

ABIRATERONE

Products Affected

- Zytiga

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient is male AND has a diagnosis of metastatic castration-resistant prostate cancer AND patient has received prior chemotherapy containing docetaxel or patient is medically unable to tolerate chemotherapy
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Abiraterone acetate 1,000 mg will be used in combination with prednisone 5 mg

ADALIMUMAB

Products Affected

- Humira
- Humira Pen-crohns Diseasestarter

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for use of Humira in combination with other biologics e.g., Enbrel, Kineret or Remicade.
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ALEFACEPT

Products Affected

- Amevive

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients using other immunosuppressive agents or patients diagnosed with HIV/AIDs
Required Medical Information	The first and second treatment cycles, each consisting of 12 weeks, must be separated by at least a 12-week interval. Retreatment with the second 12-week course may be initiated provided the CD4+ T-cell count is within the normal range. The physician should monitor CD4+ T-cell counts during treatment, dosing should be withheld if the CD4+ T-cell count is less than 250 /mm ³ and treatment should be discontinued if the count remains less than 250 /mm ³ for one month. Per manufacturer guidelines, Amevive should not be used concomitantly with other immunosuppressive agents or in patients currently receiving phototherapy. Amevive is contraindicated in patients with HIV/AIDs because it reduces CD4+ T-cell counts and, thus, may accelerate progression of HIV infection or increase complications of the disease.
Age Restrictions	Patient must be 18 years or older
Prescriber Restrictions	N/A
Coverage Duration	1 year, lifetime limit of 180 days
Other Criteria	N/A

AMBRISENTAN

Products Affected

- Letairis

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of PAH (WHO Group I) in Class II or III patients. Coverage is not provided unless pregnancy has been excluded prior to start of therapy and will be prevented thereafter with reliable contraception
Age Restrictions	N/A
Prescriber Restrictions	Consultation with or prescription by pulmonologist or cardiologist
Coverage Duration	12 months
Other Criteria	N/A

ANAKINRA

Products Affected

- Kineret

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of moderate to severe Rheumatoid Arthritis AND patient must have neutrophil counts assessed prior to beginning therapy, monthly for 3 months and then quarterly thereafter for up to a year AND patient does not have an active infection AND treatment will not be prescribed with another biologic DMARD. Patient must also have had an inadequate response to at least one biologic and nonbiologic DMARD
Age Restrictions	Patient must be 18 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ANDROGENS AND ANABOLIC STEROIDS

Products Affected

- Delatestryl
- Depo-testosterone
- Testosterone Cypionate INJ 100MG/ML
- Testosterone Enanthate

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Known or suspected carcinoma of the prostate or male breast, carcinoma of the breast in females with hypercalcemia, pregnancy, nephrosis, hypercalcemia, severe hepatic impairment
Required Medical Information	Approve if treatment is for: anemia caused by deficient red cell production (documented hematocrit less than 33 or hemoglobin less than 12) OR hereditary angioedema
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

BECAPLERMIN

Products Affected

- Regranex

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient has diagnosis of diabetes mellitus AND Patient has diabetic neuropathic ulcer(s) that extend into the subcutaneous tissue or beyond (Stages III and IV of the NPUAP/WOCN pressure ulcer staging) AND Patient's diabetic ulcer(s) has an adequate blood supply (defined as transcutaneous oxygen tension [T _{cp} O ₂] on limb where ulcer is located of greater than 30 mm Hg) AND Patient is receiving a program of good ulcer care (consisting of initial complete sharp debridement, a non-weight-bearing regimen, systemic treatment for wound-related infection if present, moist saline dressings changed twice a day, and additional debridement as necessary).
Age Restrictions	Patient is 16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

BOCEPREVIR

Products Affected

- Victrelis

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage will not be provided if patient does have any of the following contraindications to therapy: Pregnant or unwilling to comply with required contraception or Coadministration with alfuzosin, carbamazepine, phenobarbital, phenytoin, rifampin, dihydroergotamine, ergonovine, ergotamine, methylergovovine, cisapride, St. John's Wort, lovastatin, simvastatin, drospirinone, REVATIO (sildenafil) or ADCIRCA (tadalafil) (pulmonary arterial hypertension use), pimoziide, triazolam, and midazolam (orally administered).
Required Medical Information	Patient has a diagnosis of Chronic Hepatitis C Virus Genotype 1 with compensated liver disease AND Patient is receiving concurrent therapy with ribavirin and PEG-INTRON (peginterferon alfa-2b) or PEGASYS (peginterferon alfa-2a) AND Patient must also have one of the conditions: Treatment naïve to peginterferon alfa and ribavirin therapy or Been previously treated with peginterferon and ribavirin and was considered a partial responder, defined as a greater than or equal to 2-log ₁₀ reduction in HCV-RNA at week 12, but with a detectable HCV-RNA level during the therapy period or Been previously treated with peginterferon and ribavirin and was considered a prior relapser, defined as HCV-RNA undetectable at end of treatment with a pegylated interferon-based regimen, but HCV-RNA detectable during the follow-up period AND Patient has not previously failed a regimen with an HCV protease inhibitor (VICTRELIS or INCIVEK).
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Initial Review: 12 weeks Renewal Review: Dependent on patient type and HCV RNA response
Other Criteria	Renewal Review for Treatment Naïve without cirrhosis: If HCV-RNA levels at week 4 of boceprevir (TW 8) are undetectable and HCV-RNA levels at week 8 of boceprevir (TW 12) are less than 100 IU/mL, then additional approval of 12 weeks (24 wks total boceprevir, 28 TW total).

If HCV-RNA levels at week 4 of boceprevir (TW 8) are detectable and HCV-RNA levels at week 8 of boceprevir (TW 12) are less than 100 IU/mL, then additional approval of 12 weeks (24 wks total boceprevir, 28 TW total), recheck HCV-RNA at week 20 of boceprevir (TW 24). If HCV-RNA levels at week 20 of boceprevir (TW 24) are undetectable, additional approval of 8 weeks (32 wks total boceprevir, 36 TW total).

Renewal Review for Previous Partial Responders or Relapsers without cirrhosis: If HCV-RNA levels at week 8 of boceprevir (TW 12) are less than 100 IU/mL, then additional approval of 12 weeks (24 wks total boceprevir, 28 TW total), recheck HCV-RNA at week 20 of boceprevir (TW 24). If HCV-RNA levels at week 20 of boceprevir (TW 24) are undetectable, then additional approval of 8 weeks (32 wks total boceprevir, 36 TW total).

Renewal Review for Patients with cirrhosis and treatment naïve with poor interferon response: If HCV-RNA levels at week 8 of boceprevir (TW 12) are less than 100 IU/mL, then additional approval of 12 weeks (24 wks total boceprevir, 28 TW total), recheck HCV-RNA at week 20 of boceprevir (TW 24). If HCV-RNA levels at week 20 of boceprevir (TW 24) are undetectable, then additional approval of 20 weeks (44 wks total boceprevir, 48 TW total).

TW is defined as Treatment week of combination therapy of pegylated interferon, ribavirin, and boceprevir. TW includes a 4 week lead-in of pegylated interferon and ribavirin prior to initiation of boceprevir therapy.

BOSENTAN

Products Affected

- Tracleer

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Pulmonary Arterial Hypertension[PAH] (WHO Group I) in Class II, III or IV patients OR Eisenmenger's syndrome, (WHO Group I) Class III PAH OR Chronic thromboembolic pulmonary hypertension (WHO GROUP IV) AND For female patients, pregnancy has been excluded prior to the start of therapy and will be prevented thereafter with reliable contraception AND Patient is not on concomitant therapy with any of the following drugs: cyclosporine A or glyburide AND Appropriate baseline liver function tests have or will be performed prior to the start of therapy.
Age Restrictions	N/A
Prescriber Restrictions	Pulmonologist or cardiologist or documentation of consultation with pulmonologist or cardiologist
Coverage Duration	12 months
Other Criteria	N/A

BUPRENORPHINE PATCH

Products Affected

- Butrans

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for patients with any contraindications to therapy including: significant respiratory depression or severe bronchial asthma, known or suspected paralytic ileu, known hypersensitivity to any of its components or the active ingredient, buprenorphine OR patient is being treated for one of the following (listed contraindications): the management of acute pain or in patients who require opioid analgesia for a short period of time, the management of post-operative pain, including use after out-patient or day surgeries, the management of mild pain the management of intermittent pain).
Required Medical Information	Patient has diagnosis of moderate to severe pain requiring continuous, around-the-clock opioid analgesic for an extended period of time AND documentation that the patient has tried and failed/unable to tolerate at least 1 generic and/or formulary preferred therapies from each of the following two drug categories: (1) non-steroidal analgesics, (2) opioids (immediate and extended-release) and/or opioid combination products OR documentation of swallowing difficulties.
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

CIMZIA

Products Affected

- Cimzia

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Approve for FDA approved indications AND patient does not have a documented active infection, patient has been evaluated for tuberculosis risk factors and tested for latent infection prior to initiation of therapy and will be assessed periodically during therapy AND patient has failed to achieve symptom control after an adherent trial to one or more non-biologic disease modifying anti-rheumatic drugs (e.g. methotrexate, leflunomide, Hydroxychloroquine, sulfasalazine) AND patient has failed Remicade or Humira for Crohn's disease or Enbrel and Humira for rheumatoid arthritis
Age Restrictions	Patient must be 18 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

DASATINIB

Products Affected

- Sprycel

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage will not be provided when patient will concomitantly use an H2-receptor antagonist or proton pump inhibitor while taking dasatinib.
Required Medical Information	Patient has one of the following diagnoses: Patient is in the chronic phase, accelerated, or blast (myeloid or lymphoid) phase of Philadelphia chromosome positive chronic myelogenous leukemia or Patient has Philadelphia chromosome positive acute lymphoblastic leukemia
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	Prescriber is an oncologist or a healthcare provider highly familiar with prescribing and monitoring of oncology medications.
Coverage Duration	12 months
Other Criteria	Patient will have hypokalemia or hypomagnesemia corrected prior to administration of dasatinib, and levels will be monitored periodically during treatment AND Patient will have complete blood counts (CBCs) performed at baseline, weekly for the first 2 months, and monthly thereafter, or as clinically indicated.

DICLOFENAC PATCH

Products Affected

- Flector

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Approve if used for the topical treatment of acute pain due to minor strains, sprains, and contusions AND documented trial and failure of an oral NSAID or documented swallowing disorder
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ELTROMBOPAG

Products Affected

- Promacta

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage not provided for Concomitant use with other platelet-stimulating agents such as romiplostim or oprelvekin, Patient who has failed to respond to therapy with eltrombopag following at least 4 weeks at the maximum dose, Eltrombopag is being used to normalize platelet count rather than to reduce the risk of bleeding in patients with chronic ITP, Chemotherapy/drug-induced thrombocytopenia, Treatment of thrombocytopenia due to causes other than chronic ITP, Patients who have previously failed therapy with eltrombopag.
Required Medical Information	Patient has a diagnosis of relapsed/refractory chronic ITP (greater than 6 months) AND Prescriber and patient are enrolled in the Promacta Cares program (1-877-9-PROMACTA) AND Patient's baseline platelet count is less than 50,000/mcL AND Patient's degree of thrombocytopenia and clinical condition increases the risk for bleeding AND Patient had an insufficient response, intolerance, or contraindication to corticosteroids, immune globulin OR Patient had an inadequate response or contraindication to a splenectomy
Age Restrictions	Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ERLOTINIB

Products Affected

- Tarceva

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ERYTHROPOIETINS

Products Affected

- Aranesp Albumin Free INJ
100MCG/0.5ML, 100MCG/ML,
150MCG/0.3ML, 200MCG/0.4ML,
200MCG/ML, 25MCG/0.42ML,
25MCG/ML, 300MCG/0.6ML,
300MCG/ML, 40MCG/0.4ML,
40MCG/ML, 500MCG/ML,
60MCG/0.3ML, 60MCG/ML
- Procrit
- Epogen

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage not provided for prophylactic use to prevent chemotherapy-induced anemia or tumor hypoxia, sickle cell anemia, anemia associated only with radiotherapy or treatment of acute or chronic myelogenous leukemias or erythroid cancers, anemia of cancer not related to cancer treatment, anemia associated with iron deficiency, folate deficiency, B-12 deficiency, hemolysis, or bone marrow fibrosis
Required Medical Information	Pretreatment hemoglobin (Hgb) level must be less than 13 in anemic patients at high risk for perioperative blood loss and less than 10 for all other indications AND patient must have adequate iron stores prior to therapy AND patient must not have uncontrolled hypertension AND patient has not been diagnosed with antibody-mediated pure red cell aplasia AND other causes of anemia have been ruled out
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Part B vs D Determination - if patient has end stage renal disease and is on dialysis, covered under Part B. Otherwise covered under Part D.

ETANERCEPT

Products Affected

- Enbrel

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for use of Enbrel in combination with other biologics e.g., Humira, Kineret or Remicade.
Required Medical Information	Patient must have a negative tuberculin skin test, or if positive, have initiated treatment for latent TB prior to treatment with Enbrel AND active infection must be ruled out AND inadequate response to at least one nonbiologic disease modifying antirheumatic drug
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

EVEROLIMUS

Products Affected

- Afinitor

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for patients that will receive live vaccines during treatment.
Required Medical Information	Patient has a diagnosis of advanced/metastatic renal cell carcinoma (RCC) AND Patient has failed therapy (disease progressed) with sunitinib [SUTENT] or sorafenib [NEXAVAR] OR Patient has a diagnosis of progressive neuroendocrine tumors of pancreatic origin (PNET) that are unresectable, locally advanced, or metastatic OR Patient has Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis (TS) that requires therapeutic intervention but is not a candidate for curative surgical resection
Age Restrictions	Renal Cell Carcinoma: Patient is greater than or equal to 18 years of age Progressive Neuroendocrine Tumors: Patient is greater than or equal to 18 years of age Subependymal Giant Cell Astrocytoma: Patient is greater than or equal to 3 years of age
Prescriber Restrictions	Prescriber is an oncologist or a healthcare provider highly familiar with prescribing and monitoring of oncology medications
Coverage Duration	12 months
Other Criteria	If patient has a pre-existing invasive fungal infection, fungal infection treatment will be completed prior to initiation of everolimus.

FENTANYL

Products Affected

- Onsolis

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cancer and use is for breakthrough cancer pain AND Patient has no contraindications to use (1) the management of acute or postoperative pain, including headache/migraine, dental pain, or use in the emergency room, (2) opioid non-tolerant patients, (3) patients with known intolerance or hypersensitivity to any components of the drug or the drug fentanyl AND Patient, prescriber, and dispensing pharmacy are enrolled in the FOCUS REMS program AND Other formulary short-acting strong narcotic analgesic alternatives (other than fentanyl) have been ineffective, not tolerated, or contraindicated. Examples of short-acting strong narcotics include, but are not limited to, concentrated morphine oral solution, oxycodone or hydromorphone AND Patient is opioid tolerant and taking at least 60 mg morphine/day, at least 25 mcg transdermal fentanyl/hour, at least 30 mg of oxycodone daily, at least 8 mg oral hydromorphone daily or an equianalgesic dose of another opioid for a week or longer.
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

FENTANYL CITRATE BUCCAL

Products Affected

- Fentora

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage not provided in the management of acute or postoperative pain, opioid non-tolerant patients, patients with known intolerance or hypersensitivity to the drug or fentanyl
Required Medical Information	Diagnosis of cancer and use is for breakthrough cancer pain AND other formulary short acting narcotics have been ineffective, not tolerated, or contraindicated AND patient is opioid tolerant and taking at least 60 mg morphine/day or an equianalgesic dose of another opioid for a week or longer
Age Restrictions	Patient must be at least 18 years of age
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

FENTANYL, TRANSMUCOSAL

Products Affected

- Actiq
- Fentanyl Citrate Oral Transmucosal

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient must have a diagnosis of cancer and fentanyl is being used for the management of breakthrough pain. Patient must already be receiving and is tolerant to around the clock opioid therapy for cancer pain. Tolerance is defined as patients no longer responding to around the clock medicine consisting of the following or an equianalgesic dose of another opioid daily for a week or longer: morphine 60mg orally daily, or at least 25 mcg/hr transdermal fentanyl, or at least 30mg of oxycodone daily, or at least 8mg of oral hydromorphone daily.
Age Restrictions	Patient must be 16 years of age or older
Prescriber Restrictions	Prescriber is an oncologist or pain management specialist or is skilled in the use of Schedule II opioids to treat cancer pain.
Coverage Duration	12 months
Other Criteria	N/A

FILGRASTIM

Products Affected

- Neupogen INJ 300MCG/0.5ML, 480MCG/0.8ML, 480MCG/1.6ML

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with known hypersensitivity to E coli-derived proteins, filgrastim, or any component of the product
Required Medical Information	Use primary prophylaxis/prevention of febrile neutropenia in myelosuppressive chemoORmeet 1 criteria: 1)has greater than/=20% febrile neutropenia risk OR2)febrile neutropenia risk is less than 20%,with a risk factor:greater than/= 65 yrs,Poor performance,Poor nutritional status,Prv episodes of febrile neutropenia,Extensive prior tx including large radiation ports,Cytopenias due to tumor bone marrow involvement,Completed combined chemoradiotherapy,Presence of open wounds/active infections,Other serious comorbiditiesOR3) receiving dose-dense chemo in breast cancer,small cell lung cancer,or non-Hodgkin's lymphoma.Pt had neutropenic complication from prior cycle of chemo(where primary prophylaxis was not received)ORpt had autologous/allogeneic BMT or PBPC [autologous PBPC transplant, receiving therapy to mobilize progenitor cells for collection by leukapheresis,tx for myeloid reconstitution post allogeneic BMT,allogenic/autologous BMT where engraftment is delayed/has failed]ORdiagnosis of AML/ALL [scheduled to receive induction chemo or consolidation chemo for AMLORhas ALL and completed the first few days of initial induction chemo or first post-remission course]ORdx of myelodysplastic syndrome w/severe neutropenia and recurrent infectionsORdx cancer w/severe febrile neutropeniaORused as adjunct to abx in high risk patients[w/one of the following:greater than/=65 yrsORUncontrolled primary diseaseORPneumoniaORHypotensionANDmultiorgan dysfunction(sepsis syndrome)ORInvasive fungal infection ORHospitalization due to fever ORSevere(ANC less than100/mcL)or anticipated prolonged(greater than10 days)neutropenia]ORpt has diffuse aggressive lymphoma,is greater than/=65 yrs,and being treated w/curative chemo OR receiving radiation therapy,is not on chemo,and prolonged delays in treatment expected secondary to neutropeniaORdx of congenital,cyclic,or idiopathic neutropeniaORdx of AIDS with neutropeniaORdx of aplastic anemiaORdx of congenital or drug-induced agranulocytosis

Age Restrictions	N/A
Prescriber Restrictions	Patient is under the care of a physician with experience in prescribing filgrastim
Coverage Duration	4 months
Other Criteria	N/A

GOLIMUMAB

Products Affected

- Simponi

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of rheumatoid arthritis (RA), psoriatic arthritis (PsA) or ankylosing spondylitis (AS). No documented active infection. Evaluated for TB risk factors, tested for latent TB before starting therapy, assessed periodically. In adequate response to etanercept or adalimumab therapy except if not tolerated due to documented clinical side effects . For RA, golimumab is being used in combination with an oral DMARD such as methotrexate.
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For RA, patient failed to achieve symptom control after an trial to conventional treatment including methotrexate +/- one disease modifying anti-rheumatic drugs (DMARDs) +/- 1 NSAIDs unless contraindicated or intolerant AND Patient has had inadequate symptom control /response after therapy with etanercept or adalimumab except if not tolerated due to documented clinical side effects. For PsA, patient failed to achieve symptom control/response after an trial of 1 of the following DMARDs either as monotherapy OR in combination unless contraindicated or intolerant, such as methotrexate or cyclosporine AND Patient has had inadequate symptom control /response after therapy with etanercept or adalimumab except if not tolerated due to documented clinical side effects. For AS, patient failed to achieve symptom control/response after a trial of conventional therapy with 1 non-steroidal antiinflammatory drugs (NSAIDs) unless contraindicated or intolerant AND Patient has had inadequate symptom control /response after therapy with etanercept or adalimumab except if not tolerated due to documented clinical side effects.

GROWTH HORMONES

Products Affected

- Genotropin
- Genotropin Miniquick
- Humatrope
- Humatrope Combo Pack
- Norditropin Flexpro
- Norditropin Nordiflex Pen
- Nutropin INJ 10MG
- Nutropin Aq Nuspin 5
- Nutropin Aq Pen
- Omnitrope
- Saizen INJ 5MG
- Saizen Click.easy
- Serostim
- Tev-tropin
- Zorbtive

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

IBANDRONATE

Products Affected

- Boniva INJ

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient has any of the following diagnoses: Osteoporosis in a postmenopausal female or Primary or hypogonadal osteoporosis in a male AND documented trial and failure of an oral bisphosphonate for six months, OR patient has documented contraindication, intolerant to oral bisphosphonate therapy, or unable to comply with appropriate administration recommendations AND patient must receive supplemental calcium and vitamin D therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

IMATINIB

Products Affected

- Gleevec

Details	
Covered Uses	All FDA-approved indications not otherwise excluded for Part D.
Exclusion Criteria	N/A
Required Medical Information	Approve if diagnosed with Philadelphia chromosome positive chronic myelogenous leukemia, Philadelphia chromosome positive acute lymphoblastic leukemia, Gastrointestinal stromal tumor, Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic, Hypereosinophilic syndrome or chronic eosinophilic leukemia, Myelodysplastic syndrome or myeloproliferative disease associated with PDGFR gene rearrangements, Systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutational status unknown, Desmoid tumor. Approve if diagnosed with Philadelphia chromosome positive chronic myelogenous leukemia AND Patient will have complete blood counts (CBCs) performed at baseline, weekly for the first month, biweekly for the second month, and periodically thereafter as clinically indicated AND Patient will have liver function (transaminases, bilirubin, and alkaline phosphatase) monitored at baseline and monthly, or as clinically indicated AND Patient will be weighed at baseline and monitored regularly for signs and symptoms of fluid retention
Age Restrictions	Patients at least 18 years of age for FDA approved indications in adults. Patients at least 2 years of age and older for Philadelphia chromosome positive chronic myelogenous leukemia.
Prescriber Restrictions	Prescriber is an oncologist experienced in the treatment of patients with hematologic malignancies or malignant sarcomas
Coverage Duration	12 months
Other Criteria	N/A

IMMUNE GLOBULINS

Products Affected

- Carimune Nanofiltered INJ 3GM
- Gamastan S/d
- Gammagard Liquid
- Gammaplex INJ 10GM/200ML
- Gamunex
- Hizentra INJ 1GM/5ML
- Privigen INJ 20GM/200ML
- Vivaglobin

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided in patients with selective IgA deficiency, history of anaphylactic reaction or hypersensitivity to immune globulin preparations
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

INFLIXIMAB

Products Affected

- Remicade

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for use in combination with Enbrel, Kineret, or Humira.
Required Medical Information	Diagnosis RA and PsA: Member has had an inadequate response to one nonbiologic disease modifying antirheumatic drugs (DMARDS), Diagnosis AS: Member has had an inadequate response to two NSAIDs or one nonbiologic disease modifying antirheumatic drugs (DMARDS), Diagnosis Plaque Psoriasis: Member must have tried a DMARD or UVA light therapy with oral or topical psoralens (PUVA) in the past year, Diagnosis of Crohn's or UC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

INTERFERON ALFACON-1

Products Affected

- Infergen INJ 15MCG/0.5ML

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage not allowed for any of the following contraindications to therapy: Autoimmune hepatitis and hepatitis decompensation
Required Medical Information	Patient is receiving treatment for hepatitis C infection AND Patient is considered a relapser/non-responder to combination treatment with peg-interferon and ribavirin AND Patient is receiving combination therapy with ribavirin, unless contraindicated.
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Initial: 16 weeks. Renewal: Additional 32 weeks if early response at week 12.
Other Criteria	For Renewal: early virological response is defined as greater than or equal to 2 log reduction in HCV RNA is at week 12.

LAPATINIB

Products Affected

- Tykerb

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis: Patient has advanced or metastatic breast cancer whose tumor overexpresses HER2: patient received prior therapy including an anthracycline, a taxane, and trastuzumab (HERCEPTIN): and lapatinib will be used in combination with capecitabine (XELODA) OR Patient is a postmenopausal woman with hormone receptor positive metastatic breast cancer that overexpresses HER2 receptor for whom hormonal therapy is indicated and lapatinib will be used in combination with letrozole (FEMARA).
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	Prescriber is an oncologist or a healthcare provider highly familiar with prescribing and monitoring of oncology medications.
Coverage Duration	12 months
Other Criteria	Patient will have hypokalemia or hypomagnesemia corrected prior to administration of lapatinib AND Patient will have liver function (transaminases, bilirubin, and alkaline phosphatase) monitored at baseline, every 4 to 6 weeks during treatment, and as clinically indicated.

LUPRON

Products Affected

- Eligard
- Leuprolide Acetate
- Lupron Depot INJ 11.25MG, 22.5MG, 3.75MG, 30MG, 7.5MG
- Lupron Depot-ped INJ 11.25MG, 15MG

Details	
Covered Uses	All FDA-approved indications not otherwise excluded for Part D. Additional off label uses include breast cancer and ovarian cancer
Exclusion Criteria	N/A
Required Medical Information	Prostate cancer diagnosis: approve if patient has advanced or metastatic prostate cancer OR patient has an intermediate to high risk of disease recurrence AND orchiectomy is not indicated or acceptable AND estrogen therapy is not indicated or acceptable. For other conditions, verify diagnosis.
Age Restrictions	Patient must be 18 years or older for all FDA approved indications except central precocious puberty, where patient must be less than 11 years if female and less than 12 years if male
Prescriber Restrictions	For prostate, breast, and ovarian cancer diagnosis, prescriber must be an oncologist or individual highly familiar with prescribing and monitoring oncology related medications
Coverage Duration	12 months
Other Criteria	N/A

MECASERMIN

Products Affected

- Increlex

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided in the presence of: Concurrent treatment with growth hormone or Pharmacologic doses of corticosteroids, Allergy to mecasecamin (ICF-1) or any component of the formulation, growth promotion in patients with closed epiphyses, active or suspected neoplasia
Required Medical Information	1) diagnosis of growth failure due to severe primary IGFD with (a) height standard deviation less than -3.0, (b) basal IGF-1 standard deviation score less than -3.0 and (c) normal or elevated growth hormone levels OR (2) diagnosis of growth failure due to growth hormone deletion with neutralizing antibodies to growth hormone AND (3) patient does NOT have any of the following conditions: growth hormone deficiency, malnutrition, hypothyroidism or chronic treatment with pharmacologic doses of anti-inflammatory steroids.
Age Restrictions	Patient must be a pediatric patient that is at least 2 years of age
Prescriber Restrictions	Prescribing physician must be an endocrinologist
Coverage Duration	12 months
Other Criteria	N/A

MILNACIPRAN

Products Affected

- Savella
- Savella Titration Pack

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for the following contraindications to milnacipran therapy: Use of monoamine oxidase inhibitors (MAOI) concomitantly or in close temporal proximity, Uncontrolled narrow-angle glaucoma.
Required Medical Information	Patient has a diagnosis of fibromyalgia
Age Restrictions	Patient is 17 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

MODAFINIL

Products Affected

- Provigil

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of excessive sleepiness associated with narcolepsy and at least one formulary/preferred treatment, such as methylphenidate, mixed amphetamine salts, or dextroamphetamine, has been ineffective or not tolerated OR Diagnosis of excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS) when both criteria 1 and 2 below are met: There is documentation of residual excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome AND There is documentation that the patient has been compliant with CPAP or BiPAP for at least 2 months. OR Diagnosis of excessive sleepiness associated with shift-work sleep disorder [SWSD] (also referred to as circadian rhythm sleep disorder) when all criteria 1 through 3 below are met: Sleep disturbance causes specific measurable functional impairment in social, occupational, or other important areas of functioning that has persisted at least 3 months AND Sleep disturbance is not due to otherwise reversible conditions. Other reversible conditions may include, but are not limited to, another sleep disorder, mental disorder, or physiological effects of another substance AND Non-pharmacologic therapies have been inadequate in improving functional impairments. Examples of non-pharmacologic therapies include, but are not limited to, planned sleep schedules and timed light exposure.
Age Restrictions	Patient is 17 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

NILOTINIB

Products Affected

- Tassigna CAPS 200MG

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	<p>Patient is in the chronic phase or accelerated phase of Philadelphia chromosome positive chronic myelogenous leukemia AND Patient does not have long QT syndrome AND Patient will have hypokalemia or hypomagnesemia corrected prior to administration of nilotinib, and levels will be monitored periodically during treatment AND Patient will have an electrocardiogram (ECG) performed at baseline, 7 days after initiation, periodically thereafter, and following any nilotinib dose-adjustments AND Patient will have complete blood counts (CBCs) performed at baseline, every 2 weeks for the first 2 months, and monthly thereafter AND Patient will have liver function (transaminases, bilirubin, and alkaline phosphatase) monitored at baseline and periodically during therapy AND Patient will have electrolyte abnormalities (hypo/hyperkalemia, hypocalcemia, hyponatremia) corrected prior to initiation of nilotinib, and monitored periodically during therapy AND Patient does not have rare hereditary problems with galactose intolerance, severe lactase deficiency with a severe degree of intolerance to lactose-containing products, or glucose-galactose malabsorption AND Concomitant therapy with strong inhibitors or inducers of CYP3A4 agents will be avoided or if unavoidable, a dose-reduction with nilotinib will be considered and the patient's QT-interval will be closely monitored.</p>
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	Oncologist experienced in the treatment of patients with hematologic malignancies
Coverage Duration	12 months
Other Criteria	N/A

OMALIZUMAB

Products Affected

- Xolair

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of severe persistent allergic asthma AND Patient is 12 years of age or older and does not weigh more than 150 kg AND Patient has evidence of specific allergic sensitivity confirmed by positive skin test (i.e. prick/puncture test) or blood test (i.e. RAST) for a specific IgE or in vitro reactivity to a perennial allergen AND Patient has baseline serum IgE levels between 30 and 700 IU/mL AND Patient's symptoms are not adequately controlled with a high dose of inhaled corticosteroid plus long-acting beta agonist for at least three months AND Patient has impairment in activities of daily living, exacerbations affecting activity and sleep AND Patient is compliant with current asthma therapy AND Omalizumab will be administered by a physician or other licensed health care provider who has been trained to recognize and treat anaphylaxis and who has available appropriate medications, equipment, and staff to respond to anaphylaxis
Age Restrictions	Patient is 12 years of age or older
Prescriber Restrictions	Physician who specializes in allergy, immunology, or pulmonary medicine
Coverage Duration	12 months
Other Criteria	N/A

ONABOTULINUMTOXINA

Products Affected

- Botox INJ 100UNIT

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Exclude for cosmetic indications (wrinkles, frown lines, aging neck, blepharoplasty (eyelid lift))
Required Medical Information	Approve for diagnosis of chronic migraine prophylaxis (defined as headaches on 15 or more days per month lasting four hours a day or longer) in patients who have experienced treatment failure with at least 2 first line therapies from 2 different therapeutic classes that have drugs approved for migraine prophylaxis (i.e. anticonvulsants, beta-blockers) OR Diagnosis of Focal dystonia in patients with ANY of the following types: Blepharospasm or Cervical (including spasmodic torticollis) OR Diagnosis of Axillary hyperhidrosis that significantly interferes with patient's daily activities and refractory to greater than 6 months treatment with topical aluminum chloride OR Diagnosis of Spasticity (upper limb) from ANY of the following causes: Cerebral palsy, Demyelinating disorders of the central nervous system, Hereditary paraplegia, Multiple sclerosis, Spinal cord injury, Stroke, Traumatic brain injury OR Diagnosis of Strabismus associated with dystonia, including facial nerve VII disorders.
Age Restrictions	N/A
Prescriber Restrictions	For diagnosis of Migraine, Prescriber must be a Neurologist or Pain Management Specialist
Coverage Duration	12 months
Other Criteria	Although similar in certain aspects, Botulinum toxin A and B are not interchangeable. They are chemically, pharmacologically, and clinically distinct. There is no established method to convert dosing with one neurotoxin to appropriate dosing with another neurotoxin.

PAZOPANIB

Products Affected

- Votrient

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of advanced renal cell carcinoma
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	Prescriber is an oncologist or a healthcare provider highly familiar with prescribing and monitoring of oncology medications
Coverage Duration	12 months
Other Criteria	N/A

PEGFILGRASTIM

Products Affected

- Neulasta

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Approve if anticipated that patient will require at least 10 days of white blood cell CSF therapy AND drug will be used as primary prophylaxis of febrile neutropenia associated with myelosuppressive chemotherapy OR patient's risk of febrile neutropenia is at least 20% or has risk factors if less than 20%, OR patient is receiving a dose density chemotherapy regimen OR patient had neutropenic complication from a prior cycle of chemotherapy OR patient had an autologous BMT or PBPC OR patient has diffuse aggressive lymphoma, is at least 65 years old, and being treated with curative chemotherapy OR patient is receiving radiation therapy, not on chemotherapy, and expected to have prolonged delays in treatment secondary to neutropenia
Age Restrictions	N/A
Prescriber Restrictions	Patient is under the care of a physician with experience in prescribing pegfilgrastim
Coverage Duration	12 months
Other Criteria	N/A

PEGINTERFERON ALFA

Products Affected

- Peg-intron INJ 50MCG/0.5ML
- Peg-intron Redipen

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Hepatitis C Viral Infection as monotherapy or in combination with ribavirin AND HCV RNA and ANC test results are documented
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	HCV 12 to 72 weeks depending on genotype and HCV RNA response.
Other Criteria	Treatment of relapsers and non-responders: Retreatment with peginterferon plus ribavirin in patients who did not achieve an SVR after a prior full course of peginterferon plus ribavirin is not recommended, even if a different type of peginterferon is administered. Retreatment with peginterferon plus ribavirin can be considered for non-responders or relapsers who have previously been treated with non-pegylated interferon with or without ribavirin, or with peginterferon monotherapy, particularly if they have bridging fibrosis or cirrhosis. Maintenance therapy is not recommended for patients with bridging fibrosis or cirrhosis who have failed a prior course of peginterferon and ribavirin. Coverage Duration: If patient meets criteria for peginterferon alfa monotherapy or patient has HIV co-infection duration of approval is 48 weeks. If the aforementioned criteria does not apply and taking peg in combo with ribavirin, duration of approval depends on genotype. For genotype 2 and 3, approval is 24 weeks. For genotypes 4, 5, and 6 initial approval is 16 weeks and if early viral response is achieved or HCV RNA is undetectable, then additional approval = 32 weeks (total 48 weeks). For genotype 1, initial approval is 16 weeks and if complete viral response at week 12 (defined as HCV RNA undetectable [less than 50 IU/mL]), then additional approval = 32 weeks (total 48 weeks). If an early viral response is achieved (defined as greater than 2 log reduction in viral load at week 12), an additional 12

	weeks is approved, recheck HCV RNA at week 24. If HCV RNA is undetectable at week 24 (less than 50 IU/mL), then additional approval = 44 weeks (total 72 weeks)
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PEGINTERFERON ALFA-2A

Products Affected

- Pegasys

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Hepatitis C Viral Infection as monotherapy or in combination with ribavirin AND Appropriate lab tests completed and within normal limits (i.e. HCV RNA, Genotyping, ANC, Platelet count, pregnancy test, Hemoglobin) OR Diagnosis of Hepatitis B Viral Infection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	HBV 48 weeks. HCV 12 to 72 weeks depending on genotype and HCV RNA response.
Other Criteria	Treatment of HCV relapsers and non-responders: Retreatment with peginterferon plus ribavirin in patients who did not achieve an SVR after a prior full course of peginterferon plus ribavirin is not recommended, even if a different type of peginterferon is administered. Retreatment with peginterferon plus ribavirin can be considered for non-responders or relapsers who have previously been treated with non-pegylated interferon with or without ribavirin, or with peginterferon monotherapy, particularly if they have bridging fibrosis or cirrhosis. Maintenance therapy is not recommended for patients with bridging fibrosis or cirrhosis who have failed a prior course of peginterferon and ribavirin.

QUININE SULFATE

Products Affected

- Qalaaquin

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for patients with any of the following contraindications to therapy: Prolongation of QT interval, Glucose-6-phosphate dehydrogenase (G6PD) deficiency, Myasthenia gravis, Known hypersensitivity to quinine, mefloquine, or quinidine, Optic neuritis.
Required Medical Information	Diagnosis: Patient is being treated for uncomplicated Plasmodium falciparum malaria OR Patient is being treated for babesiosis.
Age Restrictions	Patient is 16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

RILONACEPT

Products Affected

- Arcalyst

Details	
Covered Uses	All FDA-approved indications not otherwise excluded for Part D.
Exclusion Criteria	Coverage is not provided for use of Arcalyst in combination with TNF inhibitors or other IL-1 blockers
Required Medical Information	Diagnosis of Familial Cold Autoinflammatory Syndrome (FCAS) OR Muckle-Wells Syndrome (MWS), patient has been screened for latent tuberculosis and has been treated by standard medical practice for TB if tested positive, patient has received all recommended vaccinations
Age Restrictions	Patient must be at least 12 year of age
Prescriber Restrictions	Diagnosed by or upon consultation with an immunologist, allergist, dermatologist, rheumatologist, neurologist, or other medical specialist
Coverage Duration	12 months
Other Criteria	N/A

ROFLUMILAST

Products Affected

- Daliresp

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for the following contraindication to therapy: moderate to severe liver impairment (Child-Pugh B or C)
Required Medical Information	Patient has a diagnosis of severe COPD (defined as FEV1 less than or equal to 50 percent of predicted and FEV1/FVC less than 0.7) associated with chronic bronchitis AND Patient has a history of COPD exacerbations which required the use of systemic corticosteroids AND Roflumilast is being used as adjunctive therapy to bronchodilator treatment (i.e. anticholinergics in combination with long-acting beta2 agonists or inhaled corticosteroids or inhaled corticosteroid long-acting beta2 agonist combinations) to reduce the risk of COPD exacerbations
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

SAPROPTERIN

Products Affected

- Kuvan

Details	
Covered Uses	All FDA-approved indications not otherwise excluded for Part D.
Exclusion Criteria	N/A
Required Medical Information	Therapeutic Trial (up to 2 months): Patient has diagnosis of Phenylketonuria (PKU) [Phe level required for documentation] AND Patient is, and will be maintained during sapropterin therapy, on a phenylalanine (Phe)-restricted diet AND Patient will have blood Phe levels measured after 1 week of therapy and periodically for up to 2 months of therapy to determine response - Continuation Therapy for Responders (after 2 months): Patient has diagnosis of Phenylketonuria (PKU) AND Patient is, and will be maintained during sapropterin therapy, on a phenylalanine (Phe)-restricted diet AND Patient has been determined to be a sapropterin responder (i.e., baseline Phe blood levels have decreased by greater than 30% from baseline level [documentation of baseline and current Phe levels are required] AND Patient will have blood Phe levels measured periodically during therapy. If the patient is a non-responder, continued therapy will not be authorized. Non-responders are those whose blood Phe levels do not decrease (i.e., by at least 30% from baseline level) after at least 1 month of therapy with a dose of 20 mg/kg/day.
Age Restrictions	Patient must be 4 years or older
Prescriber Restrictions	N/A
Coverage Duration	Initially approve new patient 2 mths. If responder, then approve 12 months.
Other Criteria	N/A

SARGRAMOSTIM

Products Affected

- Leukine

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Physician with experience in prescribing sargramostim
Coverage Duration	12 months
Other Criteria	N/A

SELEGILINE TRANSDERMAL

Products Affected

- Emsam

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage not provided for patients using Emsam in conjunction with SSRIs, SNRIs, TCAs, bupropion, buspirone, meperidine, tramadol, methadone, propoxyphene, pentazocine, dextromethorphan, St. John's Wort, mirtazaprine, cyclobenzaprine, oral selegiline, other MAOIs, oxcarbazepine, carbamazepine, and/or sympathomimetic amines
Required Medical Information	Diagnosis of major depressive disorder AND at least two oral antidepressants from differing classes OR patient is unable to take oral medications and able to adhere to dietary guidelines necessary for MAOI products
Age Restrictions	Patient must be at least 12 years of age
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

SILDENAFIL

Products Affected

- Revatio

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Pulmonary Arterial Hypertension [PAH] (WHO Group I, WHO/NYHA functional class II, III or IV) AND Patient is not taking any of the following drugs concomitantly: organic nitrates in any form, ritonavir or other potent CYP3A4 inhibitors, Viagra or any other PDE5 inhibitors
Age Restrictions	N/A
Prescriber Restrictions	Prescription is written by a pulmonologist or cardiologist or documentation of consultation with pulmonologist or cardiologist
Coverage Duration	12 months
Other Criteria	N/A

SODIUM OXYBATE

Products Affected

- Xyrem

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for patients being treated with sedative hypnotic agents, patients with succinic semialdehyde dehydrogenase deficiency, a rare disorder is an inborn error of metabolism variably characterized by mental retardation, hypotonia, and ataxia.
Required Medical Information	Documented (i.e., multiple sleep latency test) diagnosis of narcolepsy with excessive daytime sleepiness, cataplexy, or both. For a diagnosis of fibromyalgia, patients must try/fail two FDA approved drugs used for the treatment of fibromyalgia.
Age Restrictions	Patients greater than 16 years of age.
Prescriber Restrictions	N/A
Coverage Duration	Approval given for up to 3 years
Other Criteria	N/A

SOMAVERT

Products Affected

- Somavert

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of acromegaly AND Patient has had inadequate response to surgery and/or radiation therapy and/or other medical therapies, or these therapies are not appropriate.
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	Prescriber is an endocrinologist or an individual familiar with prescribing and monitoring acromegaly related medications
Coverage Duration	12 months
Other Criteria	N/A

SORAFENIB

Products Affected

- Nexavar

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient has one of the following diagnoses: Advanced renal cell carcinoma OR Unresectable hepatocellular carcinoma.
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	Prescriber is an oncologist or a healthcare provider highly familiar with prescribing and monitoring of oncology medications.
Coverage Duration	12 months
Other Criteria	N/A

SUNITINIB

Products Affected

- Sutent

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis: Patient has one of the following diagnoses: Advanced renal cell carcinoma OR Gastrointestinal stromal tumor (GIST) after disease progression on or intolerance to imatinib (GLEEVEC) OR Progressive, well-differentiated pancreatic neuroendocrine tumor (pNET) in patients with unresectable locally advanced or metastatic disease
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	Prescriber is an oncologist or a healthcare provider highly familiar with prescribing and monitoring of oncology medications.
Coverage Duration	12 months
Other Criteria	N/A

SYNAGIS

Products Affected

- Synagis INJ 50MG/0.5ML

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Used for immunoprophylaxis of respiratory syncytial virus (RSV) during the peak mths of infection in the patient’s geographic region AND not for the treatment of RSV. Patient is younger than 2 yrs of age at beginning of RSV season with chronic lung disease (CLD) and required medical therapy (supplemental oxygen, bronchodilator, diuretic, or corticosteroid therapy) for CLD within 6 mths before the anticipated start of RSV season OR Patient is less than or equal to 12 mths of age at the start of RSV season and born at less than or equal to 28 wks gestation OR Patient is less than or equal to 6 mths of age at the start of RSV season and born between 28 wks, 1 day and 32 wks of gestation OR Patient is less than or equal to 24 mths of age with hemodynamically significant cyanotic or acyanotic congenital heart disease (CHD) OR Patient is 24 mths or younger with hemodynamically significant cyanotic and acyanotic congenital heart disease OR patient is younger than 12 months with congenital heart disease and Is receiving medication to control congestive heart failure OR Has moderate to severe pulmonary hypertension OR Has cyanotic heart disease OR Patient is less than or equal to 3 months of age at the start of RSV season and born between 32 weeks, 0 days and 34 weeks, 6 days gestation with at least one of the following risk factors, Infant attends child care, defined as a home or facility where care is provided for any number of infants or young toddlers in the child care facility OR Infant has a sibling younger than 5 yrs of age AND The patient does not have hemodynamically insignificant heart disease such as: Secundum atrial septal defect, Small ventricular septal defect, Pulmonic stenosis, Uncomplicated aortic stenosis, Mild coarctation of the aorta, Patent ductus arteriosus AND patient does not have a lesion that was adequately corrected by surgery (not requiring medication for congestive heart failure) or mild cardiomyopathy that does not require medical therapy.
Age Restrictions	Patient is under 2 years of age at the start of an RSV season
Prescriber	N/A

Restrictions	
Coverage Duration	5 mths during RSV season OR until 3 months of age (max 3 monthly doses) for certain infants
Other Criteria	Prophylaxis against RSV should be initiated just before the onset of the RSV season and terminated at the end of the RSV season. In most seasons and in most regions of the Northern Hemisphere, the first dose should be administered at the beginning of November and the last dose, at the beginning of March, which will provide protection into April. Request for year-round dosing will be considered only when the Centers for Disease Control (CDC) guidance or regional health department recommendations are available. Individual requests must provide the following types of documents for clinical review, CDC's clinical data regarding RSV activity AND Clinical data regarding RSV activity from local health department.

TADALAFIL

Products Affected

- Adcirca

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with pulmonary veno-occlusive disease, coverage not provided in the presence of organic nitrates, potent CYP3A4 inducers, potent CYP3A4 inhibitors, Cialis or any other PDE5 inhibitors
Required Medical Information	Diagnosis of Pulmonary Arterial Hypertension [PAH] (WHO Group I, WHO/NYHA functional class II, III or IV) AND Patient has undergone acute vasoreactivity testing and had a negative response or an initial positive response with subsequent failure of therapy with an oral calcium channel blocker (CCB) or the patient is unstable or has severe right-heart failure or a contraindication to CCB therapy AND Patient is not taking any of the following drugs concomitantly: organic nitrates in any form, ritonavir or other potent CYP3A4 inhibitors, Viagra or any other PDE5 inhibitors
Age Restrictions	N/A
Prescriber Restrictions	Prescription is written by a pulmonologist or cardiologist or documentation of consultation with pulmonologist or cardiologist
Coverage Duration	12 months
Other Criteria	N/A

TAZAROTENE

Products Affected

- Tazorac

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of stable moderate to severe plaque psoriasis (psoriasis vulgaris) with less than 20% body surface area involvement OR Patient has a diagnosis of acne vulgaris of mild to moderate severity AND Patient has tried adequate treatment (at least 2 weeks) of two topical acne products (e.g., benzoyl peroxide, salicylic acid, clindamycin, erythromycin, adapalane, azelaic acid, and/or tretinoin) or two topical psoriasis products (e.g., medium to high potency corticosteroids and/or vitamin D analogs) OR Patient has contraindications to other topical acne or topical psoriasis medications AND Female patients of child-bearing potential are utilizing adequate birth-control measures (pharmacological and/or barrier) during therapy OR Female patients of child-bearing potential not utilizing adequate birth-control measures have a documented negative pregnancy test 2 weeks prior to initiation of tazarotene therapy AND All Female patients of child-bearing potential have been warned of the potential risk of using tazarotene
Age Restrictions	Patient is 12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

TELITHROMYCIN

Products Affected

- Ketek

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided in patients with myasthenia gravis, previous history of hepatitis and/or jaundice associated with the use of telithromycin, or any macrolide antibiotic, history of hypersensitivity to telithromycin and/or any components of telithromycin, or any macrolide antibiotic, currently taking cisapride or pimozone
Required Medical Information	Diagnosis
Age Restrictions	Patient must be 18 years or older
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	N/A

TERIPARATIDE

Products Affected

- Forteo

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Postmenopausal female with a diagnosis of osteoporosis OR male with diagnosis of hypogonadal osteoporosis with one of the following: history of osteoporotic fracture, multiple risk factors for fracture, trial and failure of oral bisphosphonate, documented contraindication or intolerance to oral bisphosphonate therapy
Age Restrictions	Patient must be 18 years or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

TETRABENAZINE

Products Affected

- Xenazine

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient must not have any of the following contraindications to therapy: Actively suicidal, Untreated or inadequately treated depression, Impaired hepatic function, Concomitant use of monoamine oxidase inhibitors (e.g., MARPLAN [isocarboxazid], NARDIL [phenelzine], PARNATE [tranylcypromine], AZILECT [rasagiline], EMSAM [selegiline], ZELAPAR [selegiline], ELDEPRYL [selegiline]), Concomitant use of reserpine or within 20 days of discontinuing reserpine.
Required Medical Information	Patient is being treated for chorea associated with Huntington's disease OR Patient is being treated for tardive dyskinesia OR Patient is being treated for Gilles de la Tourette's syndrome AND Any medication possibly contributing to the underlying symptoms of chorea and/or tardive dyskinesia has been discontinued (e.g. antipsychotics, metoclopramide, amphetamines, methylphenidate, dopamine agonists, etc.) unless cessation would be detrimental to the underlying condition AND Patient will be routinely monitored for signs/symptoms of depression and suicidality during therapy and subsequent treatment initiated if/when necessary, AND For patients requiring doses greater than 50 mg per day, patient will be genotyped for CYP2D6 to determine whether they are poor metabolizers (PMs) [do not express CYP2D6] or extensive or intermediate metabolizers (EMs or IMs) [express CYP2D6].
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	Initiated by or on recommendation/consultation of a neurologist or psychiatrist
Coverage Duration	12 months
Other Criteria	N/A

TOCILIZUMAB

Products Affected

- Actemra INJ 200MG/10ML

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for patients that have an active infection that would put the patient at risk if receiving tocilizumab OR member does have an Absolute Neutrophil Count (ANC) below 2000/mm ³ , platelet count below 100,000/mm ³ , or have ALT or AST above 1.5 times the upper limit of normal (ULN).
Required Medical Information	Patient has a diagnosis of moderate to severe rheumatoid arthritis AND Documented inadequate response to one or more TNF antagonist therapies (certolizumab [CIMZIA®], etanercept [ENBREL®], adalimumab [HUMIRA®], infliximab [REMICADE®], golimumab [SIMPONI®]) OR Patient has a diagnosis of systemic juvenile idiopathic arthritis AND Patient has a documented inadequate response or intolerance to at least one oral systemic agent (i.e., NSAID, corticosteroid).
Age Restrictions	Moderate to severe rheumatoid arthritis: Patient is greater than or equal to 18 years of age Systemic juvenile idiopathic arthritis: Patient is greater than or equal to 2 years of age
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

TOPICAL RETINOID-TYPE PRODUCTS

Products Affected

- Adapalene
- Atralin
- Avita
- Differin
- Epiduo
- Retin-a
- Retin-a Micro
- Tretinoin EXTERNAL CREA
- Tretinoin EXTERNAL GEL
- Tretin-x
- Ziana

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of mild to moderate acne vulgaris
Age Restrictions	Patients greater than 40 years of age
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

TREPROSTINIL

Products Affected

- Remodulin

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Pulmonary Arterial Hypertension [PAH] (WHO Group I) in Class III - IV patients OR Diagnosis of PAH (WHO Group I) in Class II patients who do not respond adequately to or are unable to tolerate conventional therapy, such as REVATIO (sildenafil), ADCIRCA (tadalafil), TRACLEER (bosentan) or LETAIRIS (ambrisentan).
Age Restrictions	N/A
Prescriber Restrictions	Prescription is written by a pulmonologist or cardiologist or documentation of consultation with pulmonologist or cardiologist
Coverage Duration	12 months
Other Criteria	N/A

TRIPTORELIN

Products Affected

- Trelstar Depot Mixject
- Trelstar La Mixject
- Trelstar Mixject

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for Females who are pregnant or lactating, Concomitant use with other LHRH agents.
Required Medical Information	Patient is male AND Patient has a diagnosis of advanced or metastatic prostate cancer OR Patient has as an intermediate to high risk of disease recurrence AND Orchiectomy is not indicated or not acceptable to the patient
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	Oncologist or an individual highly familiar with prescribing and monitoring of oncology related medications
Coverage Duration	12 months
Other Criteria	N/A

USTEKINUMAB

Products Affected

- Stelara

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of moderate to severe chronic plaque psoriasis AND Patient has had an inadequate response to, is intolerant to, or is contraindicated to conventional therapy with at least one of the following: Phototherapy (including, but not limited to, Ultraviolet A with a psoralen [PUVA] and/or retinoids [RePUVA]) for at least one continuous month OR One or more oral systemic treatments (i.e., methotrexate, cyclosporine, acitretin, sulfasalazine) for at least three consecutive months
Age Restrictions	Patient is at least 18 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ZOLEDRONIC ACID

Products Affected

- Reclast
- Zometa INJ 4MG/5ML

Details	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not allowed if any of the follow apply: Patient's creatinine clearance is less than 35 mL/min, Patient is hypocalcemic, Patient has a hypersensitivity to zoledronic acid or any component of the product, Patient is currently receiving ZOMETA (zoledronic acid tablets) Injection, Patient is pregnant, plans on becoming pregnant, or nursing.
Required Medical Information	Diagnoses of one of the following: Patient is a postmenopausal female for the treatment or prevention of osteoporosis or Patient is male with a diagnosis of osteoporosis and is receiving treatment to increase bone mass or Patient is receiving treatment and prevention for glucocorticoid-induced osteoporosis or Patient has a diagnosis of Paget's disease of bone with any of the following: Elevations in serum alkaline phosphatase of two times or higher than the upper limit of the age-specific normal reference range, Symptomatic disease, Risk for complications from the disease AND Patient has experienced treatment failure or intolerance to oral bisphosphonates (treatment failure is defined as new fractures in compliant patients on therapy for at least 6 months, failure to produce a clinically significant change in a biochemical marker(s) of bone turnover, or significant loss of bone mineral density (BMD) on follow-up scans after 12 to 24 months of therapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

PART B VERSUS PART D

Products Affected

- Abraxane
- Accuneb
- Acetylcysteine
- Adriamycin INJ 2MG/ML
- Albuterol Sulfate INHALATION NEBU
- Alimta INJ 500MG
- Alkeran INJ
- Aloxi
- Amifostine
- Aminosyn
- Aminosyn 8.5%/electrolytes
- Aminosyn II
- Aminosyn II 3.5%/dextrose25%
- Aminosyn II 3.5%/dextrose5%
- Aminosyn II 3.5/dextrose 25%
- Aminosyn II 4.25/dextrose10%
- Aminosyn II 4.25/dextrose20% INJ
30.6MEQ/L; 422MG/100ML;
432MG/100ML; 298MG/100ML; 20%;
258MG/100ML; 212MG/100ML;
128MG/100ML; 280MG/100ML;
425MG/100ML; 446MG/100ML;
73MG/100ML; 126MG/100ML;
307MG/100ML; 225MG/100ML;
19MEQ/L; 170MG/100ML;
85MG/100ML; 115MG/100ML;
212MG/100ML
- Aminosyn II 4.25/dextrose25%
- Aminosyn II 5/dextrose 25
- Aminosyn II 8.5%/electrolytes
- Aminosyn II M 3.5%/dextrose 5%
- Aminosyn M
- Aminosyn-hbc
- Aminosyn-hf
- Aminosyn-pf
- Aminosyn-pf 7%
- Anzemet
- Arzerra
- Atgam
- Avastin INJ 100MG/4ML
- Azasan
- Azathioprine
- Azathioprine Sodium
- Bicnu
- Bleomycin Sulfate INJ 30UNIT
- Brovana
- Budesonide INHALATION SUSP
- Busulfex
- Calcijex
- Calcitriol
- Campath
- Camptosar INJ 100MG/5ML
- Carboplatin INJ 150MG/15ML
- Carnitor
- Cellcept
- Cellcept Intravenous
- Cerubidine
- Cesamet
- Cisplatin INJ 100MG/100ML
- Cladribine
- Clinimix 2.75%/dextrose 5%
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 20%
- Clinimix 4.25%/dextrose 25%
- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix 5%/dextrose 25%
- Clinimix E 2.75%/dextrose 10%
- Clinimix E 2.75%/dextrose 5%
- Clinimix E 4.25%/dextrose 25%
- Clinimix E 4.25%/dextrose 5%
- Clinimix E 5%/dextrose 15%
- Clinimix E 5%/dextrose 20%
- Clinimix E 5%/dextrose 25%
- Clinisol Sf 15%
- Clolar
- Cosmegen
- Cromolyn Sodium NEBU
- Cubicin
- Cyclophosphamide ORAL TABS

- Cyclosporine INJ
- Cyclosporine ORAL CAPS
- Cyclosporine Modified ORAL CAPS 100MG, 50MG
- Cyclosporine Modified SOLN
- Cytarabine INJ 500MG
- Cytarabine Aqueous
- Dacarbazine INJ 200MG
- Daunorubicin Hcl INJ 20MG
- Dexrazoxane INJ 500MG
- Dextrose 10% Flex Container
- Dextrose 5%
- Docetaxel INJ 80MG/8ML
- Doxil
- Doxorubicin Hcl INJ 2MG/ML
- Dronabinol
- Duoneb
- Elitek INJ 1.5MG
- Ellence INJ 200MG/100ML
- Eloxatin INJ 100MG/20ML
- Elspar
- Emend ORAL CAPS
- Engerix-b INJ 10MCG/0.5ML, 10MCG/0.5ML, 20MCG/ML
- Epirubicin Hcl INJ 50MG/25ML
- Ethyol
- Etopophos
- Etoposide INJ
- Faslodex
- Firmagon
- Fludara
- Fludarabine Phosphate INJ 50MG
- Fluorouracil INJ 500MG/10ML
- Freamine III INJ 72MEQ/L; 600MG/100ML; 810MG/100ML; 3MEQ/L; 14MG/100ML; 1190MG/100ML; 240MG/100ML; 590MG/100ML; 770MG/100ML; 620MG/100ML; 450MG/100ML; 480MG/100ML; 10MMOLE/L; 115MG/100ML; 950MG/100ML; 500MG/100ML; 10MEQ/L; 340MG/100ML; 130MG/100ML; 560MG/100ML
- Freamine III 3%
- Gemcitabine Hcl INJ 1GM
- Gemzar INJ 1GM
- Gengraf
- Granisetron Hcl INJ 0.1MG/ML, 1MG/ML
- Granisetron Hcl TABS
- Granisol
- Hectorol
- Hepatamine
- Hepatasol
- Herceptin
- Hycamtin INJ
- Idamycin Pfs INJ 20MG/20ML
- Idarubicin Hcl INJ 10MG/10ML
- Ifex INJ 3GM
- Ifosfamide INJ 1GM
- Ifosfamide/mesna
- Imovax Rabies (h.d.c.v.)
- Imuran
- Intralipid
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Irinotecan INJ 100MG/5ML
- Istodax
- Ixempra Kit INJ 45MG
- Leustatin
- Levalbuterol
- Levocarnitine
- Liposyn II
- Liposyn III
- Marinol
- Melphalan Hydrochloride
- Mesna
- Mesnex INJ
- Methotrexate
- Mitomycin INJ 20MG
- Mitoxantrone Hcl
- Mustargen
- Mycophenolate Mofetil
- Myfortic
- Nebupent
- Neoral

- Nephramine
- Nipent
- Novantrone
- Ondansetron Hcl INJ 4MG/2ML
- Ondansetron Hcl ORAL SOLN
- Ondansetron Hcl ORAL TABS
- Ondansetron Odt
- Ontak
- Orthoclone Okt3
- Oxaliplatin INJ 100MG/20ML
- Paclitaxel INJ 300MG/50ML
- Pentam 300
- Pentostatin
- Perforomist
- Premasol
- Procalamine
- Prograf
- Proleukin
- Prosol
- Pulmicort
- Pulmozyme
- Rabavert
- Rapamune
- Recombivax Hb INJ 10MCG/ML, 40MCG/ML
- Rocaltrol
- Sancuso
- Sandimmune
- Simulect INJ 20MG
- Tacrolimus
- Taxotere INJ 80MG/2ML, 80MG/4ML
- Tetanus Toxoid Adsorbed
- Thiotepa
- Thymoglobulin
- Tobin
- Toposar
- Topotecan Hcl INJ 4MG
- Travasol
- Treanda INJ 100MG
- Trexall
- Trisenox
- Trophamine
- Twinrix
- Vancomycin Hcl INJ 1000MG, 10GM, 500MG
- Velcade
- Vidaza
- Vinblastine Sulfate INJ 10MG
- Vincasar Pfs
- Vincristine Sulfate
- Vinorelbine Tartrate INJ 50MG/5ML
- Xopenex
- Zanosar
- Zemplar
- Zinecard INJ 250MG
- Zofran
- Zofran Odt
- Zortress
- Zuplenz
- Zortress
- Zuplenz

Details

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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