

2010 – Drugs Requiring Prior Authorization

Drugs	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage duration	Other Criteria
Actemra (tocilizumab)	All FDA-approved indications not otherwise excluded from Part D.					12 months	
Adcirca (tadalafil)	All FDA-approved indications not otherwise excluded from Part D.					12 months	
Alfa Interferons - Alferon N - Infergen - PEG-Intron - PEG-Intron Redipen - Pegasys	All FDA approved indications not otherwise excluded from Part D. Additional covered off-label uses are multiple myeloma, Philadelphia chromosome positive chronic phase myelogenous leukemia (CML) in a patient who is minimally pretreated, and renal cell carcinoma.					12 months	
Androgens and Anabolic Steroids	All FDA-approved indications not otherwise excluded					12 months	

<ul style="list-style-type: none"> - Anadrol-50 - Androderm - Androgel - Android - Androxy - Delatestryl - Depo-Testosterone - Methitest - Oxandrin - Oxandrolone - Striant - Testim - Testosterone cypionate - Testosterone enanthate - Testred 	<p>from Part D.</p>						
<p>Cimzia (certolizumab pegol)</p>	<p>All FDA-approved indications not otherwise excluded from Part D.</p>	<p>Coverage is not provided for use of Cimzia in combination with other biologics, e.g., Humira or Remicade.</p>	<p>Coverage is provided in situations where the patient has been evaluated and screened for the presence of latent TB infection prior to initiating treatment with Cimzia.</p>			<p>12 months</p>	
<p>Colony</p>	<p>All FDA-approved</p>	<p>Combination</p>				<p>12 months</p>	

<p>Stimulating Factors</p> <ul style="list-style-type: none"> - Leukine - Neulasta - Neupogen 	<p>indications not otherwise excluded from Part D. Additional off-label coverage is provided for neutropenia due to other drugs, AIDS/HIV, and myelodysplastic syndrome.</p>	<p>therapy with Neulasta, Neupogen or Leukine.</p>					
<p>Enbrel (etanercept)</p>	<p>All FDA-approved indications not otherwise excluded from Part D</p>	<p>Coverage is not provided for use of Enbrel in combination with other biologics, e.g., Humira, Kineret or Remicade.</p>	<p>Coverage is provided in situations where the patient has been evaluated and screened for the presence of latent TB infection prior to initiating treatment with Enbrel.</p>			<p>12 months</p>	<p>For the treatment of moderate to severe rheumatoid arthritis: coverage is provided when Enbrel is used in combination with methotrexate or when the patient has had an inadequate response to treatment with methotrexate unless the patient is unable to receive methotrexate. For the treatment of moderate to severe plaque psoriasis:</p>

							patient is a candidate for phototherapy or systemic therapy, and has been treated previously with at least one of the following: phototherapy, methotrexate (oral or IM), cyclosporine, or acitretin.
Erythroid Stimulants - Aranesp - Epogen - Procrit	All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for anemia secondary to HIV infection or HIV drug therapy, myelodysplasia, and chronic hepatitis C treatment from ribavirin and interferon therapy.					1 month-allogeneic blood transfusions, 2 months-anemia due to chemotherapy, 12 months-others	
Fentanyl transmucosal - Actiq - Fentanyl	All FDA-approved indications not otherwise excluded from Part D.	Coverage is not provided for patients who are not		Approve for patients 16 years of age or older		12 months	

<p>citrate oral transmucosal</p> <ul style="list-style-type: none"> - Fentora - Onsolis 		<p>already receiving and who are not tolerant to opioid therapy.</p>					
<p>Golimumab (Simponi)</p>	<p>All FDA-approved indications not otherwise excluded from Part D.</p>	<p>Coverage is not provided for use of Simponi in combination with other biologics, e.g., Enbrel, Cimzia, Humira, Kineret or Remicade.</p>	<p>Coverage is provided in situations where the patient has been evaluated and screened for the presence of latent TB infection prior to initiating treatment with Simponi.</p>			<p>12 months</p>	<p>For the treatment of moderate to severe rheumatoid arthritis or psoriatic arthritis: coverage is provided when Simponi is used in combination with methotrexate or when the patient has had an inadequate response to treatment with methotrexate unless the patient is unable to receive methotrexate.</p>

<p>Growth Hormones</p> <ul style="list-style-type: none"> - Genotropin - Genotropin Miniquick - Humatrope - Norditropin - Norditropin Nordiflex - Nutropin - Nutropin AQ - Omnitrope - Saizen - Saizen Click Easy - Serostim - Tev-Tropin - Zorbtive 	<p>All FDA-approved indications not otherwise excluded from Part D</p>		<p>HIV cachexia is defined by unintentional weight loss of at least 10 percent of baseline weight, or BMI less than 20 kg/m², not attributable to other causes, when optimal antiviral therapy has been instituted.</p>			<p>12 months</p>	
<p>Humira (adalimumab)</p>	<p>All FDA-approved indications not otherwise excluded from Part D.</p>	<p>Coverage is not provided for use of Humira in combination with other biologics, e.g., Enbrel, Kineret or Remicade.</p>	<p>Coverage is provided in situations where the patient has been evaluated and screened for the presence of latent TB infection prior to initiating treatment with Humira.</p>			<p>12 months</p>	<p>For the treatment of moderate to severe rheumatoid arthritis or psoriatic arthritis: coverage is provided when Humira is used in combination with methotrexate or when the patient has had an inadequate</p>

							response to treatment with methotrexate unless the patient is unable to receive methotrexate. For the treatment of moderate to severe plaque psoriasis: patient has already been treated with or is not a candidate for phototherapy and any other systemic treatments such as methotrexate (oral or IM), cyclosporine, and acitretin.
Immune Globulins - Carimune Nanofiltered - Flebogamma - Gamastan S/D - Gammagard Liquid - Gamunex	All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for post bone marrow transplantation, post transfusion purpura, autoimmune hemolytic anemia,					12 months	

<ul style="list-style-type: none"> - Octagam - Polygam S/D - Vivaglobin 	<p>Guillain-Barre syndrome, chronic inflammatory demyelinating polyneuropathy, pediatric HIV infection, toxic shock syndrome, refractory dermatomyositis, refractory polymyositis, myasthenic crisis in patients with contraindications to plasma exchange.</p>						
<p>Kineret (anakinra)</p>	<p>All FDA-approved indications not otherwise excluded from Part D.</p>	<p>Coverage is not provided for use of Kineret in combination with other biologics, e.g., Humira, Enbrel, or Remicade.</p>		<p>Approve for patients 18 years of age or older</p>		<p>12 months</p>	<p>Coverage is provided when the patient has had an inadequate response to treatment with methotrexate or other disease-modifying antirheumatic drug.</p>
<p>Letairis (ambrisentan)</p>	<p>All FDA-approved indications not otherwise excluded from Part D.</p>					<p>12 months</p>	

Nuvigil (armodafinil)	All FDA-approved indications not otherwise excluded from Part D.					12 months	
Orencia (abatacept)	All FDA-approved indications not otherwise excluded from Part D.	Coverage is not provided for use of Orencia in combination with other biologics, e.g., Humira, Enbrel, or Remicade.	Coverage is provided in situations where the patient has been evaluated and screened for the presence of latent TB infection prior to initiating treatment with Orencia.			12 months	
Provigil (modafinil)	All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for idiopathic hypersomnia and fatigue due to multiple sclerosis.					12 months	
Remicade (infliximab)	All FDA-approved indications not otherwise excluded from Part D.	Coverage is not provided for use of Remicade in combination	Coverage is provided in situations where the patient has been evaluated			12 months	For the treatment of ankylosing spondylitis: patient must have previously tried

		with other biologics, e.g., Enbrel, Kineret or Humira. Coverage of doses greater than 5 mg/kg is not provided in patients with Class III or IV heart failure.	and screened for the presence of latent TB infection prior to initiating treatment with Remicade.				and not had adequate symptom relief from at least one other treatment such as NSAIDs, COX-2 inhibitors, or methotrexate, unless the patient is unable to take one or more these drugs. For the treatment of plaque psoriasis: patient is a candidate for phototherapy or systemic therapy, and has been treated previously with at least one of the following: phototherapy, methotrexate (oral or IM), cyclosporine, or acitretin.
Revatio (sildenafil)	All FDA approved indications not otherwise excluded from Part D.					12 months	

<p>Rituxan (rituximab)</p>	<p>All FDA approved indications not otherwise excluded from Part D. Additional coverage for off-label use is provided for relapsed or refractory chronic lymphoid lymphoma, relapsed or refractory Waldenstrom's macroglobulinemia, and refractory idiopathic thrombocytopenic purpura.</p>			<p>For rheumatoid arthritis: Approved for patients 18 years of age or older</p>		<p>6 months for rheumatoid arthritis, 12 months for other indications</p>	<p>For rheumatoid arthritis: patient has experienced an inadequate response to at least one TNF inhibitor, or has been intolerant to treatment with at least two TNF inhibiting drugs.</p>
<p>Thalomid (thalidomide)</p>	<p>All FDA approved indications not otherwise excluded from Part D. Additional coverage for off-label uses includes Crohn's disease, aphthous ulcers in the presence of HIV or AIDS, malignant melanoma, and myelodysplastic syndrome.</p>					<p>12 months</p>	

Tracleer (bosentan)	All FDA-approved indications not otherwise excluded from Part D.					12 months	
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The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.		
Abelcet	Dextrose 5% / Lactated Ringers	Neoral
Accuneb	Dextrose 10%	Nephramine
Acetylcysteine	Dextrose 10% / NaCl 0.2%	Normosol-M in D5W
Acyclovir sodium injection	Dilaudid-HP	Normosol-R
Adriamycin	Doxil	Normosol-R in D5W
Albuterol sulfate neb	Doxorubicin hcl	Novamine
Alcohol 5% / Dextrose 5%	Dronabinol	Ondansetron hcl, oral
Ambisome	Duoneb	Ondansetron ODT
Aminosyn	Duramorph	Orthoclone OKT3
Aminosyn / Electrolytes	Emend	Pamidronate disodium
Aminosyn II	Engerix-B	Perforomist
Aminosyn II / Dextrose	Fentanyl citrate injection	Plasma-Lyte A
Aminosyn II / Electrolytes	Fluorouracil injection	Plasma-Lyte 148
Aminosyn II M / Dextrose	Foscarnet sodium	Plasma-Lyte 148 / D5W
Aminosyn M	Foscavir	Plasma-Lyte 56
Aminosyn-HBC	Freamine HBC 6.9%	Plasma-Lyte 56 / D5W
Aminosyn-HF	Freamine III	Plasma-Lyte-R
Aminosyn-PF	Freamine III 3%	Premasol
Aminosyn-PF 7%	Gengraf	Privigen
Amphotec	Granisetron hcl, oral	Procalamine
Amphotericin B	Granisol	Prograf
Anzemet	Heptamine	Prosol

Aredia	Hepatasol	Pulmicort neb
Arzerra	Hydromorphone hcl injection	Pulmozyme
Astramorph	Imuran	Rapamune
Atgam	Infumorph	Recombivax-HB
Azasan	Intralipid	Remodulin
Azathioprine	Ionosol-B / Dextrose 5%	Renamin
Azathioprine sodium	Ionosol-MB / Dextrose 5%	Sandimmune
Bleomycin sulfate	Ionosol-T / Dextrose 5%	Simulect
Brovana	Ipratropium bromide neb	Tacrolimus
Budesonide neb	Ipratropium bromide/albuterol sulf neb	Thymoglobulin
Cellcept	Isolyte-H / Dextrose 5%	TOBI
Cellcept Intravenous	Isolyte-M / Dextrose 5%	Torisel
Cesamet	Isolyte-P / Dextrose 5%	TPN Electrolytes FTV
Cladribine	Isolyte-S	Travasol
Clinmix / Dextrose	Isolyte-S / Dextrose 5%	Travasol / Dextrose
Clinmix E / Dextrose	KCl / D5W / LR	Travasol / Electrolytes
Clinisol SF 15%	Kytril, oral	Trophamine
Cromolyn sodium neb	Lactated Ringers	Ventavis
Cyclophosphamide	Leustatin	Vinblastine sulfate
Cyclosporine	Levalbuterol neb	Vincasar PFS
Cyclosporine, modified	Liposyn II	Vincristine sulfate
Cytarabine	Liposyn III	Virazole
Cytarabine aqueous	Marinol	Xopenex neb
Cytovene	Meperidine hcl injection	Zenapax
Cytoxan	Morphine sulfate injection	Zofran, oral
Demerol injection	Mycophenolate mofetil	Zofran ODT
Dextrose 10% / NaCl 0.45%	Myfortic	Zometa
Dextrose 5% / Electrolyte #48	Nebupent	

Last updated: July 2010