

Drug*	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
* Listing does not indicate formulary coverage. Please refer to membership materials to determine if medication is covered under your selected plan.							
Actimmune	Patient has Chronic Granulomatous Disease OR Patient has severe, malignant osteopetrosis					1 year	
Actiq	Patient has a diagnosis of cancer with breakthrough cancer pain			Patient is 16 years of age or older		1 year	Patient is already receiving opioid therapy and TOLERANT to opioid therapy as defined as receiving: At least 60mg morphine per day, OR At least 25mcg/hr transdermal fentanyl/hour, OR At least 30mg of oxycodone daily, OR At least 8mg of oral hydromorphone daily, OR An equianalgesic dose of another opioid for a week or longer.
Ambien CR, Sonata	Treatment of insomnia.					1 year	Patient has tried, failed or is intolerant to both a generic sedative hypnotic and Lunesta in the previous 180 days.

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Amevive	Patient has a diagnosis of chronic moderate to severe plaque psoriasis and All FDA-approved indications not otherwise excluded from Part D	Currently receiving other immunosuppressive therapy or phototherapy. Patient is HIV positive. CD4+ T lymphocyte count less than 250 cells per microliter. History of recurrent infection, or current chronic infection or clinically important infection, or positive tuberculin skin test History of systemic malignancy within last 5 years. Pregnant women or nursing mothers	Greater than 10% of body surface area with plaque psoriasis or Less than or equal to 10% body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia)	Patient is 18 years of age or older		12 wks. 2nd 12 wk if CD4+ T counts and normal and if at least 12 wks since previous tx	Failure of phototherapy or other systemic therapies to achieve an adequate clinical response, or a medical contraindication to the use of phototherapy or other systemic therapies (e.g. methotrexate). Disease is not controlled with topical therapy. Re-treatment with a second 12 week course may be initiated if CD4+ T lymphocyte counts are normal and if at least 12 weeks have passed since the previous course of treatment
AMINESS	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						
AMINOSYN	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						
AMINOSYN 7%/ELECTROLYTES	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						
AMINOSYN 8.5%/ELECTROLYTES	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						
AMINOSYN II	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						
AMINOSYN II 3.5%/DEXTR OSE25%	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						
AMINOSYN II 3.5%/DEXTR OSE5%	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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AMINOSYN II 3.5/DEXTROS E25%	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						
AMINOSYN II 4.25/DEXTRO SE10%	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						
AMINOSYN II 4.25/DEXTRO SE20%	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						
AMINOSYN II 4.25/DEXTRO SE25%	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						
AMINOSYN II 5/DEXTROSE 25	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						
AMINOSYN II 8.5%/ELECTR OLYTES	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						
AMINOSYN II M 3.5%/DEXTR OSE 5%	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						
AMINOSYN II M 4.25/DEXTRO SE 10%	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						
AMINOSYN M	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						
AMINOSYN- HBC	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						
AMINOSYN- HF	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						
AMINOSYN- PF	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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AMINOSYN-PF 7%	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						
ANZEMET	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination						
Aranesp	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						
Arthrotec	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						
AZASAN	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination						
AZATHIOPRINE	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination						
AZATHIOPRINE SODIUM	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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Botox/ Myobloc	Strabismus, Achalasia, Chronic anal fissures, treatment of the following disorders if associated with spasticity or dystonia: Blepharospasm, Equinus foot, if related to cerebral palsy, Hereditary spastic paraplegia, Infantile cerebral palsy, Multiple sclerosis, Neuromyelitis optica, Schilder's disease, Spastic hemiplegia, Spasticity related to stroke, or spinal cord injury, Idiopathic torsion dystonia, Organic writer's cramp, Orofacial dyskinesia (i.e., jaw closure dystonia), Spasmodic dysphonia or laryngeal dystonia (a disorder of speech due to abnormal control of the laryngeal muscles present only during the specific task of speaking), Symptomatic torsion dystonia, Facial nerve (VII) dystonia, Other forms of upper motor neuron spasticity, Treatment of significant	Botulinum toxin is considered cosmetic as a treatment of skin wrinkles or other cosmetic indications and is not approvable. Botulinum toxin may not be approved for the treatment of any other conditions including, but not limited to, the following: Headache, including but not limited to tension, migraine or chronic daily headaches, Anismus, Chronic motortic disorder, Fibromyalgia/fibromyositis, Gastroparesis, Low back pain, Myofascial pain syndrome, Neck pain not related to conditions mentioned above, Parkinson's disease, Tics associated with Tourette's Syndrome, Tourette's Syndrome, Tremors, Urinary and anal sphincter dysfunction, Stuttering, Carpal tunnel syndrome	For Cervical Dystonia (spasmodic torticollis) of moderate or greater severity when all of the following criteria are met: History of recurrent clonic and/or tonic involuntary contractions of one or more of the following muscles: sternocleidomastoid, splenius, trapezius and/or posterior cervical muscles, and Sustained head tilt and/or abnormal posturing with limited range of motion in the neck, and The duration of the condition is greater than 6 months.			1 year	treatment of hyperhidrosis will be approved for patients who have failed a 6 month trial of any one or more types of nonsurgical treatment

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Botox/ Myobloc (continued)	drooling in patients who are unable to tolerate scopolamine, Treatment of Cervical Dystonia (spasmodic torticollis) of moderate or greater severity. Treatment of incontinence related detrusor overreactivity and incontinence of neurogenic origin (i.e., spinal cord injury, multiple sclerosis) that is inadequately controlled with anticholinergic therapy. Detrusor sphincter dyssynergia of neurogenic origin and all other FDA-approved indications not otherwise excluded from Part D.						
Celebrex	Patient has Familial Adenomatous Polyposis (FAP) and All other FDA-approved indications not otherwise excluded from Part D					1 year	for any diagnosis except FAP, patient had treatment failure two (2) prescription Non-Steroidal Anti-Inflammatory Drugs (NSAID) or salicylates within the previous 180 days. FAP approved without requiring another product to be tried first
CELLCEPT	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug t						
CELLCEPT INTRAVENOUS	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 t						

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Cimzia	Member has a diagnosis of moderate to severe Crohn's Disease	Individuals with CHF who develop new symptoms or worsening symptoms of pre-existing CHF, Tuberculosis or other active serious infections, including chronic or localized infections, Individuals who have not had a tuberculin skin test to rule out latent tuberculosis, Multiple sclerosis or other demyelinating neurological disease, Concurrent administration of live (including attenuated) vaccines with certolizumab pegol (Cimzia), Currently receiving other TNF blocking agents or anakinra (Kineret), Any other indication not listed		Member is 18 years of age or older		1 year	Member has had an inadequate response or is unable to tolerate conventional therapies (e.g. sulfasalazine, mesalamine products, corticosteroids, immunosuppressants (6-mercaptopurine, azathioprine, cyclosporine, or methotrexate)), AND Member has had an inadequate response or is intolerant to Remicade (infliximab)
CLIMIMIX E 4.25%/DEXTR OSE 5%	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						
CLINIMIX 2.75%/DEXTR OSE 5%	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						
CLINIMIX 4.25%/DEXTR OSE 10%	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						
CLINIMIX 4.25%/DEXTR OSE 20%	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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CLINIMIX 4.25%/DEXTR OSE 5%	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						
CLINIMIX 5%/DEXTROS E 15%	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						
CLINIMIX 5%/DEXTROS E 20%	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						
CLINIMIX 5%/DEXTROS E 25%	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						
CLINIMIX E 2.75%/DEXTR OSE 10%	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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CLINIMIX E 5%/DEXTROS E 25%	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						
CLINIMIX E 5%/DEXTROS E 35%	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						
CLINISOL SF 15%	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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Colony Stimulating Factors	<p>Prevention of FN in patients who have a risk of FN of 20% or greater when there are no equally effective regimens not requiring CSFs available. Prevention of FN when the risk of developing FN is less than 20% in patients who have other risk factors for FN including any of the following: Patient age greater than 65 years, Poor performance status, Previous episodes of FN, Extensive prior treatment including large radiation ports, After completion of combined chemoradiotherapy, Bone marrow involvement by tumor producing cytopenias, Poor nutritional status, The presence of open wounds or active infections, More advanced cancer or Other serious comorbidities.</p>		<p>Per American Society of Clinical Oncology (ASCO), the patients are at high risk based on: Age, Medical history, Disease characteristics, Myelotoxicity of the chemotherapy regimen. Prognostic factors predictive of clinical deterioration: Expected prolonged (greater than 10 day) and profound (less than 0.1 x 10 to the power of 9/L) neutropenia, Age greater than 65 years, Uncontrolled primary disease, Pneumonia, Hypotension and multi organ dysfunction (sepsis syndrome), Invasive fungal infection, Hospitalized at the time of the development of fever.</p>			1 year	
Colony Stimulating Factors (continued)	<p>Secondary Prophylaxis for patients who experienced a neutropenic complication from a prior cycle of chemotherapy (for which primary prophylaxis was not received), in which a reduced dose may compromise disease-free or overall survival or treatment outcome.</p> <p>Adjunctive use with antibiotics in high-risk, febrile, neutropenic patients who are at high risk for infection-associated complications or have any of the prognostic factors predictive of clinical deterioration. Use for Dose Dense Therapy in the treatment of node positive breast cancer, small cell lung cancer and diffuse aggressive non Hodgkin's lymphoma. Adjunct to Progenitor Cell Transplantation to mobilize PBPC often in conjunction with chemotherapy and their administration after autologous PBPC transplant. For administration shortly after the completion of induction chemotherapy of AML with patients over 55 years of age most likely to benefit or for patients of any age, after the completion of consolidation chemotherapy for AML. In ALL, for administration after completion of the first few days of chemotherapy of the initial induction or first post-remission course.</p> <p>For severe neutropenia and recurrent infection in MDS patients. In the absence of chemotherapy, if prolonged delays secondary to neutropenia are expected. Prophylactic use with diffuse administration for high-risk pediatric patients. Exposure to lethal doses of total body radiotherapy or accidental total body radiation. Chronic administration to reduce the incidence and duration</p>						

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Copaxone	relapsing-remitting multiple sclerosis	Patients with progressive MS OR Patients with secondary progressive MS without relapsing disease OR Use of glatiramer acetate in patients with secondary progressive MS, or those with an initial demyelinating event OR Increased dosages or glatiramer.				1 year	
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	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 MODIFIED	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination						
CYTOXAN	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						
DRONABINOL	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						
Elidel, Protopic	atopic dermatitis		diagnosis of chronic mild to moderate atopic dermatitis	Member is equal to or greater than 2 years of age		1 year	A trial of one topical prescription corticosteroid within the previous 120 days
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						

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Enbrel	Diagnosis of Active Ankylosing Spondylitis and has failed, had an inadequate response to or is not indicated for treatment with ONE OF THE FOLLOWING: sulfasalazine, methotrexate, or non-steroidal anti-inflammatory drugs. OR a diagnosis of Moderate to severe Chronic Plaque Psoriasis that was not controlled with topical therapy and had a failure to achieve an adequate clinical response or medical contraindication to phototherapy OR ONE other systemic therapies (e.g. methotrexate, acitretin, or cyclosporine). OR a diagnosis of Moderately to severely active Rheumatoid Arthritis or moderate to severe active polyarticular-course juvenile idiopathic arthritis (JIA) and patient has failed or had an inadequate response to ONE of the disease modifying	Latex allergy as Enbrel prefilled syringe cover contains latex. Tuberculosis or a history of recurrent infection, chronic current infection, or clinically important infection. Patients who have not had a tuberculin skin test to rule out latent tuberculosis. History of systemic malignancy within the last 5 years. Moderate to severe (NYHA Class III/IV) Congestive Heart Failure (CHF), Multiple Sclerosis or other demyelinating disease. Using Enbrel in combination with other TNF agents or Kineret. Patient is currently receiving phototherapy, systemic psoriasis therapy (except for methotrexate, glucocorticoids, salicylates, non-steroidal anti-inflammatory drugs, or analgesics), immunosuppressive therapy, or Anakinra.	A diagnosis of Moderately to severely active rheumatoid arthritis. OR a Diagnosis of moderate to severe plaque psoriasis with either of the following: Patient has greater than 10% of body surface area with plaque psoriasis OR Less than or equal to 10% of body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia). OR a Diagnosis of Psoriatic Arthritis is Patient has active arthritis, with at least 3 swollen joints and 3 tender joints	Patient is 18 years of age or older, except for the diagnosis of Juvenile Rheumatoid Arthritis		1 year	
Enbrel (continued)	anti-rheumatic agents (DMARDs). OR a diagnosis of Psoriatic Arthritis and patient has failure or contraindicated for ONE of the DMARDs OR All other FDA-approved indications not otherwise excluded from Part D.						

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ENGERIX-B	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination						
Epogen and Procrit	Treatment of anemia associated with Chronic Renal Failure (CRF), including both patients on dialysis [endstage renal disease (ESRD)], and patients not on dialysis with Hgb less than 10g/dL. Treatment of Anemia induced by concomitantly administered chemotherapy known to produce anemia in patients with a diagnosis of cancer other than acute leukemia. Treatment of Anemia in Myelodysplastic syndrome with an endogenous erythropoietin level less than 500 mU/liter. Treatment of Anemia related to therapy with zidovudine in HIV-infected patients when the endogenous serum erythropoietin level is less than or equal to 500 mUnits/mL and when the dose of zidovudine is less than or equal to 4200 mg/week.	Anemia in patients due to other factors such as iron deficiency, folate deficiency or B12 deficiency, hemolysis, gastrointestinal bleeding, other active or occult bleeding, or underlying hematologic diseases (such as sickle cell anemia, thalassemia, and porphyria). Sudden loss of response with severe anemia and low reticulocyte count. Increase in dosage at intervals more frequently than once a month. Treatment of anemia in patients with cancer not treated by chemotherapy known to produce anemia.	Hematocrit (Hct)/hemoglobin (Hgb) levels are less than 32% /10 g/dL, prior to initiation of therapy (unless otherwise specified) AND Prior to and during therapy, the patient's iron status, including transferrin saturation and serum ferritin is evaluated with transferrin saturation at least 20% and ferritin at least 100 ng/mL prior to initiation of therapy AND For patients with uncontrolled hypertension, blood pressure is adequately controlled before initiation of therapy and closely monitored and controlled during therapy. Reduction of Allogeneic Blood Transfusion in Pre-Operative Surgery Patients: Patient's hemoglobin is greater than 10 and less than or equal to 13 g/dL,			12 weeks for anemia caused by CRF, 8 weeks for all other indications	In the absence of response, use of Epoetin Alfa is considered not medically necessary beyond 8 weeks for anemia in myelodysplastic syndrome and 12 weeks for anemia caused by CRF. For anemia caused by CRF, Chemotherapy, Myelodysplastic syndrome, zidovudine, and allogeneic bone marrow transplantation, Continued use of epoetin alfa is considered not medically necessary when the hemoglobin level exceeds 12 g/dL unless otherwise specified. For anemia caused by CRF, Chemotherapy, Myelodysplastic syndrome, zidovudine, Hepatitis C Virus Infection, chronic inflammatory bowel disease on chemotherapy, and allogeneic bone marrow transplantation,

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<p>Epogen and Procrit (continued)</p>	<p>Treatment of Anemia and Reduction of Allogeneic Blood Transfusion in Pre-Operative Surgery Patients. Treatment of Anemia in Patients being treated for Hepatitis C Virus Infection who are being concomitantly treated with the combination of ribavirin and interferon alfa, or ribavirin and peginterferon alfa. Treatment of Anemia induced by concomitantly administered chemotherapy known to produce anemia in patients with a diagnosis of a chronic inflammatory disease. Allogeneic Bone Marrow Transplantation.</p>		<p>Patient is scheduled to undergo elective, noncardiac, nonvascular surgery, Patient is at high risk for perioperative transfusions with significant, anticipated blood loss, Patient is unable or unwilling to donate autologous blood, Antithrombotic prophylaxis has been considered.</p>				<p>Continued use of epoetin alfa may only be approved beyond 8 weeks if the hemoglobin does not exceed 12 g/dL AND Iron stores (including transferrin saturation and ferritin) are adequately maintained and monitored periodically during therapy. For anemia caused by Chemotherapy, The continuation of epoetin alfa is considered not medically necessary beyond 8 weeks after therapy with chemotherapy known to produce anemia is completed.</p>

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Erbix	Patient has a diagnosis of metastatic colon cancer, rectal cancer or colorectal cancer. Patient has a diagnosis of Head and/or Neck cancer. Patient has a diagnosis of non-small cell lung cancer.	For metastatic colon cancer, rectal cancer, or colorectal cancer, patient has received prior treatment with panitumumab (Vectibix) or Erbitux is used in combination with other monoclonal antibodies. For NSCLC, patient has received prior treatment with panitumumab (Vectibix) or Erbitux is used in combination with other monoclonal antibodies.				6 months	Metastatic colon cancer, rectal cancer or colorectal cancer has progressed on Fluoropyrimidine-containing chemotherapy regimens, Oxaliplatin (Eloxatin®)-containing chemotherapy regimens, and Irinotecan (Campto®)-containing chemotherapy regimens. For Head and/or Neck cancer, Erbitux is used in combination with radiation therapy, for the treatment of locally or regionally advanced squamous cell carcinoma of the head and neck or as a single agent for the treatment of patients with recurrent or metastatic squamous cell carcinoma of the head and neck for whom prior platinum-based therapy has failed.

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Fentora	Patient is diagnosed with cancer with breakthrough cancer pain.			Patient is 18 years of age or older		1 year	Patient is already receiving opioid therapy and TOLERANT to opioid therapy as defined as receiving: At least 60mg morphine per day, OR At least 25mcg/hr transdermal fentanyl/hour, OR At least 30mg of oxycodone daily, OR At least 8mg of oral hydromorphone daily, OR An equianalgesic dose of another opioid for a week or longer. Physician has discussed the appropriate disposal of unused medication with the patient.

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Forteo	Patient has osteoporosis.		Patient has very low bone mineral density (-3 or below). Patient has sustained a fragility fracture or compression fracture due to osteoporosis despite treatment with antiresorptive therapy. A Bone Mineral Density (BMD) must be provided with all requests. Osteoporosis is defined as a BMD T-Score of less than or equal to -2.5 as compared to young normal adults. BMD T-Scores greater than -2.5 (closer to 0 or positive) are not considered osteoporotic. Request site of fragility or compression fractures. The following are not considered as strongly associated with the progression of osteoporosis: Feet, Toes, Fingers, Ribs.			2 years. Requests to continue therapy beyond 24 months (2 years) should not be approved.	Intolerant or has a contraindication to other osteoporosis therapy. Intolerance or contraindications to bisphosphonates are defined as having at least one of the following: Allergy to both Actonel and Fosamax, Inability to sit or stand upright for at least 30 minutes, Pre-existing gastrointestinal disorders (Barrett's esophagus, hypersecretory disorders, etc.).
FREAMINE HBC 6.9%	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						
FREAMINE III	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						
FREAMINE III 3%	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						
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						

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Gleevec	Patient presents with a diagnosis of Philadelphia chromosome positive (Ph+) chronic myeloid leukemia (CML), Patient presents with Philadelphia chromosome-positive (Ph+) acute lymphoblastic leukemia (ALL), Patient presents with a diagnosis of gastrointestinal stromal tumors (GIS), Patient presents with dermatofibrosarcoma protuberans tumors, Patient has hypereosinophilic syndrome, Patient has aggressive systemic mastocytosis, Myeloproliferative disorders					1 year	
GnRH Prostate	prostate cancer and All other FDA-approved indications not otherwise excluded from Part D		For Prostate cancer: Palliative treatment of advanced or metastatic prostate cancer. Neoadjuvant or adjuvant therapy with radiation therapy in the management of localized prostate cancer in men with a high risk or very high risk of recurrence (Stage T3a or greater if staging is available or If stage is undetermined, a Gleason score of 8-10 or a PSA level greater than20 ng/ml).			1 year	
GRANISETRO N HCL	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination						

Drug*	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
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GRANISOL	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						
HEPATAMINE	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						
HEPATASOL	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						
Human Growth Hormone	Documented growth hormone deficiency in Children under the age of 18 (all products, except Serostim and Zorbtive), reconstructive treatment in Children under the age of 18 (all products, except Serostim and Zorbtive), Transitioning adolescent patients with childhood onset GH deficiency (GHD) to treatment in adulthood (all products, except Accretropin, Tev-tropin, Serostim and Zorbtive), Adult growth hormone deficiency or somatotropin deficiency syndrome for patients with Documented GHD in childhood OR Documented hypopituitarism as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy, or trauma (all products, except Accretropin, Tev-tropin, Serostim and Zorbtive),		GHD: Diminished peak serum GH response (less than 10 ng/ml) to at least 1 provocative stimuli, Neonates with hypoglycemia and clinical and hormone evidence of hypopituitarism and low GH (at least one GH stimulation test is subnormal) OR presence of at least 3 other pituitary hormone deficiencies. Recon GH tx: Est final adult ht, based on bone age, of greater than 2.5 SD below the mean with a condition known to be responsive to GH tx. Children who are born small for gest age (birth weight or length 2 or more SD below the mean for gest age), Child fails to manifest catch up growth by age 2 years (height 2 or more SD below the mean for age and sex) AND Other causes for short stature have been ruled out. Transitioning adolescent patients: GH tx has been stopped for at least 3 months,			1 year, except for AIDs- Wasting is 3 months	Continuation of GH therapy may be approved in children who previously met criteria for GHD or reconstructive treatment when the following are met: Review should occur on an annual basis for all conditions, a doubling of pre-treatment growth rate or an increase in pre-treatment growth rate of 3 cm/year or more seen in the first year of therapy, for therapy continuing past the first year, growth rate remains above 2.5 cm/year (does not apply to children with prior documented hypopituitarism), for children over age ten: an X-ray report with evidence that epiphyses have not yet closed (does not apply to children with prior documented hypopituitarism).

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<p>Human Growth Hormone (continued)</p>	<p>HIV patients with AIDS wasting syndrome (Serostim only), Short bowel syndrome receiving specialized nutritional support in conjunction with optimal management of short bowel syndrome (Zorptive only).</p>		<p>and GHD has been reconfirmed: idiopathic isolated GHD (subnormal response to 2 standard GH stimulation tests, OR subnormal response to 1 provocative test and low IGF-I/IGFBP-3) OR multiple pituitary hormone deficiency with or without tumor/ radiation, or patients with identified genetic or structural defect of GH production/ secretion (subnormal response to 1 provocative GH test and/or low IGF-I/IGFBP-3).  Subnormal response is defined as serum GH concentration of less than 10 ng/mL. Adult GHD must be confirmed, or reconfirmed: subnormal response in adults to two standard GH stimulation tests (Serum GH concentration of less than or equal to 5 ng/ml when using insulin induced hypoglycemia testing OR Serum GH concentration of less than or equal to 4.1 ng/ml when using arginine) OR Subnormal response to 1 stimulation test for adults with hypothalamic or pituitary disease and one or more additional pituitary hormone deficits OR presence of at least three other pituitary hormone deficiencies. HIV with AIDS wasting syndrome: greater than 10% of baseline weight loss that cannot be explained illness other than HIV infection.</p>				<p>GH therapy used for reconstruction should be terminated when any of the following criteria are met: Bone age =16 years (male), or = 14 years (female) is reached OR Epiphyseal fusion has occurred OR “Mid-parenteral height” is achieved. Mid-parenteral height = (father’s height +mother’s height) divided by 2, plus 2.5 inches (male) or minus 2.5 inches (female). Patients treated with GH for AIDS wasting must simultaneously be treated with antiviral therapy.</p>

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Humira	Patient has a diagnosis of moderately to severely active Rheumatoid Arthritis, diagnosis of Psoriatic Arthritis, Diagnosis of Active Ankylosing Spondylitis, Crohn's Disease, Diagnosis of Chronic moderate to severe plaque psoriasis, diagnosis of moderate to severe polyarticular Juvenile Idiopathic Arthritis.	Using Humira in combination with other TNF agents or Kineret (anakinra), Tuberculosis or a history of recurrent infection, chronic current infection, or clinically important infection, Patients who have not had a tuberculin skin test to rule out latent tuberculosis, Latex allergy as Humira prefilled syringe cover contains latex, Multiple Sclerosis or other demyelinating disease, Individuals with CHF who develop new symptoms or worsening symptoms of pre-existing CHF, Pregnant women or nursing mothers. For Psoriatic Arthritis, Currently receiving phototherapy, systemic psoriasis therapy (except for methotrexate, glucocorticoids, salicylates, nonsteroidal anti-inflammatory drugs, or analgesics), or immunosuppressive therapy.	Moderately to severely active rheumatoid arthritis: Markedly swollen and painful joints, significant joint involvement, ESR near 10mm, frequent anemia, fatigue, functionally limited. Psoriatic Arthritis: Patient has active arthritis, with at least 3 swollen joints and 3 tender joint and Patient has presence of plaque psoriasis with a qualifying target lesion at least 2 cm, in diameter AND Patient has arthritis in any of the following distributions: Distal interphalangeal joint involvement, Polyarticular arthritis without rheumatoid nodules, Arthritis mutilans, Asymmetric arthritis, Ankylosing spondylitis-like arthritis. For Chronic moderate to severe plaque psoriasis Patient has a diagnosis of moderate to severe plaque psoriasis with either of the following:	Patient is 18 years of age or older for all indications except JIA. Patient must be at least 4 years old for JIA.		1 year	For RA, Psoriatic Arthritis, Patient has failed or had an inadequate response to one or more disease-modifying anti-rheumatic agents (DMARD) in the previous 6 months. For Ankylosing Spondylitis, Patient has failed, had an inadequate response to or is not indicated for treatment with sulfasalazine, methotrexate, or non-steroidal anti-inflammatory drugs. For Crohn's disease, Patient has had an inadequate response to conventional therapy (ex: sulfasalazine, oral mesalamine, corticosteroids, and antibiotics) and Patient has not been previously treated with a tumor necrosis antagonist or Patient has previously been treated with infliximab (Remicade) but have lost response to or are intolerant of infliximab (Remicade). For plaque psoriasis,

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Humira (continued)			Patient has greater than 10% of body surface area with plaque psoriasis OR Less than or equal to 10% of body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).				Disease is not controlled with topical therapy and Patient has failed, has a contraindication, or is intolerant to, but is otherwise a candidate for other systemic therapies.
IMURAN	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						
Interferons for MS	Patients with a single demyelinating episode with consistent MRI findings, considered at high risk for clinically definite MS OR Patients with MS with relapsing or remitting disease OR Patients with secondary progressive MS with a history of superimposed relapses OR All FDA-approved indications not otherwise excluded from Part D	Patients with progressive MS OR Patients with secondary progressive MS without relapsing disease OR Increased dosages of IFN-b				1 year	
INTRALIPID	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						
INTRALIPID 20%	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						
ITP	Diagnosis of chronic immune (idiopathic) thrombocytopenia purpura (ITP)		Patient is at risk for bleed as a result of thrombocytopenia and clinical condition			1 year	Previous treatment failure with one of the following interventions: a) corticosteroids or b) immunoglobulins or c) splenectomy

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IVIG	Treatment of primary immunodeficiencies, including: Hypogammaglobulinemia, Congenital agammaglobulinemia (X-linked gammaglobulinemia), Common variable immunodeficiency, X-linked immunodeficiency with hyperimmunoglobulin M, OR Severe combined immunodeficiency, Wiskott-Aldrich syndrome Treatment of idiopathic thrombocytopenic purpura (ITP). Treatment of Kawasaki Syndrome. Patients with hypogammaglobulinemia and/or recurrent bacterial infection associated with B-cell chronic lymphocytic leukemia (CLL). To reduce the risk of graft-versus-host disease associated with interstitial pneumonia (infectious or idiopathic) and infections (cytomegalovirus infections,	IVIG may not be approved for treatment of Recurrent Spontaneous Abortion (RSA)				1 year	
IVIG (continued)	Varicella-zoster virus infection, and recurrent bacterial infection) in allogeneic bone marrow transplant (BMT) patients in the first 100 days after transplantation. Prevention of infection in HIV infected pediatric patients. Prevention of infection in Bone marrow transplant patients. Antenatal alloimmune thrombocytopenia. Autoimmune neutropenia. Chronic inflammatory demyelinating polyneuropathy (IVIG should be considered as a first-line treatment of CIDP. IVIG is used alone or following therapeutic plasma exchange to prolong its effect. IVIG is considered easier to use than repeated therapeutic plasma exchange and to have fewer complications than long-term glucocorticoid therapy.) Dermatomyositis, refractory (IVIG is used as a second line treatment of dermatomyositis. Corticosteroids are first-line treatments of dermatomyositis.) Lambert-Eaton myasthenic syndrome treatment. Guillain-Barre Syndrome (acute demyelinating polyneuropathy) as an equivalent alternative to plasma exchange. Hyperimmunoglobulinemia E syndrome (HIE) treatment. Multifocal motor neuropathy in patients with anti GM1 antibodies and conduction block. Multiple sclerosis, relapsing-remitting treatment. IVIG is used as a second-line treatment of relapsing-remitting multiple sclerosis.						

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IVIG (continued)	<p>Myasthenia Gravis, severe refractory. Polymyositis, routine use of IVIG is not recommended. IVIG may be considered in patients with severe polymyositis for whom other treatments have been unsuccessful, have become intolerable, or are contraindicated. Prior to a medically necessary renal transplantation for suppression of panel reactive anti-HLA antibodies in patients with high panel reactive antibody (PRA) levels to human leukocyte antigens (HLA). Prevention of infections in high-risk, preterm, low birth weight neonates. Stiff-person syndrome not controlled by other therapies. Toxic shock syndrome caused by staphylococcal or streptococcal organisms refractory to several hours of aggressive therapy. Solid organ transplant recipients at risk for CMV. Treatment of chronic parvovirus B19 infection and severe anemia associated with bone marrow suppression. Refractory auto-immune mucocutaneous blistering diseases including: pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid, epidermolysis bullosa acquisita</p>						
Kineret	<p>Patient must have diagnosis of moderate to severe active rheumatoid arthritis (RA),</p>	<p>Latex allergy, as prefilled syringe cover contains latex, Tuberculosis or a history of recurrent infection, chronic current infection, or clinically important infection, Patients who have not had a tuberculin skin test to rule out latent tuberculosis, History of systemic malignancy within the last 5 years, Moderate to severe (NYHA Class III/IV) Congestive Heart Failure (CHF), Multiple Sclerosis or other demyelinating disease, Using Kineret (anakinra) in combination with other TNF agents, Patient is not currently receiving phototherapy, systemic psoriasis therapy (except for methotrexate, glucocorticoids, salicylates, non-steroidal anti-inflammatory drugs, or analgesics), immunosuppressive therapy.</p>	<p>Moderate to severe active rheumatoid arthritis: Markedly swollen and painful joints, significant joint involvement, ESR near 10mm, frequent anemia, fatigue, functionally limited.</p>	<p>Patient must be 18 years of age or older</p>		<p>1 year</p>	<p>Patient has failed or had an inadequate response to one or more disease modifying anti-rheumatic agents (DMARDs).</p>
KYTRIL	<p>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</p>						

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Leukotriene Modifiers	The patient has persistent asthma AND is receiving an inhaled corticosteroid, a long-acting beta-agonist, or a short acting beta-agonist					1 year	For Zyflo: The patient has tried and failed or has had a documented adverse reaction with Accolate and Singulair.
lidocaine	Lidocaine IV will be used for infiltration and nerve block, Lidocaine IV will be used for acute management of cardiac arrhythmia	Lidocaine IV may not be approved for the treatment of chronic pain				1 year	
Lotronex	Diagnosis of severe diarrhea-predominant Irritable Bowel Syndrome (IBS)		Severe diarrhea-predominant Irritable Bowel Syndrome (IBS) where severe includes diarrhea and 1 of the following: Frequent and severe abdominal pain/discomfort, Frequent bowel urgency or fecal incontinence, Disability or restriction of daily activities due to IBS.			1 year	Patient is female AND Patient has chronic symptoms of IBS that have persisted for 6 months or longer AND Patient has a documented failure or intolerance to at least one anti-diarrheal agent.
Lunesta	Treatment of insomnia.			Lunesta 3mg not covered for patients 65 and older		1 year	Patient has tried, failed or is intolerant to zolpidem (immediate release) in the previous 180 days.

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Lupron	Lupron 5mg: prostate cancer, IVF, Ovarian Cancer. Lupron Depot 3.75mg (1 month): Endometriosis, prostate cancer, Uterine Fibroids, Breast cancer. Lupron Depot 7.5mg, 22.5mg, and 30mg(1, 3, 4months): prostate cancer. Lupron Depot 11.25mg (3 months): Endometriosis, Uterine Fibroids. Lupron Depot Ped: Central Precocious Puberty		For Prostate cancer: Palliative treatment of advanced or metastatic prostate cancer. Neoadjuvant or adjuvant therapy with radiation therapy in the management of localized prostate cancer in men with a high risk or very high risk of recurrence (Stage T3a or greater if staging is available or If stage is undetermined, a Gleason score of 8-10 or a PSA level greater than20 ng/ml). For Gynecology Uses: Endometriosis, Chronic pelvic pain – not to continue beyond three months if there is no symptomatic relief, To decrease endometrial thickness prior to endometrial ablation procedures, Preoperative treatment as adjunct to surgical treatment of uterine fibroids (leiomyoma uteri). May be used to reduce size of fibroids to allow for a vaginal procedure,			1 year, except for Endometriosis:6months, Uterine Fibroids:3 months	

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Lupron (continued)			Prior to surgical treatment (myomectomy or hysterectomy) in patients with documented anemia. To induce amenorrhea in women in certain patient populations including menstruating women diagnosed with severe thrombocytopenia or aplastic anemia, Infertility (Adjunctive treatment with in vitro fertilization regimens) used in conjunction with urofollitropin or menotropins to suppress luteinizing hormone (LH) production in members with documented premature LH surge, or used in "super-ovulation" regimens associated with in vitro fertilization. Precocious puberty, defined as sexual maturation before age 8 until age 11 in girls and before age 9 until age 12 in boys, and tumor has been ruled out by lab tests, CT, MRI, or ultrasound. Delayed puberty with growth hormone based on inclusion in the Compendia, AHFS.				
Lyrica	Member has a diagnosis of epilepsy or seizures, Member has diagnosis of neuropathic pain associated with diabetic peripheral neuropathy, Member has a diagnosis of post herpetic neuralgia, Member has a diagnosis of Fibromyalgia,		For Fibromyalgia: Patient has widespread pain (on the left and right side of the body and above and below the waist) AND axial skeletal pain (cervical spine or anterior chest or thoracic spine or low back) present for at least 3 months AND Pain in at least 11 of 18 specific tender point sites after digital palpation with an approximate force of 4 kg. Tender point sites are bilateral and include the following: Occiput, Low Cervical, Trapezius, Supraspinatus, Second rib, Lateral epicondyle, Gluteal, Greater trochanter, Knee			1 year	For diabetic peripheral neuropathy, member had a trial of an FDA approved or medically accepted medication for neuropathic pain within the past 180 days (Cymbalta, Carbamazepine, Tricyclic antidepressants, Gabapentin, Trazadone). For post herpetic neuralgia, member had a trial of an FDA approved or medically accepted medication for post herpetic neuralgia within the past 180 days (Carbamazepine, Gabapentin, Lidocaine patch (Lidoderm), Tricyclic antidepressants). For Fibromyalgia, member had a trial of an FDA approved or medically accepted medication for Fibromyalgia (Cyclobenzaprine, Tricyclic antidepressants, fluoxetine, or Cymbalta (duloxetine)).

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MARINOL	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						
MYFORTIC	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						
NEORAL	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						
NEPHRAMINE	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						
Neumega	The prevention of severe thrombocytopenia and the reduction of the need for platelet transfusion following myelosuppressive chemotherapy in in adult patients at high risk of severe thrombocytopenia and All FDA-approved indications not otherwise excluded from Part D					1 Year	
Nexavar	Diagnosis of Renal Cell Carcinoma or Kidney Cancer or Diagnosis of Advanced Hepatocellular Carcinoma (HCC) or Liver Cancer					1 year	

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non-pegylated interferons	FDA approved or medically accepted diagnosis other than Chronic Hepatitis C, in combination with ribavirin for Hepatitis C Genotype 1, 2, or 3, and Hepatitis C in Patients with a Contraindication to Ribavirin.		Confirmed hepatitis C with compensated liver disease for Genotype 1 or 4: Detectable HCV RNA, Liver biopsy (unless contraindicated or not warranted by the treating physician's judgement) shows some fibrosis and inflammation or necrosis, For Genotype 2 or 3: Detectable HCV RNA. EVR: decrease in HCV RNA greater than 2 log to the power of 10 (i.e. from 1,200,000 to 12,000) from baseline OR a decrease in HCV RNA to undetectable levels at week 12 of initial therapy.	non-pegylated interferons may be approved for patients less than 18 years of age if other criteria are met		1yr except for Initial Tx of HepC Gen1: 15 wks, Tx of HepC Gen2or3: 24wks, CI to ribavirin: 48wks,	Hepatitis C Genotype 1: Intron-A or Roferon-A in combination with ribavirin may be approved in treatment naïve patients less than 18 years of age or with renal failure who have compensated liver disease. Infergen in combination with ribavirin may be approved in patients who have not responded to therapy with a pegylated interferon and ribavirin who have confirmed hepatitis C (HCV) genotype 1 with compensated liver disease. All Non-Pegylated interferons in combination with
non-pegylated interferons (continued)				ribavirin may be approved in patients with HCV genotype 1 currently receiving therapy who require an additional 36 weeks of treatment (to complete a total of 48 weeks) and who have documented early viral response (EVR). Hepatitis C Genotype 2 or 3: Non-Pegylated interferon in combination with ribavirin may be approved in treatment naïve patients less than 18 years of age or with renal failure and who have compensated liver disease. Infergen in combination with ribavirin may be approved in patients who have not responded to therapy with a pegylated interferon and ribavirin and who have compensated liver disease.			
non-pegylated interferons (continued)				Hepatitis C in Patients with a Contraindication to Ribavirin: Non-Pegylated interferon monotherapy may be approved in treatment naïve patients less than 18 years of age or with renal failure with a contraindication to ribavirin and confirmed hepatitis C (HCV) with compensated liver disease OR Infergen may be approved in patients who have not responded to therapy with a pegylated interferon who have confirmed hepatitis C (HCV) with compensated liver disease.			

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NOVAMINE	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination						
ONDANSETRON HCL	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination						
ONDANSETRON ODT	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination						
Oral Androgens	androxyl: breast cancer, Delayed puberty, Hypogonadotropic hypogonadism, Primary hypogonadism. Anadrol 50:Acquired aplastic anemia, Anemia of chronic renal failure, Antineoplastic adverse reaction - Myelosuppression, Fanconi's anemia, Pure red cell aplasia, Cachexia associated with AIDS. Android: Delay in sexual development AND/OR puberty, Male, Hypogonadotropic hypogonadism, Primary hypogonadism, breast cancer. For all drugs, All FDA-approved indications not otherwise excluded from Part D					1 year	
Orencia	Diagnosis is moderately to severely active RA OR Diagnosis of moderate to severe Polyarticular Juvenile Idiopathic Arthritis (JIA) and All FDA-approved indications not otherwise excluded from Part D	Using in combination with other tumor necrosis factor blocking agents or Kineret.		For RA, Patient is 18 years of age or older. For JIA, Patient is 6 years of age or older		1 year	For RA, Patient has had an inadequate response to ONE DMARD AND Patient has had an inadequate response to EITHER Remicade OR Enbrel. For JIA, member has had an inadequate response to Enbrel

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ORTHOCLON E OKT3	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						
Pegylated Interferons	<p>Hepatitis C Genotype 1: Pegylated interferon in combination with ribavirin may be approved in patients with confirmed hepatitis C (HCV) with compensated liver disease for up to an initial 12 weeks of therapy. Hepatitis C Genotype 2 or 3: Pegylated interferon in combination with ribavirin may be approved in patients with confirmed hepatitis C (HCV) for a course of treatment not to exceed 24 weeks in duration. Hepatitis C Antiviral Therapy in Patients with a Contraindication to Ribavirin: Pegylated interferon monotherapy may be approved in patients with a contraindication to ribavirin and confirmed HCV (any genotype) with compensated liver disease for up to 48 weeks. All FDA-approved indications not otherwise excluded from Part D.</p>		<p>Confirmed hepatitis C with compensated liver disease for Genotype 1 or 4: Detectable HCV RNA, Liver biopsy (unless contraindicated or not warranted by the treating physician's judgement) shows some fibrosis and inflammation or necrosis, For Genotype 2 or 3: Detectable HCV RNA, EVR: a decrease in HCV RNA greater than 2 log 10 (i.e. from 1,200,000 to 12,000) from baseline OR a decrease in HCV RNA to undetectable levels at week 12 of initial therapy</p>			<p>HCV Gen 1 initial: 15wks, con't: up to 1 yr, Gen 2 or 3: 24wks, CI to ribavirin: 1 yr</p>	<p>Hepatitis C Genotype 1: Treatment naïve patients OR Patients with significant fibrosis or cirrhosis who received previous treatment using non-pegylated interferon onotherapy or in combination with ribavirin who demonstrate no response or have relapsed OR Patient has not received previous treatment with pegylated interferon in combination with ribavirin. Pegylated interferon in combination with ribavirin may be approved for patients with HCV genotype 1 currently receiving therapy who require an additional 36 weeks of treatment (to complete a total of 48 weeks) of therapy when Patients have documented early viral response (EVR). Hepatitis C Genotype 2 or 3: Treatment naïve patients, OR Patient has received previous</p>
Pegylated Interferons (continued)	<p>Pegasys for Hepatitis B: HBeAg either positive or negative, AND detectable levels of Hepatitis B DNA, AND ALT at least 2X upper limit of normal</p>						<p>non-pegylated interferon monotherapy with no response or relapse has occurred.</p>

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Penlac	Diagnosis of onychomycosis.		Patient has a confirmed fungal infection (i.e. physical exam).			1 year	Patient has had a trial of, or is contraindicated to Sporanox and Lamisil OR Patient has used Penlac within the previous 6 months. For Onychomycosis with no comorbidity, Evidence of functional impairment (such as loss of one or more toenails, pain, or swelling) is present.
PREMASOL	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						
Pristiq	All FDA-approved indications not otherwise excluded from Part D					1 year	Trial of a generic selective serotonin reuptake inhibitor (SSRI) AND Trial of venlafaxine/Effexor XR and is unable to tolerate doses greater than 150mg OR Member is currently taking a medication that would interact with venlafaxine/Effexor XR (e.g. CYP2D6 inducers/inhibitors) where Pristiq would be the better drug of choice, please specify
PROGRAF	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination						
PROSOL	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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Provigil	Excessive daytime sleepiness due to narcolepsy, OR Fatigue associated with Multiple Sclerosis, OR Obstructive sleep apnea/hypopnea syndrome, OR Shift work sleep disorder					1 year	
quinine	Patient has a diagnosis of uncomplicated Plasmodium falciparum malaria resistant to chloroquine					1 year	
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						
Raptiva	Diagnosis of moderate to severe plaque psoriasis	History of recurrent infection, or current chronic infection or clinically important infection, Positive tuberculin skin test, History of systemic malignancy within the last 5 years, Currently receiving other immunosuppressive therapy or phototherapy, Pregnant women or nursing mothers	Greater than 10% of body surface area with plaque psoriasis or Less than or equal to 10% body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia)	Patient must be 18 years of age or older		1 year	Failure of phototherapy or other systemic therapies to achieve an adequate clinical response, or a medical contraindication to the use of phototherapy or other systemic therapies (e.g. methotrexate) and Disease is not controlled with topical therapy
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						
Regranex	Patient has a diabetic ulcer of the lower extremities, including legs, ankles, and feet.		Ulcer is stage 3 or 4 of the IAET (International Association for Enterostomal Therapy) guide to wound staging.			1 year	The Patient has undergone sharp debridement of the ulcer.
Relistor	Diagnosis of opioid-induced constipation		Patient has advanced illness and receiving palliative care			1 year	Trial and failure of conventional laxative therapy

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Relenza	Medication is being used for the treatment of influenza OR Medication is being used for the prophylaxis of influenza			treatment of influenza: Patient is 7 years of age and older. prophylaxis of influenza: Patient is 5 years of age and older		for treatment of (community outbreak) prophylaxis, three fills (28 days). All other uses 1 fill.	

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Remicade	Moderately to severely active Rheumatoid Arthritis (RA). Moderately to severely active Crohn's disease. Patient has signs and symptoms of moderately to severely active ulcerative colitis. Patient has signs and symptoms of active ankylosing spondylitis. Active psoriatic arthritis. Extensive or disabling treatment resistant chronic plaque psoriasis. Reactive Arthritis (Reiter's Syndrome) and Arthritis Associated with Inflammatory Bowel Disease.	Hypersensitivity to any murine proteins or other components of the product, Moderate to severe (NYHA Class III/IV) Congestive Heart Failure (CHF), Individuals with CHF who develop new symptoms or worsening symptoms of pre-existing CHF, Tuberculosis or a history of recurrent infection, current chronic infection, or clinically important infection, Patients who have not had a tuberculin skin test to rule out latent tuberculosis, Multiple sclerosis and other demyelinating diseases, In combination with other tumor necrosis factor blocking agents or anakinra (Kineret). For psoriatic arthritis, Currently receiving phototherapy, systemic psoriasis therapy (except methotrexate), or immunosuppressive therapy or Pregnant women or nursing mothers.	A diagnosis of Moderately to severely active rheumatoid arthritis. Moderately to severely active Crohn's disease. For psoriatic arthritis, Patient has active arthritis, with at least 5 swollen joints and 5 tender joints. Diagnosis of moderate to severe plaque psoriasis: Greater than 10% of body surface area with plaque psoriasis OR Less than or equal to 10% body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).	For all indications except Crohn's Disease, Patient is 18 years of age or older. For Crohn's Disease, Patient is 6 years of age or older.		1 year	For RA, Patient is currently on methotrexate (if patient is intolerant to methotrexate, in combination with another immunosuppressive agent that has also been demonstrated to prevent the development of human anti-chimeric antibodies [HACA], i.e. azathioprine, cyclosporine, or sulfasalazine), AND Patient has had an inadequate response to one or more DMARDs. For Crohn's Disease, Patient had an inadequate response to conventional therapy OR Patient has fistulizing Crohn's disease with draining enterocutaneous or rectovaginal fistulas, of at least 3 months duration OR Patient has fistulizing or moderately to severely active Crohn's disease and has responded to previous therapy with infliximab. For UC, AS and psoriatic arthritis, Patient has had an inadequate response to conventional therapy

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Remicade (continued)							conventional therapy. For chronic plaque psoriasis, Disease is not controlled with topical therapy AND Failure of phototherapy or other systemic therapies to achieve an adequate clinical response, or a medical contraindication to the use of phototherapy or other systemic therapies.
RENAMIN	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						
Revatio	Patient has catheterization-proven diagnosis of Pulmonary Arterial Hypertension	Patient is NOT on concurrent therapy with oral erectile dysfunction drugs AND Patient is NOT on concurrent therapy with nitrates (nitric oxide is excluded) AND Patient does NOT have Retinitis Pigmentosa	Patient is New York Heart Association (NYHA) or World Health Organization (WHO) Functional Class II or III			1 year	

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Revlimid	Patient has a diagnosis of transfusion-dependent anemia associated with low- or intermediate-1-risk myelodysplastic syndromes (MDS) associated with a deletion of 5q cytogenetic abnormality OR Patient has a diagnosis of multiple myeloma OR patient has relapsed or refractory chronic lymphoid leukemia.					1 year	For multiple myeloma, using in combination with dexamethasone.
Rituxan	Diagnosis of moderately to severely active rheumatoid arthritis. Relapsed or refractory, low-grade or follicular, CD20-positive, B-cell non-Hodgkin's lymphoma OR Diffuse large B-cell, CD20-positive, non-Hodgkin's lymphoma. Relapsed/refractory chronic lymphocytic leukemia (CLL) .Relapsed/refractory Waldenstrom's macroglobulinemia. Immune or idiopathic thrombocytopenic purpura.			For RA, Patient is 18 years of age or older.		1 year	For RA, Patient is currently taking methotrexate AND Patient has had an inadequate response to Enbrel and Remicade. For Diffuse large B-cell, CD20-positive, non-Hodgkin's lymphoma, Rituxan is in combination with CHOP (cyclophosphamide, adriamycin, vincristine and prednisone) or other anthracycline-based chemotherapy regimens.
SANDIMMUNE	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						
SIMULECT	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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Sprycel	Diagnosis of chronic myeloid leukemia (CML) or Philadelphia chromosome-positive acute lymphoblastic leukemia (ALL).			approved for 18 years of age and older		1 year	Has disease progression or developed intolerance while using other chemotherapy.
Subutex, Suboxone	Treatment of opioid dependence				Physician has a valid Data 2000 waiver or "X" number in addition to their DEA number documented on the prescription.	6 months	
Sutent	Diagnosis of gastrointestinal stromal tumor (GIST) OR Patient presents with a diagnosis of renal cell carcinoma (RCC) or Kidney Cancer OR patient has a diagnosis of metastatic breast cancer.					1 year	For GIST, has disease progression or intolerance while on imatinib (Gleevec). For metastatic breast cancer, patient was previously treated with chemotherapy.
Synarel Nasal Solution	Endometriosis, Central Precocious Puberty		Precocious puberty, defined as sexual maturation before age 8 until age 11 in girls and before age 9 until age 12 in boys, and tumor has been ruled out by lab tests, CT, MRI, or ultrasound.			1 year	

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Tamiflu	Medication is being used in the treatment of influenza OR Medication is being used for prophylaxis of influenza			Patient is 1 year of age and older		For prophylaxis treatment approve quantity and fills needed for 6 weeks. All other uses, 1 fill.	
Tarceva	Diagnosis of metastatic NSCLC (non-small cell lung cancer). Diagnosis of pancreatic cancer.					1 year	For NSCLC, Experienced disease progression despite treatment with another antineoplastic agent. For pancreatic cancer, Tarceva will be used in combination with Gemzar (gemcitabine).
Targretin	Diagnosis of cutaneous T-cell lymphoma OR diagnosis of AIDS related Kaposi's sarcoma					1 year	For cutaneous T-cell lymphoma, patient has received at least one prior systemic therapy including but not limited to: Psoralen + ultraviolet A (PUVA), Methotrexate, Bexarotene, Denileukin, Isotretinoin, Pentostatin, Fludarabine, Cladarabine, Photophoresis (extra-corporeal photochemotherapy).

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Tasigna	Diagnosis of chronic phase OR accelerated phase Philadelphia chromosome positive chronic myelogenous leukemia (CML)			Patient is Age greater than 18 years		1 year	resistant or intolerant to prior therapy that included Gleevec (imatinib)
Thalomid	Diagnosis of Erythema nodosum leprosum (ENL) treatment, Erythema nodosum leprosum (ENL) suppression, Multiple Myeloma in combination with dexamethasone, Behcet's syndrome, HIV associated wasting syndrome, Aphthous stomatitis treatment, Esophageal aphthous ulcers in HIV-infected patients, AIDS-related Kaposi's sarcoma, cancer associated cachexia, recurrent Glioblastoma multiforme of CNS, Graft versus host disease following a cancer-related bone marrow transplant, prostate cancer, Waldenstrom's macroglobulinemia (lymphoplasmacytic lymphoma), mycobacterial infection caused by mycobacterium tuberculosis and nontuberculous mycobacteria, Crohn's disease, brain tumor.					1 year	Approve a category X medicine for a woman taking prenatal vitamins if the member is not pregnant.

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Topamax	Diagnosis of Epilepsy or Seizures OR, Lennox-Gastaut syndrome OR, Migraine Headache prophylaxis OR, Bipolar disorder					1 year	
Topical Androgens	Diagnosis of hypogonadism or testicular hypofunction OR Member has had an orchiectomy OR All FDA-approved indications not otherwise excluded from Part D					1 year	Patient is male. For hypogonadism or testicular hypofunction, testosterone level is provided for members beginning treatment with topical testosterone OR member is continuing successful treatment. For diagnosis other than hypogonadism or testicular hypofunction, testosterone level is provided and is below the reference laboratory range for members beginning treatment with topical testosterone OR member is continuing successful treatment.
TPN ELECTROLYT ES FTV	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						
TRAVASOL	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						
TRAVASOL 2.75%/DEXTR OSE 10%	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						
TRAVASOL 2.75%/DEXTR OSE 5%	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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TRAVASOL 3.5%/ELECTR OLYTES	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						
TRAVASOL 4.25%/DEXTR OSE 10%	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						
TRAVASOL 4.25%/DEXTR OSE 25%	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						
TRAVASOL 5.5%/DEXTR OSE 10%	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						
TRAVASOL 5.5%/DEXTR OSE 20%	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						
TRAVASOL 5.5%/ELECTR OLYTES	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						
TRAVASOL 8.5%/DEXTR OSE 10%	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						
TRAVASOL 8.5%/DEXTR OSE 20%	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						
TRAVASOL 8.5%/DEXTR OSE 50%	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						
TRAVASOL 8.5%/ELECTR OLYTES	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						
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						

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Tykerb	Diagnosis of advanced or metastatic breast cancer		Cancer has been confirmed HER2 positive			1 year	Using in combination with Xeloda (capecitabine) AND Prior therapy Herceptin,a taxane, (e.g., Paclitaxel, Abraxane,Onxol, Taxol, Docetaxel, Taxotere) AND an anthracycline (e.g., Doxorubicin, Adriamycin, Doxil, Epirubicin, Ellence)
Tyzeka	Diagnosis of chronic hepatitis B		chronic hepatitis B with evidence of viral replication and either evidence of persistent elevations in serum aminotransferases (ALT or AST) or histologically active disease.	Patient is 16 years of age or older		1 year	

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Vectibix	Diagnosis of metastatic colon cancer, rectal cancer or colorectal cancer OR diagnosis of advanced non-small cell lung cancer	For metastatic colon cancer, rectal cancer or colorectal cancer, patient has received prior treatment with cetuximab (Erbix) or Vectibix is used in combination with other monoclonal antibodies. For NSCLC, patient has received prior treatment with cetuximab (Erbix) or Vectibix is used in combination with other monoclonal antibodies.				6 months	For metastatic colon cancer, rectal cancer or colorectal cancer, patient's cancer has progressed on or following treatment with all of the following: Fluoropyrimidine-containing chemotherapy regimens [5-Fluorouracil (5-FU), Capecitabine (Xeloda), Floxuridine (FUDR)], Oxaliplatin (Eloxatin®)-containing chemotherapy regimens, Irinotecan (Campto®)-containing chemotherapy regimens. For advanced non-small cell lung cancer, patient is using Vectibix in combination with standard chemotherapy regimens.

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Vfend	Transitioning from inpatient treatment of IV antifungal to an outpatient setting, Invasive Aspergillosis, Scedosporium apiospermum, Fusarium spp., Candidemia in a nonneutropenic patient, Esophageal Candidiasis, Disseminated (deep tissue) Candida infections in the abdomen, kidney, bladder wall or wounds AND the patient has had an inadequate response or is contraindicated to one or more antifungal agents, OR The physician indicates that Vfend is to be used to treat any other medical condition(s) AND the physician has confirmed sensitivity to Vfend.	Requests for onychomycosis will not be approved.				1 year	
Vytorin	hypercholesterolemia					1 year	1. Patient has had at least a 30 day trial of Lipitor 40mg, 80mg or simvastatin 80mg and did not achieve LDL cholesterol goal OR 2. Patient requires greater than 50% reduction in LDL cholesterol OR 3. Patient has had a trial of simvastatin OR Lipitor (any strength) AND is intolerant or has adverse drug reaction
Xenazine	Diagnosis of chorea associated with Huntington's disease					1 year	

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Xolair	Diagnosis of Moderate Persistent or Severe Persistent Asthma		Patient has a positive skin test or in vitro reactivity to a perennial aeroallergen, AND Patient has an FEV1 less than 80% predicted AND Patient's IgE level is equal to or greater than 30 IU/ml. Severe asthma as defined by the National Heart, Lung, and Blood Institute:	Patient is 12 years of age or older		1 year	Patient's symptoms are inadequately controlled with combination controller therapy (medium to high dose inhaled corticosteroids plus long acting beta-2 agonists and/or Leukotriene receptor antagonists), or cannot tolerate these medications
Xolair (continued)			Severe Persistent Asthma: Continual symptoms, limited physical activity, and frequent exacerbations, Nocturnal symptoms are frequent, FEV1 or PEF is less than or equal to 60% predicted, PEF variability greater than 30%. Moderate Persistent Asthma as defined by the National Heart, Lung, and Blood Institute: Daily symptoms, daily use of inhaled short-acting beta2-agonist, exacerbations affect activity, and exacerbations are greater than 2 times a week and may last for days, Nocturnal symptoms occur greater than 1 time per week, FEV1 or PEF is greater than 60% and less then 80% predicted, PEF variability is greater than 30%.				
ZENAPAX	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination						
Zetia	Hypercholesterolemia					1 Year	Patient is concurrently taking a statin OR Patient has previously tried a statin and is not able to tolerate [i.e. myalgia, GI upset, elevated liver function tests (LFTs = ALT or AST) of 3x the upper normal limits (UNL)] OR Patient is using Zetia to treat homozygous familial sitosterolemia OR Patient has a condition that is contraindicated for statin therapy.

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ZOFRAN	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						
ZOFRAN 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						
Zolinza	Patient has a diagnosis of cutaneous T-cell lymphoma					1 year	Patient has received at least two prior therapies including but not limited to: Topical methclorethamine, topical carmustine, Psoralen + ultraviolet A (PUVA), Methotrexate, Bexarotene, Denileukin diftitox, Interferon, Gemcitabine, Cyclophosphamide, Chlorambucil, Doxorubicin, Isotretinoin, Pentostatin, Fludarabine, Cladarabine, Glucocorticoids (e.g., prednisone, dexamethasone), Photophoresis (extra-corporeal photochemotherapy)

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Zyvox	Patient has confirmed non-colonized vancomycin-resistant enterococcus (VRE) infection OR Patient has confirmed non-colonized methicillin-resistant S. aureus (MRSA) infection and has failed or has contraindications to 1st line therapy, OR Patient has nosocomial or community acquired pneumonia caused by susceptible gram (+) organisms OR Patient has complicated and uncomplicated skin/skin structure infects (inc. diabetic foot infections w/o concomitant osteomyelitis) OR Patient started treatment with Zyvox in the hospital and requires continued outpatient therapy, OR Patient has failed treatment with or has a contraindication to conventional antibiotics and requires initiation of therapy in the outpatient setting OR patient has febrile neutropenia					30 day supply/On e time only	
Zyvox (continued)	OR patient has FDA-approved indication or accepted off-label indication not otherwise excluded from Part D .						