE MODIFIED MYELOFIBROSIS SYMPTOM ASSESSMENT FORM (MFSAF) V2.0 OR 50% OR GREATER REDUCTION IN PALPABLE SPLEEN LENGTH, OR REDUCTION OF 35% OR GREATER FROM BASELINE SPLEEN VOLUME AFTER 6 MONTHS OF THERAPY.			INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS	
SIMEPREVIR	OLYSIO	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		HCV RNA LEVEL OR VIRAL LOAD. FOR ALL GENOTYPE 1, INTERFERON INELIGIBLE PATIENTS USING OLYSIO AND SOVALDI AND HAVE GENOTYPE 1A: NS3 80K POLYMORPHISM LAB TEST AT BASELINE.	18 YEARS OF AGE AND OLDER.	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.	12 WEEKS. SEE OTHER CRITERIA FIELD FOR MORE INFORMATION.	GENOTYPE 1A NOT POSITIVE FOR NS3 Q80K POLYMORPHISM OR 1B WITH USE IN COMBINATION WITH RIBAVIRIN AND PEG-INTERFERON ALFA: MAXIMUM DURATION OF 12 WEEKS. GENOTYPE 1A NOT POSITIVE FOR NS3 Q80K POLYMORPHISM OR 1B AND NOT USING RIBAVIRIN PLUS PEG-INTERFERON WITH CONTRAINDICATION TO INTERFERON (SUCH AS CONCURRENT DIAGNOSIS OF AUTOIMMUNE HEPATITIS OR HAS KNOWN HYPERSENSITIVITY REACTION SUCH AS URTICARIA, ANGIOEDEMA, BRONCHOSPASM AND ANAPHYLAXIS TO ALPHA INTERFERONS OR ANY COMPONENT OF THE PRODUCT, DOCUMENTATION OF DEPRESSION, DECOMPENSATED HEPATIC DISEASE, A BASELINE NEUTROPHIL COUNT BELOW 1500 PER MICROLITER, A BASELINE PLATELET COUNT BELOW 90,000, OR A BASELINE HEMOGLOBIN BELOW 10G/DL THAT HAS NOT RESPONDED TO TREATMENT): COMBINATION REGIMEN SOVALDI AND OLYSIO FOR 12 WEEKS AS LONG AS PATIENT HAS NOT COMPLETED A PRIOR COURSE OF THERAPY WITH ANY HCV PROTEASE INHIBITOR (SUCH AS INCIVEK OLYSIO, OR VICTRELIS) AND HAS NOT ACHIEVED A SUSTAINED VIROLOGIC RESPONSE.
SOFOSBUVIR	SOVALDI	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	PATIENT WITH END STAGE RENAL DISEASE OR REQUIRES DIALYSIS.	FOR ALL GENOTYPE 1, INTERFERON INELIGIBLE PATIENTS USING OLYSIO AND SOVALDI AND HAVE GENOTYPE 1A: NS3 80K POLYMORPHISM LAB TEST AT BASELINE.	18 YEARS OF AGE AND OLDER.	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.	DURATION PER GENOTYPE DIAGNOSIS. SEE OTHER CRITERIA FIELD FOR MORE INFORMATION.	HEPATITIS C: USE WITH RIBAVIRIN: GENOTYPE 1, 2, 3, 4, 5 OR 6 WITH HEPATOCELLULAR CARCINOMA (THAT MEETS MILAN CRITERIA) AND IS AWAITING LIVER TRANSPLANT: MAXIMUM DURATION OF TREATMENT UP TO 48 WEEKS. GENOTYPE 1 WITHOUT USE OF RIBAVIRIN AND WITH CONTRAINDICATION TO INTERFERON (SUCH AS CONCURRENT DIAGNOSIS OF AUTOIMMUNE HEPATITIS OR HAS KNOWN HYPERSENSITIVITY REACTION SUCH AS URTICARIA, ANGIOEDEMA, BRONCHOSPASM AND ANAPHYLAXIS TO ALPHA INTERFERONS OR ANY COMPONENT OF THE PRODUCT, DOCUMENTATION OF DEPRESSION, DECOMPENSATED HEPATIC DISEASE, A BASELINE NEUTROPHIL COUNT BELOW 1500 PER MICROLITER, A BASELINE PLATELET COUNT BELOW 90,000, OR A BASELINE HEMOGLOBIN BELOW 10G/DL THAT HAS NOT RESPONDED TO TREATMENT): COMBINATION REGIMEN SOVALDI AND OLYSIO FOR 12 WEEKS AS LONG AS PATIENT HAS NOT COMPLETED A PRIOR COURSE OF THERAPY WITH ANY HCV PROTEASE INHIBITOR (SUCH AS INCIVEK OLYSIO, OR VICTRELIS) AND HAS NOT ACHIEVED A SUSTAINED VIROLOGIC RESPONSE UP TO 12 WEEKS FOR GENOTYPE 1B OR GENOTYPE 1A WITHOUT A NS3 Q80K

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								POLYMORPHISM. GENOTYPE 1, 4, 5, OR 6 WITH USE OF PEGINTERFERON AND RIBAVIRIN: MAXIMUM UP TO 12 WEEKS WITHOUT USE OF CONCURRENT PRESCRIPTION FOR ANY HCV PROTEASE INHIBITOR (SUCH AS INCIVEK OLYSIO, OR VICTRELIS). GENOTYPE 2 WITH RIBAVIRIN: MAXIMUM DURATION UP TO 12 WEEKS. GENOTYPE 3 WITH PEGINTERFERON AND RIBAVIRIN: MAXIMUM DURATION UP TO 12 WEEKS. GENOTYPE 3 WITH RIBAVIRIN (CONTRAINDICATION TO INTERFERON): MAXIMUM DURATION UP TO 24 WEEKS. GENOTYPE 1 OR 1A WITH CONTRAINDICATION TO INTERFERON, WHEN USED WITH RIBAVIRIN (TREATMENT NAIVE OR WITH N3 Q80K POLYMORPHISM OR WITH PREVIOUS FAILURE OF A HCV PROTEASE INHIBITOR): MAXIMUM DURATION UP TO 24 WEEKS.
SOMATROPIN - GROWTH HORMONE	GENOTROPIN | HUMATROPE | NORDITROPIN FLEXPRO | NORDITROPIN NORDIFLEX | NUTROPIN | NUTROPIN AQ | NUTROPIN AQ NUSPIN | OMNITROPE | SAIZEN | TEV-TROPIN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES, GROWTH FAILURE DUE TO CHRONIC RENAL INSUFFICIENCY(CRI) IF PATIENT HAS HAD A RENAL TRANSPLANT, OR GROWTH FAILURE DUE TO CRI WITH CLOSED EPIPHYSES.	INDUCTION - PATIENT'S HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. RENEWAL: GROWTH VELOCITY AND/OR TARGET HEIGHT.		ENDOCRINOLOGIST.	12 MONTHS.	FOR GROWTH FAILURE DUE TO (CRI): PATIENT HAS NOT UNDERGONE A RENAL TRANSPLANT. RENEWAL: GROWTH VELOCITY OF 2 CM OR MORE COMPARED WITH WHAT WAS OBSERVED FROM THE PREVIOUS YEAR AND/OR PATIENT HAS NOT REACHED 50TH PERCENTILE FOR TARGET HEIGHT FOLLOWING GROWTH HORMONE THERAPY.
SOMATROPIN - SEROSTIM	SEROSTIM	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES	HIV/WASTING: MEETS CRITERA OF WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, OR 7.5% OVER 6 MONTHS, OR 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN), 23% (WOMEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BMI LESS THAN 20 KG PER METER SQUARED.			HIV/AIDS: 3 MONTHS.	HIV/WASTING: CURRENTLY ON ANTIRETROVIRAL THERAPY. IF CURRENTLY ON GROWTH HORMONE, PATIENT HAS SHOWN CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT OR IF NOT ON GROWTH HORMONE, PATIENT HAS HAD INADEQUATE RESPONSE TO PREVIOUS THERAPY. (I.E. EXERCISE TRAINING, NUTRITIONAL SUPPLEMENTS, APPETITE STIMULANTS OR ANABOLIC STEROIDS).
SOMATROPIN - ZORBTIVE	ZORBTIVE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES	SHORT-BOWEL SYNDROME: CURRENTLY ON SPECIALIZED NUTRITIONAL SUPPORT.			SHORT BOWEL: 4 WEEK ONCE.	
SORAFENIB TOSYLATE	NEXAVAR	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
SUNITINIB MALATE	SUTENT	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	GASTROINTESTIONAL STROMAL TUMORS (GIST): TRIAL OF OR CONTRAINDICATION TO GLEEVEC.
TELAPREVIR	INCIVEK	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	COMPLETED PRIOR COURSE OF THERAPY WITH TELAPREVIR (INCIVEK) OR BOCEPREVIR (VICTRELIS) AND DID NOT ACHIEVE A SUSTAINED VIROLOGIC RESPONSE. CURRENTLY TAKING RIFAMPIN OR HAS A CO-INFECTION WITH HEPATITIS B.	CHRONIC HEPATITIS C, GENOTYPE 1. HCV RNA LEVEL/VIRAL LOAD OF LESS THAN 1,000 IU/ML AT 4 WEEKS OF TELAPREVIR THERAPY.	PATIENT 18 YEARS OF AGE OR OLDER.	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST) OR SPECIALLY TRAINED GROUP (E.G. EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES). HEP C AND ORGAN TRANSPLANT: TRANSPLANT CENTER AND TRANSPLANT PHYSICIAN.	INITIAL: 8 WEEKS RENEWAL: 4 WEEKS	HEP C: CONCURRENT USE OF RIBAVIRIN AND PEGINTERFERON ALFA.
TERIFLUNOMIDE	AUBAGIO	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	TRIAL OF OR CONTRAINDICATION TO ONE INTERFERON THERAPY (SUCH AS AVONEX, BETASERON, EXTAVIA, OR REBIF) AND TO COPAXONE.
TERIPARATIDE	FORTEO	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	GREATER THAN 24 MONTHS OF THERAPY.	A PATIENT WITH EITHER A DIAGNOSIS OF SEVERE OSTEOPOROSIS (T-SCORE LESS THAN -2.5 WITH FRAGILITY FRACTURE) OR A T SCORE EQUAL TO OR LESS THAN -2.5 AND MULTIPLE RISK FACTORS FOR FRACTURE (E.G. HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS), OR FAILED AN ADEQUATE TRIAL OF BISPHOSPHONATES, IS INTOLERANT, OR HAS A CONTRAINDICATION TO BISPHOSPHONATES.			12 MONTHS	
TESTOSTERONE	ANDRODERM | ANDROGEL | AXIRON | TESTOSTERONE CYPIONATE | TESTOSTERONE ENANTHATE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		MALE HYPOGONADISM CONFIRMED BY EITHER: 1) LAB CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL OF LESS THAN 300 NG/DL OR 2) A LOW TOTAL SERUM TESTOSTERONE LEVEL AS INDICATED BY A LAB RESULT WITH A REFERENCE RANGE OBTAINED WITHIN 90 DAYS, OR 3) A FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 50 NG/L.			LIFETIME OF MEMBERSHIP IN PLAN	
TETANUS TOXOID VACCINE BVD DETERMINATION	TETANUS TOXOID ADSORBED	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.						
TETRABENAZINE	XENAZINE	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.				NEUROLOGIST	12 MONTHS	
THALIDOMIDE	THALOMID	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL COVERAGE CONSIDERATION FOR ANEMIA DUE TO MYELODYSPLASTIC SYNDROME AND WALDENSTROM'S MACROGLOBULINEMIA.					12 MONTHS	

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THIAZOLIDINEDIONE	AVANDAMET | AVANDARYL | AVANDIA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	APPLIES TO NEW STARTS ONLY. TRIAL OR CONTRAINDICATION TO METFORMIN, METFORMIN ER, GLYBURIDE/METFORMIN, GLIPIZIDE/METFORMIN OR A SULFONYLUREA AND PIOGLITAZONE.
TOCILIZUMAB	ACTEMRA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		ACTIVE RHEUMATOID ARTHRITIS, SJIA, OR PJIA RENEWAL: AT LEAST 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT.	JIA: 2 YEARS AND OLDER	PRESCRIBED BY OR RECOMMENDED BY A RHEUMATOLOGIST.	RA INITIAL: 6 MONTHS. RENEWAL: 6 MONTHS. JIA: 12 MONTHS.	TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE OF THE FOLLOWING: ENBREL, HUMIRA, REMICADE, SIMPONI OR CIMZIA.
TOCILIZUMAB SC	ACTEMRA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		DIAGNOSIS: ACTIVE RHEUMATOID ARTHRITIS. RENEWAL: AT LEAST 20% IMPROVEMENT OR MAINTENANCE IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT.		PRESCRIBED BY OR RECOMMENDED BY A RHEUMATOLOGIST.	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS	TRIAL OF HUMIRA AND CIMZIA.
TOFACITINIB	XELJANZ	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		RENEWAL: RHEUMATOID ARTHRITIS: EXPERIENCED OR MAINTAINED 20 PERCENT IMPROVEMENT IN TENDER OR SWOLLEN JOINT COUNT WHILE ON THERAPY.		RHEUMATOLOGIST	RA: INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.	RHEUMATOID ARTHRITIS INITIAL: TRIAL OR CONTRAINDICATION TO HUMIRA AND CIMZIA.
TOPICAL TRETINOIN	AVITA | TRETINOIN	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.	WRINKLES, PHOTOAGING, MELASMA.				12 MONTHS	BRAND TRETINON WILL REQUIRE TRIAL OF GENERIC TOPICAL TRETINOIN.
TOTAL PARENTARAL NUTRITION AGENT BVD DETERMINATION	AMINOSYN | AMINOSYN II | AMINOSYN M | AMINOSYN-HBC | AMINOSYN-PF | CLINIMIX | CLINIMIX E | CLINISOL | DEXTROSE IN WATER | HEPATAMINE | HEPATASOL | INTRALIPID | LIPOSYN III | NEPHRAMINE | PREMASOL | PROCALAMINE | PROSOL | TRAVASOL | TROPHAMINE	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.					
TRAMETINIB DIMETHYL SULFOXIDE	MEKINIST	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	
TRASTUZUMAB	HERCEPTIN	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		BREAST CANCER, METASTATIC BREAST CANCER, GASTRIC CANCER: HER2 POSITIVE			12 MONTHS	B VS D COVERAGE CONSIDERATION. BREAST CANCER: USED IN COMBINATION WITH CHEMOTHERAPY (EXAMPLES INCLUDE: DOXORUBICIN AND CYCLOPHOSPHAMIDE FOLLOWED BY PACLITAXEL OR DOCETAXEL AND CARBOPLATIN OR DOCETAXEL FOLLOWED BY FLUOROURICIL/EPIRUBICIN/CYCLOPHOSPHAMIDE OR DOXORUBICIN/CYCLOPHOSPHAMIDE FOLLOWED BY DOCETAXEL OR PACLITAXEL. GASTRIC CANCER: USED IN COMBINATION WITH CHEMOTHERAPY (EXAMPLES INCLUDE: CISPLATIN AND FLUOROPYRIMIDINE.
TREPROSTINIL DIOLAMINE	ORENITRAM ER	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.				PRESCRIBED OR IN CONSULTATION WITH A CARDIOLOGIST OR A PULMONOLOGIST.	12 MONTHS	
USTEKINUMAB	STELARA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 10 PERCENT BODY SURFACE AREA OR PASI SCORE GREATER THAN OR EQUAL TO 12. PATIENT'S WEIGHT.		DERMATOLOGIST OR RHEUMATOLOGIST	INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS	FOR SEVERE PLAQUE PSORIASIS COVERING 10% BSA: TRIAL/FAILURE/INTOLERABLE SIDE AFFECTS TO AT LEAST ONE PREFERRED THERAPY (PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE). RENEWAL: PHYSICIAN'S GLOBAL ASSESMENT EQUAL TO ZERO OR ONE OR A DECREASE OF PASI OF AT LEAST 50% OR GREATER.
VANDETANIB	CAPRELSA	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	CRITERIA APPLIES TO NEW STARTS ONLY.
VEMURAFENIB	ZELBORAF	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.		BRAFV600E MUTATION			12 MONTHS	
VILAZODONE	VIIBRYD	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	TRIAL OF OR CONTRAINDICATION TO A SSRI (PAROXETINE, SERTARLINE, CITALOPRAM, FLUOXETINE, OR ESCITALOPRAM) AND A SECOND AGENT (BUPROPION HCL (IR, SR, OR XL), MIRTAZAPINE, OR VENLAFAXINE (IR OR XR)).
VISMODEGIB	ERIVEDGE	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.					12 MONTHS	

*This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
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