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Prior Auth List**

ABILIFY 1MG/ML SOLN *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling/compendia	Psychiatry/ Neurology	12 months				
ABILIFY 2MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling/compendia	Psychiatry/ Neurology	12 months				
ABILIFY 5MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling/compendia	Psychiatry/ Neurology	12 months				
ABILIFY ODT 10MG TAB *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling/compendia	Psychiatry/ Neurology	12 months				
ABILIFY ODT 15MG TAB *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling/compendia	Psychiatry/ Neurology	12 months				
ABILIFY 10MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling/compendia	Psychiatry/ Neurology	12 months				
ABILIFY 15MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling/compendia	Psychiatry/ Neurology	12 months				
ABILIFY 20MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling/compendia	Psychiatry/ Neurology	12 months				

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ABILIFY 30MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling/compendia	Psychiatry/ Neurology	12 months			
ACTIMMUNE 3MU/.5ML INJ *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis, Bone biopsy if osteopetrosis, Antibiotic failure if chronic granulomatous disease	Ages approved in FDA labeling/compendia	Infectious Disease/Hematology/Orthopedist	12 months	Sulfamethoxazole/Trimethoprim and itraconazole for chronic granulomatous disease. Osteopetrosis must be severe malignant		
ANADROL-50 TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, CBC	Ages approved in FDA labeling/compendia	Hematologist/oncologist	up to 12 months	Failure or contraindication to Epoetin or Darbepoetin, and failure of Vitamin B/folate therapy or Iron therapy when deficient.		
APOKYN 10MG/ML INJ *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history	Ages approved in FDA labeling/compendia	Neurologist	12 months	Patient must have poorly controlled off time episodes and failed dopamine agonist and COMT inhibitor		
ARANESP 25MCG/ML INJ *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications OR uncorrected iron deficiency OR ESRD use	Medical notes and Scr and HGB and T-sat and Ferritin	Ages approved in FDA labeling		6 months	For CKD anemia patient must have an HGB less than 11g/dl on initiation and less than 12g/dl for maintenance. Patient must have adequate iron stores to initiate and continue treatment.		
ARANESP 40MCG/0.4ML SURECLCK*	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications OR uncorrected iron deficiency OR ESRD use	Medical notes and Scr and HGB and T-sat and Ferritin	Ages approved in FDA labeling		6 months	For CKD anemia patient must have an HGB less than 11g/dl on initiation and less than 12g/dl for maintenance. Patient must have adequate iron stores to initiate and continue treatment.		
ARANESP 40MCG/ML INJ *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications OR uncorrected iron deficiency OR ESRD use	Medical notes and Scr and HGB and T-sat and Ferritin	Ages approved in FDA labeling		6 months	For CKD anemia patient must have an HGB less than 11g/dl on initiation and less than 12g/dl for maintenance. Patient must have adequate iron stores to initiate and continue treatment.		

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ARANESP 60MCG/0.3M L INJ *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications OR uncorrected iron deficiency OR ESRD use	Medical notes and Scr and HGB and T-sat and Ferritin	Ages approved in FDA labeling		6 months	For CKD anemia patient must have an HGB less than 11g/dl on initiation and less than 12g/dl for maintenance. Patient must have adequate iron stores to initiate and continue treatment.			
ARANESP 60MCG/ML INJ *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications OR uncorrected iron deficiency OR ESRD use	Medical notes and Scr and HGB and T-sat and Ferritin	Ages approved in FDA labeling		6 months	For CKD anemia patient must have an HGB less than 11g/dl on initiation and less than 12g/dl for maintenance. Patient must have adequate iron stores to initiate and continue treatment.			
ARANESP 100MCG/0.5M L SNGLJCT *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications OR uncorrected iron deficiency OR ESRD use	Medical notes and Scr and HGB and T-sat and Ferritin	Ages approved in FDA labeling		6 months	For CKD anemia patient must have an HGB less than 11g/dl on initiation and less than 12g/dl for maintenance. Patient must have adequate iron stores to initiate and continue treatment.			
ARANESP 100MCG/ML INJ *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications OR uncorrected iron deficiency OR ESRD use	Medical notes and Scr and HGB and T-sat and Ferritin	Ages approved in FDA labeling		6 months	For CKD anemia patient must have an HGB less than 11g/dl on initiation and less than 12g/dl for maintenance. Patient must have adequate iron stores to initiate and continue treatment.			
ARANESP 200MCG/ML INJ *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications OR uncorrected iron deficiency OR ESRD use	Medical notes and Scr and HGB and T-sat and Ferritin	Ages approved in FDA labeling		6 months	For CKD anemia patient must have an HGB less than 11g/dl on initiation and less than 12g/dl for maintenance. Patient must have adequate iron stores to initiate and continue treatment.			

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ARANESP 300MCG/0.6ML INJ *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications OR uncorrected iron deficiency OR ESRD use	Medical notes and Scr and HGB and T-sat and Ferritin	Ages approved in FDA labeling		6 months	For CKD anemia patient must have an HGB less than 11g/dl on initiation and less than 12g/dl for maintenance. Patient must have adequate iron stores to initiate and continue treatment.			
ARCALYST 220MG INJ *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, Labs C-Reactive protein, Serum amyloid alpha protein a	Ages approved in FDA labeling	Immunologist	12 months	Coverage will be based on : Diagnosis of CAPS, failure of 1 other treatment used for this condition such as canakinumab, nsaid			
ARIXTRA 2.5MG/0.5ML INJ *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, previous treatment history, associated studies	Ages approved in FDA labeling/compendia	none	up to 12 months	Coverage will be based on allergy to Lovenox or other condition where Lovenox use is not appropriate			
ARIXTRA 5MG/0.4ML INJ *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, previous treatment history, associated studies	Ages approved in FDA labeling/compendia	none	up to 12 months	Coverage will be based on allergy to Lovenox or other condition where Lovenox use is not appropriate			
ARIXTRA 7.5MG/0.6ML INJ *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, previous treatment history, associated studies	Ages approved in FDA labeling/compendia	none	up to 12 months	Coverage will be based on allergy to Lovenox or other condition where Lovenox use is not appropriate			
ARIXTRA 10MG/0.8ML INJ *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, previous treatment history, associated studies	Ages approved in FDA labeling/compendia	none	up to 12 months	Coverage will be based on allergy to Lovenox or other condition where Lovenox use is not appropriate			

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AVASTIN 25MG/ML INJ *	1	All medically accepted indications not otherwise excluded from part D OR Metastatic carcinoma of the colon or rectum when used in combination with intravenous 5-Fluorouracil based chemotherapy for first-line or second-line treatment OR Metastatic human epidermal growth factor receptor 2 (HER2)-negative breast cancer when used in combination with paclitaxel for the treatment of patients who have not received chemotherapy for metastatic HER2-negative breast cancer OR Nonsquamous non-small cell lung cancer in combination with carboplatin and paclitaxel for the first-line treatment of patients with unresectable or locally advanced or recurrent or metastatic non-squamous cell disease OR Central	FDA labeled contraindications	Medical notes and previous treatment history and associated studies	Ages approved in FDA labeling	Oncologist, ophthalmologist	up to 12 months				
BANZEL 40MG/ML SUSP *	1	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Diagnosis	ages 4 and up	Neurology	12 months				
BANZEL 200MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Diagnosis	ages 4 and up	Neurology	12 months				

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BANZEL 400MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Diagnosis	ages 4 and up	Neurology	12 months				
BONIVA 3MG/3ML INJ KIT *	1	All FDA-approved indications not otherwise excluded from Part D when patient has failed an oral bisphosphonate OR has intolerance to and oral bisphosphonate or a contraindication to oral bisphosphonates	FDA labeled contraindications OR Crcl Less than 30 ml/min	Diagnosis, DEXA/BMD , 25-OH vitamin D levels	Ages approved in FDA labeling		12 months	Must have adequate 25-OH vitamin D stores			
BOTOX 100U INJ *	1	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications OR cosmetic conditions	Diagnosis, supporting notes	Ages approved in FDA labeling		12 months				
BUDESONID E EC 3MG/24HR CAP *	0	All FDA approved indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, previous treatment history	Ages approved in FDA labeling	Gastroenterologist	3 months	Covered for Short term use in mild to moderate Crohn's up to 3 months as approved in FDA Label			
BUPHENYL 500MG TAB *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, associated studies	Ages approved in FDA labeling	Gastroenterologist/Hepatologist/Neurologist/medical geneticist/hematologist	up to 12 months	Coverage will be based on medical history/status, response to previous treatments, and the consideration of other therapeutic options			
BUPRENORP HINE 2MG SL TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications, prescriber not licensed to treat addiction, use for pain management	Diagnosis	Ages approved in FDA labeling	Physician licensed to use the medication for addiction	up to 12 months				

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BUPRENORP HINE 8MG SL TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications, prescriber not licensed to treat addiction, use for pain management	Diagnosis	Ages approved in FDA labeling	Physician licensed to use the medication for addiction	up to 12 months			
BYETTA 10MCG/0.04M L INJ *	1	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, HA1c BG	Ages approved in FDA labeling	none	12 months	Patient must be on maximal tolerated doses of sulfonylurea and Metformin unless contraindicated, must not be on Insulin		
BYETTA 5MCG/0.02M L INJ *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, HA1c BG	Ages approved in FDA labeling	none	12 months	Patient must be on maximal tolerated doses of sulfonylurea and Metformin unless contraindicated, must not be on Insulin		
CEREDASE 80U/ML INJECTABLE *	1	All FDA-approved indications not otherwise excluded from Part D. Approved for treatment of type 1 Gaucher's with a history of Thrombocytopenia OR splenomegaly OR bone disease OR hepatomegaly		Medical notes	Ages approved in FDA labeling	Medical Geneticist	12 months			
CEREZYME 200U INJ *	1	All FDA-approved indications not otherwise excluded from Part D. Approved for treatment of type 1 Gauchers with a history of Thrombocytopenia OR splenomegaly OR bone disease OR hepatomegaly		Medical notes	Ages approved in FDA labeling	Medical Geneticist	12 months			
CHANTIX 0.5MG TAB *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Previous Treatment History	Ages approved in FDA labeling	none	12 weeks	Patient must have participated in Quitsmart Smoking Cessation program or currently enrolled in Quitsmart and tried Bupropion SR		

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CHANTIX 1MG TAB *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Previous Treatment History	Ages approved in FDA labeling	none	12 weeks	Patient must have participated in Quitsmart Smoking Cessation program or currently enrolled in Quitsmart and tried Bupropion SR			
DRONABINO L 10MG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Previous Treatment History	Ages approved in FDA labeling	Infectious disease/oncologist/gastroenterologist	up to 12 months	For HIV/Cancer related cachexia patient must fail megestrol, For Chemotherapy induced nausea, patient must fail Emend and Ondansetron.			
DRONABINO L 2.5MG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Previous Treatment History	Ages approved in FDA labeling	Infectious disease/oncologist	up to 12 months	For HIV/Cancer related cachexia patient must fail megestrol, For Chemotherapy induced nausea, patient must fail Emend and Ondansetron.			
DRONABINO L 5MG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Previous Treatment History	Ages approved in FDA labeling	Infectious disease/oncologist/gastroenterologist	up to 12 months	For HIV/Cancer related cachexia patient must fail megestrol, For Chemotherapy induced nausea, patient must fail Emend and Ondansetron.			
ELAPRASE 6MG/3ML INJ *	1	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Previous Treatment History, medical notes supporting diagnosis	Ages approved in FDA labeling	Medical Geneticist	12 months				
ELITEK 1.5MG INJ *	1	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Previous Treatment History	Ages approved in FDA labeling	oncologist	up to 12 months	Patient must fail xanthine oxidase inhibitor			
EMEND 125- 80MG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Previous treatment history	Ages approved in FDA labeling	Hematologist/oncologist	up to 12 months	Patient must fail treatment with ondansetron (not applicable for PONV)			
EMEND 40MG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Previous treatment history	Ages approved in FDA labeling	Hematologist/oncologist/anesthesiologist/surgeon	up to 12 months	Patient must fail treatment with ondansetron (not applicable for PONV)			

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EMEND 80MG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Previous treatment history	Ages approved in FDA labeling	Hematologist/oncologist	up to 12 months	Patient must fail treatment with ondansetron (not applicable for PONV)			
EMSAM 6MG/24HR PATCH *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, prior medication failures	Ages approved in FDA labeling	Psychiatry/Neurology	12 months	Patient must fail 6 week trial with two formulary anti-depressants			
EMSAM 9MG/24HR PATCH *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, prior medication failures	Ages approved in FDA labeling	Psychiatry/Neurology	12 months	Patient must fail 6 week trial with two formulary anti-depressants			
ENBREL 25MG INJ VIAL KIT *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications combination with other biologic	Medical notes	Ages approved in FDA labeling	Rheumatology/ Dermatology or Specialist trained in management of prescribed condition	12 months	For RA Patient must fail adequate trial of MTX in combination with a DMARD If MTX contraindicated, must try combination of 2- nonbiologic DMARDS. For Ankylosing Spondylitis PT must fail 2 NSAIDS within past 6 months. For Plaque Psoriasis patient must fail MTX or Soriatane and Phototherapy. for Psoriatic Arthritis Patient must fail adequate trial of MTX or LEF in past 6 months.			

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ENBREL 50MG/ML INJ (PFS) *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications combination with other biologic	Medical notes	Ages approved in FDA labeling	Rheumatology/ Dermatology or Specialist trained in management of prescribed condition	12 months	For RA Patient must fail adequate trial of MTX in combination with a DMARD If MTX contraindicated, must try combination of 2- nonbiologic DMARDS. For Ankylosing Spondylitis PT must fail 2 NSAIDS within past 6 months. For Plaque Psoriasis patient must fail MTX or Soriatane and Phototherapy. for Psoriatic Arthritis Patient must fail adequate trial of MTX or LEF in past 6 months.			
ENTOCORT EC 3MG/24HR CAP *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, previous treatment history	Ages approved in FDA labeling	Gastroenterologist	3 months	Covered for Short term use in mild to moderate Crohn's up to 3 months as approved in FDA Label			
EXJADE 125MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, iron indices	Ages approved in FDA labeling	Hematologist/oncologist	12 months	Patient must fail or have contraindication to deferoximine			
EXJADE 250MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, iron indices	Ages approved in FDA labeling	Hematologist/oncologist	12 months	Patient must fail or have contraindication to deferoximine			
EXJADE 500MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, iron indices	Ages approved in FDA labeling	Hematologist/oncologist	12 months	Patient must fail or have contraindication to deferoximine			
FABRAZYME 5MG INJ **	1	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history	Ages approved in FDA labeling	Medical Geneticist	12 months	Patient must have a diagnosis of Fabry's disease with significant cardiac or renal manifestations.			
FANAPT 1MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				

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FANAPT 2MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
FANAPT 4MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
FANAPT 6MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
FANAPT 8MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
FANAPT 10MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
FANAPT 12MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
FENTANYL 12MCG/HR PATCH *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, previous treatment history	Ages approved in FDA labeling	Pain management physician/oncologist	12 months				
FENTANYL 25MCG/HR PATCH *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, previous treatment history	Ages approved in FDA labeling	Pain management physician/oncologist	12 months				

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FENTANYL 50MCG/HR PATCH *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, previous treatment history	Ages approved in FDA labeling	Pain management physician/oncologist	12 months				
FENTANYL 75MCG/HR PATCH *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, previous treatment history	Ages approved in FDA labeling	Pain management physician/oncologist	12 months				
FENTANYL 100MCG/HR PATCH *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, previous treatment history	Ages approved in FDA labeling	Pain management physician/oncologist	12 months				
FENTANYL 1200MCG ORAL LOZENGE*	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Previous treatment history	Ages approved in FDA labeling	Pain management physician/oncologist	12 months	Covered for breakthrough pain in patients receiving long acting opioid treatment and are opioid tolerant. Patient must fail two immediate release C-II opioid such as hydromorphone, morphine, oxycodone.			
FENTANYL 1600MCG ORAL LOZENGE*	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Previous treatment history	Ages approved in FDA labeling	Pain management physician/oncologist	12 months	Covered for breakthrough pain in patients receiving long acting opioid treatment and are opioid tolerant. Patient must fail two immediate release C-II opioid such as hydromorphone, morphine, oxycodone.			
FENTANYL 200MCG ORAL LOZENGE*	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Previous treatment history	Ages approved in FDA labeling	Pain management physician/oncologist	12 months	Covered for breakthrough pain in patients receiving long acting opioid treatment and are opioid tolerant. Patient must fail two immediate release C-II opioid such as hydromorphone, morphine, oxycodone.			

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FENTANYL 400MCG ORAL LOZENGE*	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Previous treatment history	Ages approved in FDA labeling	Pain management physician/oncologist	12 months	Covered for breakthrough pain in patients receiving long acting opioid treatment and are opioid tolerant. Patient must fail two immediate release C-II opioid such as hydromorphone, morphine, oxycodone.			
FENTANYL 600MCG ORAL LOZENGE*	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Previous treatment history	Ages approved in FDA labeling	Pain management physician/oncologist	12 months	Covered for breakthrough pain in patients receiving long acting opioid treatment and are opioid tolerant. Patient must fail two immediate release C-II opioid such as hydromorphone, morphine, oxycodone.			
FENTANYL 800MCG ORAL LOZENGE*	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Previous treatment history	Ages approved in FDA labeling	Pain management physician/oncologist	12 months	Covered for breakthrough pain in patients receiving long acting opioid treatment and are opioid tolerant. Patient must fail two immediate release C-II opioid such as hydromorphone, morphine, oxycodone.			
FORTEO 600MCG/2.4ML INJ PEN *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications/cumulative tx more than 24month	Medical notes, previous treatment history, BMD, PTH, VITD	Late adolescents and Adults only	none	12 months	Patient must fail or have contraindication to bisphosphonates, Vitamin D (25,OH), PTH must be WNL			
FOSRENOL 500MG CHEW TAB *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Previous treatment history, CA, PO4, IPTH	Ages approved in FDA labeling	Nephrologist	12 months	Patient must fail or not be a candidate for calcium based phosphate binders based on KDOQI guidelines for use			
FOSRENOL 750MG CHEW TAB *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Previous treatment history, CA, PO4, IPTH	Ages approved in FDA labeling	Nephrologist	12 months	Patient must fail or not be a candidate for calcium based phosphate binders based on KDOQI guidelines for use			

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FOSRENOL 1000MG CHEW TAB *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Previous treatment history, CA, PO4, IPTH	Ages approved in FDA labeling	Nephrologist	12 months	Patient must fail or not be a candidate for calcium based phosphate binders based on KDOQI guidelines for use			
GAMMAGAR D 1G/10ML INJ *	1	All FDA-approved indications not otherwise excluded from Part D, All other indications must be in compliance with CMS national and local coverage determinations for intravenous immunoglobulin therapy.		Medical notes, immunoglobulin studies	Ages approved in FDA labeling		up to 12 months				
GENOTROPI N 0.8MG INJ *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, studies establishing diagnosis of growth hormone deficiency or ISS	Ages approved in FDA labeling	Endocrinologist	12 months	Prescribed dose is not feasible with Omnitrope or Allergy to Omnitrope, or Allergy to Benzoyl alcohol (Omnitrope Preservative)			
GENOTROPI N 1.2MG INJ *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, studies establishing diagnosis of growth hormone deficiency or ISS	Ages approved in FDA labeling	Endocrinologist	12 months	Prescribed dose is not feasible with Omnitrope or Allergy to Omnitrope, or Allergy to Benzoyl alcohol (Omnitrope Preservative)			
GENOTROPI N 1.6MG INJ *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, studies establishing diagnosis of growth hormone deficiency or ISS	Ages approved in FDA labeling	Endocrinologist	12 months	Prescribed dose is not feasible with Omnitrope or Allergy to Omnitrope, or Allergy to Benzoyl alcohol (Omnitrope Preservative)			
GENOTROPI N 13.8MG INJ *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, studies establishing diagnosis of growth hormone deficiency or ISS	Ages approved in FDA labeling	Endocrinologist	12 months	Prescribed dose is not feasible with Omnitrope or Allergy to Omnitrope, or Allergy to Benzoyl alcohol (Omnitrope Preservative)			
GENOTROPI N 1MG INJ *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, studies establishing diagnosis of growth hormone deficiency or ISS	Ages approved in FDA labeling	Endocrinologist	12 months	Prescribed dose is not feasible with Omnitrope or Allergy to Omnitrope, or Allergy to Benzoyl alcohol (Omnitrope Preservative)			

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GENOTROPI N 5.8MG INJ	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, studies establishing diagnosis of growth hormone deficiency or ISS	Ages approved in FDA labeling	Endocrinologist	12 months	Prescribed dose is not feasible with Omnitrope or Allergy to Omnitrope, or Allergy to Benzoyl alcohol (Omnitrope Preservative)			
GEODON 20MG INJ *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
GEODON 20MG CAPSULE *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
GEODON 40MG CAPSULE *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
GEODON 60MG CAPSULE *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
GEODON 80MG CAPSULE *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
HEPSERA 10MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, associated studies	Ages approved in FDA labeling		12 months				
HUMATROPE 5MG/VIAL INJ *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, studies establishing diagnosis of growth hormone deficiency or ISS	Ages approved in FDA labeling	Endocrinologist	12 months	Prescribed dose is not feasible with Omnitrope or Allergy to Omnitrope, or Allergy to Benzoyl alcohol (Omnitrope Preservative)			
HUMATROPE 12MG CARTRIDGE KIT *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, studies establishing diagnosis of growth hormone deficiency or ISS	Ages approved in FDA labeling	Endocrinologist	12 months	Prescribed dose is not feasible with Omnitrope or Allergy to Omnitrope, or Allergy to Benzoyl alcohol (Omnitrope Preservative)			

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HUMATROPE 24MG CARTRIDGE KIT *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, studies establishing diagnosis of growth hormone deficiency or ISS	Ages approved in FDA labeling	Endocrinologist	12 months	Prescribed dose is not feasible with Omnitrope or Allergy to Omnitrope, or Allergy to Benzoyl alcohol (Omnitrope Preservative)			
HUMIRA 40MG/0.8ML INJ KIT *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications combination with other biologic	Medical notes	Ages approved in FDA labeling	Dermatologist/rheumatologist/Gastroenterologist	12 months	Patient must fail Enbrel or not be a candidate for Enbrel for RA, PSA, AS, Plaque psoriasis, Pt must fail Remicade for Crohn's			
INCRELEX 40MG/4ML INJ *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, previous treatment history	Ages approved in FDA labeling	Endocrinologist	12 months				
ITRACONAZ OLE 100MG CAPSULE *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, previous treatment history, fungal culture and sensitivity	Ages approved in FDA labeling		up to 12 months	Failure of terbinafine for onychomycosis			
JAKAFI 5MG TABLET *	1	All FDA approved indications not otherwise excluded from part D	FDA labeled contraindications, Low risk Disease, combination therapy with other antineoplastic/anti proliferative	Diagnosis	Ages approved in FDA labeling	Hematology-oncology	3 months	Continuation will be based on reduction in spleen size from baseline or symptomatic improvement.			
JAKAFI 10MG TABLET *	1	All FDA approved indications not otherwise excluded from part D	FDA labeled contraindications, Low risk Disease, combination therapy with other antineoplastic/anti proliferative	Diagnosis	Ages approved in FDA labeling	Hematology-oncology	3 months	Continuation will be based on reduction in spleen size from baseline or symptomatic improvement.			
JAKAFI 15MG TABLET *	1	All FDA approved indications not otherwise excluded from part D	FDA labeled contraindications, Low risk Disease, combination therapy with other antineoplastic/anti proliferative	Diagnosis	Ages approved in FDA labeling	Hematology-oncology	3 months	Continuation will be based on reduction in spleen size from baseline or symptomatic improvement.			

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JAKAFI 20MG TABLET *	1	All FDA approved indications not otherwise excluded from part D	FDA labeled contraindications, Low risk Disease, combination therapy with other antineoplastic/anti proliferative	Diagnosis	Ages approved in FDA labeling	Hematology-oncology	3 months	Continuation will be based on reduction in spleen size from baseline or symptomatic improvement.			
JAKAFI 25MG TABLET *	1	All FDA approved indications not otherwise excluded from part D	FDA labeled contraindications, Low risk Disease, combination therapy with other antineoplastic/anti proliferative	Diagnosis	Ages approved in FDA labeling	Hematology-oncology	3 months	Continuation will be based on reduction in spleen size from baseline or symptomatic improvement.			
JANUVIA 25MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications, Non FDA approved combinations	Medical notes, previous treatment history, HA1c BG	Ages approved in FDA labeling		12 months	Patient must be on maximal tolerated doses of sulfonylurea and Metformin unless contraindicated			
JANUVIA 50MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications, Non FDA approved combinations	Medical notes, previous treatment history, HA1c BG	Ages approved in FDA labeling		12 months	Patient must be on maximal tolerated doses of sulfonylurea and Metformin unless contraindicated			
JANUVIA 100MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications, Non FDA approved combinations	Medical notes, previous treatment history, HA1c BG	Ages approved in FDA labeling		12 months	Patient must be on maximal tolerated doses of sulfonylurea and Metformin unless contraindicated			
KINERET 100MG/.67ML INJ *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications combination with other biologic	Medical notes	Ages approved in FDA labeling	Rheumatology	12 months	Failure of 2 Tumor Necrosis Factor Alpha antagonists			

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KUVAN 100MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history	Ages approved in FDA labeling	Medical Geneticist, neurologist,hepa tologist	12 months	Coverage will be based on medical history/status, response to previous treatments, and the consideration of other therapeutic options			
LATUDA 40MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
LATUDA 80MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
LIDODERM 5% PATCH *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes	Ages approved in FDA labeling		up to 12 months	Covered for PHN, patient must fail gabapentin			
LOTRONEX 0.5MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes	Ages approved in FDA labeling	Physician enrolled in Lotronex program	up to 12 months				
LOTRONEX 1MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes	Ages approved in FDA labeling	Physician enrolled in Lotronex program	up to 12 months				
LOVAZA 1GM CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, Lipid panel	Ages approved in FDA labeling		12 months	Patient must Have TG greater than 500mg/dl, failed or intolerant to the following therapies- Fibrate, Niacin, Statin			

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LYRICA 25MG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes	Ages approved in FDA labeling	Neurologist, endocrinologist (DPN only), Neurologist (Seizures only)	12 months	For DPN Patient must fail gabapentin and one other medication with a medically acceptable use for DPN (i.e. Cymbalta, TCA, tramadol). For PHN Pt must fail Gabapentin. For Fibromyalgia Patient must Fail Gabapentin and one other medication with medically acceptable use for fibromyalgia (i.e.. Cymbalta, TCA, cyclobenzaprine, NSAID, Fluoxetine)	. For Seizures prescriber must be a neurologist		
LYRICA 50MG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes	Ages approved in FDA labeling	Neurologist, endocrinologist (DPN only), Neurologist (Seizures only)	12 months	For DPN Patient must fail gabapentin and one other medication with a medically acceptable use for DPN (i.e. Cymbalta, TCA, tramadol). For PHN Pt must fail Gabapentin. For Fibromyalgia Patient must Fail Gabapentin and one other medication with medically acceptable use for fibromyalgia (i.e.. Cymbalta, TCA, cyclobenzaprine, NSAID, Fluoxetine)	. For Seizures prescriber must be a neurologist		

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LYRICA 75MG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes	Ages approved in FDA labeling	Neurologist, endocrinologist (DPN only), Neurologist (Seizures only)	12 months	For DPN Patient must fail gabapentin and one other medication with a medically acceptable use for DPN (i.e. Cymbalta, TCA, tramadol). For PHN Pt must fail Gabapentin. For Fibromyalgia Patient must Fail Gabapentin and one other medication with medically acceptable use for fibromyalgia (i.e.. Cymbalta, TCA, cyclobenzaprine, NSAID, Fluoxetine)	. For Seizures prescriber must be a neurologist		
LYRICA 100MG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes	Ages approved in FDA labeling	Neurologist, endocrinologist (DPN only), Neurologist (Seizures only)	12 months	For DPN Patient must fail gabapentin and one other medication with a medically acceptable use for DPN (i.e. Cymbalta, TCA, tramadol). For PHN Pt must fail Gabapentin. For Fibromyalgia Patient must Fail Gabapentin and one other medication with medically acceptable use for fibromyalgia (i.e.. Cymbalta, TCA, cyclobenzaprine, NSAID, Fluoxetine)	. For Seizures prescriber must be a neurologist		

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LYRICA 150MG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes	Ages approved in FDA labeling	Neurologist, endocrinologist (DPN only), Neurologist (Seizures only)	12 months	For DPN Patient must fail gabapentin and one other medication with a medically acceptable use for DPN (i.e. Cymbalta, TCA, tramadol). For PHN Pt must fail Gabapentin. For Fibromyalgia Patient must Fail Gabapentin and one other medication with medically acceptable use for fibromyalgia (i.e.. Cymbalta, TCA, cyclobenzaprine, NSAID, Fluoxetine)	. For Seizures prescriber must be a neurologist		
LYRICA 200MG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes	Ages approved in FDA labeling	Neurologist, endocrinologist (DPN only), Neurologist (Seizures only)	12 months	For DPN Patient must fail gabapentin and one other medication with a medically acceptable use for DPN (i.e. Cymbalta, TCA, tramadol). For PHN Pt must fail Gabapentin. For Fibromyalgia Patient must Fail Gabapentin and one other medication with medically acceptable use for fibromyalgia (i.e.. Cymbalta, TCA, cyclobenzaprine, NSAID, Fluoxetine)	. For Seizures prescriber must be a neurologist		

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LYRICA 225MG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes	Ages approved in FDA labeling	Neurologist, endocrinologist (DPN only), Neurologist (Seizures only)	12 months	For DPN Patient must fail gabapentin and one other medication with a medically acceptable use for DPN (i.e. Cymbalta, TCA, tramadol). For PHN Pt must fail Gabapentin. For Fibromyalgia Patient must Fail Gabapentin and one other medication with medically acceptable use for fibromyalgia (i.e.. Cymbalta, TCA, cyclobenzaprine, NSAID, Fluoxetine)	. For Seizures prescriber must be a neurologist		
LYRICA 300MG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes	Ages approved in FDA labeling	Neurologist, endocrinologist (DPN only), Neurologist (Seizures only)	12 months	For DPN Patient must fail gabapentin and one other medication with a medically acceptable use for DPN (i.e. Cymbalta, TCA, tramadol). For PHN Pt must fail Gabapentin. For Fibromyalgia Patient must Fail Gabapentin and one other medication with medically acceptable use for fibromyalgia (i.e.. Cymbalta, TCA, cyclobenzaprine, NSAID, Fluoxetine)	. For Seizures prescriber must be a neurologist		
NAGLAZYME 1MG/ML INJ *	1	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes	Ages approved in FDA labeling	medical geneticist	12 months	Must demonstrate improvement in 3 minute stair climb or 12 minute walk distance for continuation at 24 weeks			
NICOTROL INHALER *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history	Ages approved in FDA labeling		24 weeks	Patient must have failed bupropion and be actively enrolled in smoking cessation program, plan sponsors Quit Smart			

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NORDITROPI N NRDFLEX 5MG/1.5ML*	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, studies establishing diagnosis of growth hormone deficiency or ISS	Ages approved in FDA labeling	Endocrinologist	12 months	Prescribed dose is not feasible with Omnitrope or Allergy to Omnitrope, or Allergy to Benzoyl alcohol (Omnitrope Preservative)			
NORDITROPI N NRDFLX 15MG/1.5ML*	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, studies establishing diagnosis of growth hormone deficiency or ISS	Ages approved in FDA labeling	Endocrinologist	12 months	Prescribed dose is not feasible with Omnitrope or Allergy to Omnitrope, or Allergy to Benzoyl alcohol (Omnitrope Preservative)			
NULOJIX 250MG INJ *	1	All FDA approved indications not otherwise excluded from part D	Seronegative for Epstein Barr-Virus exposure, Liver Transplantation	Diagnosis, previous treatment history, EBV titers	Ages approved in FDA labeling	Transplant/nephrology	12 months	Documentation of failure or intolerance to calcineurin inhibitor			
NUTROPIN 10MG INJ *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, studies establishing diagnosis of growth hormone deficiency or ISS	Ages approved in FDA labeling	Endocrinologist	12 months	Prescribed dose is not feasible with Omnitrope or Allergy to Omnitrope, or Allergy to Benzoyl alcohol (Omnitrope Preservative)			
OLANZAPINE 2.5MG TABLET *	0	All FDA approved indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
OLANZAPINE 5MG TABLET *	0	All FDA approved indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
OLANZAPINE 7.5MG TABLET *	0	All FDA approved indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
OLANZAPINE 10MG TABLET *	0	All FDA approved indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
OLANZAPINE 15MG TABLET *	0	All FDA approved indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
OLANZAPINE 20MG TABLET *	0	All FDA approved indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				

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OLANZAPINE ODT 5MG TABLET *	0	All FDA approved indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
OLANZAPINE ODT 10MG TABLET *	0	All FDA approved indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
OMNITROPE 5.8MG INJ *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, studies establishing diagnosis of growth hormone deficiency or ISS	Ages approved in FDA labeling	Endocrinologist	12 months				
OMNITROPE 10MG/1.5ML INJ *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, studies establishing diagnosis of growth hormone deficiency or ISS	Ages approved in FDA labeling	Endocrinologist	12 months				
OMNITROPE 5MG/1.5ML INJ *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, studies establishing diagnosis of growth hormone deficiency or ISS	Ages approved in FDA labeling	Endocrinologist	12 months				
ONGLYZA 2.5MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications, Non FDA approved combinations	Medical notes, previous treatment history, HA1c BG	Ages approved in FDA labeling		12 months	Patient must be on maximal tolerated doses of sulfonylurea and Metformin unless contraindicated			
ONGLYZA 5MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications, Non FDA approved combinations	Medical notes, previous treatment history, HA1c BG	Ages approved in FDA labeling		12 months	Patient must be on maximal tolerated doses of sulfonylurea and Metformin unless contraindicated			
ORENCIA 250MG INJ *	1	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications, combination therapy with other biologics	Medical notes, previous treatment history	Ages approved in FDA labeling	Rheumatologist	12 months	Patient must fail two TNF antagonists.			

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ORFADIN 10MG CAP *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, associated studies	Ages approved in FDA labeling	Medical Geneticist, neurologist, hepatologist, nephrologist	12 months	Coverage will be based on medical history/status, response to previous treatments, and the consideration of other therapeutic options			
OXANDRIN 2.5MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Oncologist/hematologist/endocrinologist, gastroenterologist, infectious disease	up to 12 months				
PEGASYS 180MCG/0.5M L KIT *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications, HCV Retreatment for Peg INF+RBV Non-responders	Medical notes, Viral Load	Ages approved in FDA labeling	Gastroenterologist/ Infectious Disease	up to 12 months	For HCV patient must have allergy of contraindication to Peg-Intron. For HBV Patient must be Pegasys naive, with chronic HBV infection with chronically elevated transaminases.			
PEG-INTRON 50MCG/0.5M L KIT *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications, HCV Retreatment for Peg INF+RBV Non-responders	Medical notes, Viral Load	Ages approved in FDA labeling	Gastroenterologist/ Infectious Disease	up to 12 months	patient must have active HCV infection . Coverage will be 24 weeks for genotypes 2,3 and 48 weeks for genotypes 1,4. PT must show 2 log drop in viral load at 12 weeks post initiation			
PEG-INTRON 80MCG REDIPEN KIT*	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications, HCV Retreatment for Peg INF+RBV Non-responders	Medical notes, Viral Load	Ages approved in FDA labeling	Gastroenterologist/ Infectious Disease	up to 12 months	patient must have active HCV infection . Coverage will be 24 weeks for genotypes 2,3 and 48 weeks for genotypes 1,4. PT must show 2 log drop in viral load at 12 weeks post initiation			
PEG-INTRON 120MCG REDIPEN KIT*	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications, HCV Retreatment for Peg INF+RBV Non-responders	Medical notes, Viral Load	Ages approved in FDA labeling	Gastroenterologist/ Infectious Disease	up to 12 months	patient must have active HCV infection . Coverage will be 24 weeks for genotypes 2,3 and 48 weeks for genotypes 1,4. PT must show 2 log drop in viral load at 12 weeks post initiation			

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PEG-INTRON 150MCG REDIPEN KIT*	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications, HCV Retreatment for Peg INF+RBV Non-responders	Medical notes, Viral Load	Ages approved in FDA labeling	Gastroenterologist/ Infectious Disease	up to 12 months	patient must have active HCV infection . Coverage will be 24 weeks for genotypes 2,3 and 48 weeks for genotypes 1,4. PT must show 2 log drop in viral load at 12 weeks post initiation			
PROCRIT 2,000 U/ML INJ *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications, uncorrected iron deficiency, ESRD use	Medical notes, Scr, HGB, T-sat, Ferritin	Ages approved in FDA labeling		6 months	For CKD anemia patient must have an HGB less than 11g/dl on initiation and less than 12g/dl for maintenance. Patient must have adequate iron stores to initiate and continue treatment.			
PROCRIT 3,000 U/ML INJ *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications, uncorrected iron deficiency, ESRD use	Medical notes, Scr, HGB, T-sat, Ferritin	Ages approved in FDA labeling		6 months	For CKD anemia patient must have an HGB less than 11g/dl on initiation and less than 12g/dl for maintenance. Patient must have adequate iron stores to initiate and continue treatment.			
PROCRIT 4,000 U/ML INJ *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications, uncorrected iron deficiency, ESRD use	Medical notes, Scr, HGB, T-sat, Ferritin	Ages approved in FDA labeling		6 months	For CKD anemia patient must have an HGB less than 11g/dl on initiation and less than 12g/dl for maintenance. Patient must have adequate iron stores to initiate and continue treatment.			
PROCRIT 10,000 U/ML INJ *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications, uncorrected iron deficiency, ESRD use	Medical notes, Scr, HGB, T-sat, Ferritin	Ages approved in FDA labeling		6 months	For CKD anemia patient must have an HGB less than 11g/dl on initiation and less than 12g/dl for maintenance. Patient must have adequate iron stores to initiate and continue treatment.			

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PROCRIT 20,000 U/ML INJ *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications, uncorrected iron deficiency, ESRD use	Medical notes, Scr, HGB, T-sat, Ferritin	Ages approved in FDA labeling		6 months	For CKD anemia patient must have an HGB less than 11g/dl on initiation and less than 12g/dl for maintenance. Patient must have adequate iron stores to initiate and continue treatment.			
PROCRIT 40,000 U/ML INJ *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications, uncorrected iron deficiency, ESRD use	Medical notes, Scr, HGB, T-sat, Ferritin	Ages approved in FDA labeling		6 months	For CKD anemia patient must have an HGB less than 11g/dl on initiation and less than 12g/dl for maintenance. Patient must have adequate iron stores to initiate and continue treatment.			
PROMACTA 12.5MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical Notes, CBC , Platelet count less than 50,000	Ages approved in FDA labeling	Hematologist/oncologist	12 months	Chronic ITP Refractory to IVIG, corticosteroids or splenectomy as per FDA approval studies			
PROMACTA 50MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical Notes, CBC , Platelet count less than 50,000	Ages approved in FDA labeling	Hematologist/oncologist	12 months	Chronic ITP Refractory to IVIG, corticosteroids or splenectomy as per FDA approval studies			
PROVIGIL 100MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, Sleep study or MSLT when appropriate	Ages approved in FDA labeling	None	12 months				
PROVIGIL 200MG CAPLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, Sleep study or MSLT when appropriate	Ages approved in FDA labeling	None	12 months				
PULMOZYM E INHALANT SOLUTION *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, Spirometry	Ages approved in FDA labeling	Pulmonologist	12 months	For Patients with Cystic Fibrosis with an FVC greater or equal to 40% of predicted value, who have had recurrent pulmonary infections			

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RANEXA 1000MG ER TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Recent Cardiology notes, previous treatment history for angina	Ages approved in FDA labeling	Cardiologist	12 months	Pt must fail two of the three following medication classes used for angina Nitrate, CCB, or Beta blocker			
RANEXA 500MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Recent Cardiology notes, previous treatment history for angina	Ages approved in FDA labeling	Cardiologist	12 months	Pt must fail two of the three following medication classes used for angina Nitrate, CCB, or Beta blocker			
RELISTOR 12MG/0.6ML INJ *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Previous treatment history	Ages approved in FDA labeling	Pain management physician, gastroenterologist, oncologist	12 months	Covered for patients with advanced illness receiving palliative opioid treatment who fail Lactulose and metoclopramide at therapeutic doses.			
REMICADE 100MG INJ *	1	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications, combination therapy with other biologics	Medical notes	Ages approved in FDA labeling	Rheumatology/ Dermatology or Specialist trained in management of prescribed condition	12 months	For RA Plaque Psoriasis, or Psoriatic Arthritis patient must fail Humira, For Crohn's disease and ulcerative colitis patient must have moderate to severe disease and cannot maintain remission despite adequate doses of anti-inflammatories (mesalamine compounds) and immunosuppressives (AZA, 6-MP, MTX)			
REMODULIN 10MG/ML INJ *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications, combination therapy with other PAH medications	Medical notes, previous treatment history, 6 min walk, diffusion studies, Rt Heart Cath	Ages approved in FDA labeling	Pulmonologist/ Cardiologist	12 months	Pulmonary hypertension must be diagnosed by heart catheterization ,Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral, Patient must fail Tracleer.			

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REMODULIN 1MG/ML INJ *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications, combination therapy with other PAH medications	Medical notes, previous treatment history, 6 min walk, diffusion studies,Rt Heart Cath	Ages approved in FDA labeling	Pulmonologist/ Cardiologist	12 months	Pulmonary hypertension must be diagnosed by heart catheterization ,Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral. Patient must be a WHO class III or IV and fail Tracleer.			
REMODULIN 2.5MG/ML INJ *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications, combination therapy with other PAH medications	Medical notes, previous treatment history, 6 min walk, diffusion studies,Rt Heart Cath	Ages approved in FDA labeling	Pulmonologist/ Cardiologist	12 months	Pulmonary hypertension must be diagnosed by heart catheterization ,Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral, Patient must fail Tracleer.			
REMODULIN 5MG/ML INJ *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications, combination therapy with other PAH medications	Medical notes, previous treatment history, 6 min walk, diffusion studies,Rt Heart Cath	Ages approved in FDA labeling	Pulmonologist/ Cardiologist	12 months	Pulmonary hypertension must be diagnosed by heart catheterization ,Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral, Patient must fail Tracleer.			
REVATIO 20MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, previous treatment history, 6 min walk, diffusion studies,Rt Heart Cath	Ages approved in FDA labeling	Pulmonologist/ Cardiologist	12 months	Pulmonary hypertension must be diagnosed by heart catheterization ,Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral ,Coverage will be based on medical history/status, vasoreactivity tests, response to previous treatments, and the consideration of other therapeutic options including Revatio			

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REVLIMID 5MG CAPSULE *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, CBC, Bone Marrow Biopsy, Karyotype	Ages approved in FDA labeling	Hematologist/oncologist	12 months	Patient must fail Thalidomide for Multiple Myeloma.			
REVLIMID 10MG CAPSULE *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, CBC, Bone Marrow Biopsy, Karyotype	Ages approved in FDA labeling	Hematologist/oncologist	12 months	Patient must fail Thalidomide for Multiple Myeloma.			
REVLIMID 15MG CAPSULE *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, CBC, Bone Marrow Biopsy, Karyotype	Ages approved in FDA labeling	Hematologist/oncologist	12 months	Patient must fail Thalidomide for Multiple Myeloma.			
REVLIMID 25MG CAPSULE *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, CBC, Bone Marrow Biopsy, Karyotype	Ages approved in FDA labeling	Hematologist/oncologist	12 months	Patient must fail Thalidomide for Multiple Myeloma.			
RILUTEK 50MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, associated studies	Ages approved in FDA labeling	Neurologist	12 months	Diagnosis is definite or probable ALS by Neurology, symptoms present for less than 5 years, Vital Capacity is 60% or more of predicted, patient does not have a tracheotomy			
RITUXAN 100MG VL INJ *	1	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, immunohistopathy	Ages approved in FDA labeling	Hematologist/oncologist, rheumatologist	12 months	For Rheumatoid Arthritis coverage patient must fail 2 TNF antagonists. Patient must also be on methotrexate unless contraindicated or intolerant.			
SABRIL 500MG ORAL SOLUTION *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes	Ages approved in FDA labeling	Neurologist	12 months	Patient must fail treat with adjunctive treatment combination (applies to Refractory Partial Complex only)			

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SABRIL 500MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes	Ages approved in FDA labeling	Neurologist	12 months	Patient must fail treat with adjunctive treatment combination (applies to Refractory Partial Complex only)			
SAIZEN 5MG VIAL INJ *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, studies establishing diagnosis of growth hormone deficiency or ISS	Ages approved in FDA labeling	Endocrinologist	12 months	Prescribed dose is not feasible with Omnitrope or Allergy to Omnitrope, or Allergy to Benzoyl alcohol (Omnitrope Preservative)			
SAIZEN 8.8MG CLICKEASY DEVICE*	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, studies establishing diagnosis of growth hormone deficiency or ISS	Ages approved in FDA labeling	Endocrinologist	12 months	Prescribed dose is not feasible with Omnitrope or Allergy to Omnitrope, or Allergy to Benzoyl alcohol (Omnitrope Preservative)			
SAPHRIS 10MG S/L TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
SAPHRIS 5MG S/L TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
SENSIPAR 30MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, associated studies	Ages approved in FDA labeling	Nephrologist/en docrinologist/on cologist	12 months	For secondary hyperparathyroidism related to CKD, patient must fail active vit-D therapy/phosphate binders, iPTH must be greater than 300 in ESRD			
SENSIPAR 60MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, associated studies	Ages approved in FDA labeling	Nephrologist/en docrinologist/on cologist	12 months	For secondary hyperparathyroidism related to CKD, patient must fail active vit-D therapy/phosphate binders, iPTH must be greater than 300 in ESRD			
SENSIPAR 90MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, associated studies	Ages approved in FDA labeling	Nephrologist/en docrinologist/on cologist	12 months	For secondary hyperparathyroidism related to CKD, patient must fail active vit-D therapy/phosphate binders, iPTH must be greater than 300 in ESRD			

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SEROQUEL 25MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
SEROQUEL 50MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
SEROQUEL 100MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
SEROQUEL 200MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
SEROQUEL 300MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
SEROQUEL 400MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
SEROQUEL- XR 200MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
SEROQUEL- XR 300MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
SEROQUEL- XR 400MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				

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SOLARAZE 3% GEL *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Dermatologist	12 months				
SOMAVERT 10MG INJ **	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes	Ages approved in FDA labeling	Endocrinologist	12 months				
SPORANOX 10MG/ML ORAL SOLN *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications, onychomycosis	Medical notes, previous treatment history, associated studies, fungal culture	Ages approved in FDA labeling		up to 12 months				
SUBOXONE 2MG/0.5MG SL TAB *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications, prescriber not licensed to treat addiction, use for pain management	Diagnosis	Ages approved in FDA labeling	Physician licensed to use the medication for addiction	up to 12 months				
SUBOXONE 8MG/2MG SL TAB *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications, prescriber not licensed to treat addiction, use for pain management	Diagnosis	Ages approved in FDA labeling	Physician licensed to use the medication for addiction	up to 12 months				
SYLATRON 296MCG INJ KIT *	1	All FDA approved indications not otherwise excluded from part D	FDA labeled contraindications	FDA labeled contraindications	Ages approved in FDA labeling	oncology	up to 12 months	Must be used as adjuvant treatment within 84 days of surgical resection in patients with metastatic melanoma with nodal involvement			
SYLATRON 444MCG INJ KIT *	1	All FDA approved indications not otherwise excluded from part D	FDA labeled contraindications	FDA labeled contraindications	Ages approved in FDA labeling	oncology	up to 12 months	Must be used as adjuvant treatment within 84 days of surgical resection in patients with metastatic melanoma with nodal involvement			
SYLATRON 888MCG INJ KIT *	1	All FDA approved indications not otherwise excluded from part D	FDA labeled contraindications	FDA labeled contraindications	Ages approved in FDA labeling	oncology	up to 12 months	Must be used as adjuvant treatment within 84 days of surgical resection in patients with metastatic melanoma with nodal involvement			

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SYMLIN 0.6MG/ML INJ *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, HA1c BG	Ages approved in FDA labeling	Endocrinologist	12 months	Patient BG must be non-controlled on optimal doses of insulin			
SYNAREL 2MG/ML NASAL SOLN *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling		up to 12 months	Must fail Lupron			
TASIGNA 150MG CAP *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes	Ages approved in FDA labeling	Hematologist/oncologist	12 months	Covered for failure or relapse of CML when previously treated with imatinib. Covered for newly diagnosed CML patients who are Philadelphia chromosome +. Will also be covered for intolerance or adverse reaction to imatinib. Combination therapy with other tyrosine kinase inhibitors or MTOR inhibitors for CML is not supported.			
TASIGNA 200MG CAP *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes	Ages approved in FDA labeling	Hematologist/oncologist	12 months	Covered for failure or relapse of CML when previously treated with imatinib. Covered for newly diagnosed CML patients who are Philadelphia chromosome +. Will also be covered for intolerance or adverse reaction to imatinib. Combination therapy with other tyrosine kinase inhibitors or MTOR inhibitors for CML is not supported.			
TAZORAC 0.05% CREAM *	1	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Previous treatment history	Ages approved in FDA labeling	dermatologist	12 months	For Psoriasis patient must have failed medium to high potency topical corticosteroid, For acne patient must have failed Tretinoin and oral antibiotic			

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TAZORAC 0.1% CREAM *	1	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Previous treatment history	Ages approved in FDA labeling	dermatologist	12 months	For Psoriasis patient must have failed medium to high potency topical corticosteroid, For acne patient must have failed Tretinoin and oral antibiotic			
TAZORAC 0.1% TOP GEL *	1	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Previous treatment history	Ages approved in FDA labeling	dermatologist	12 months	For Psoriasis patient must have failed medium to high potency topical corticosteroid, For acne patient must have failed Tretinoin and oral antibiotic			
TEV-TROPIN 5MG VIAL INJ *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Medical notes, studies establishing diagnosis of growth hormone deficiency or ISS	Ages approved in FDA labeling	Endocrinologist	12 months	Prescribed dose is not feasible with Omnitrope or Allergy to Omnitrope, or Allergy to Benzoyl alcohol (Omnitrope Preservative)			
THALOMID 50MG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications		Ages approved in FDA labeling	Hematologist/oncologist/infectious disease	12 months				
THALOMID 100MG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications		Ages approved in FDA labeling	Hematologist/oncologist/infectious disease	12 months				
THALOMID 150MG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications		Ages approved in FDA labeling	Hematologist/oncologist/infectious disease	12 months				
THALOMID 200MG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications		Ages approved in FDA labeling	Hematologist/oncologist/infectious disease	12 months				
TOBI 300MG/5ML INH SOLN *	1	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications		Ages approved in FDA labeling	pulmonologist/infectious disease	12 months				

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TRACLEER 125MG TAB *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, Right heart Catheterization, 6 Minute Walk time	Ages approved in FDA labeling	Pulmonologist or cardiologist	12 months	Pulmonary hypertension must be diagnosed by heart catheterization ,Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral ,Coverage will be based on medical history/status, vasoreactivity tests, response to previous treatments, and the consideration of other therapeutic options including Revatio			
TRACLEER 62.5MG TAB *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, Right heart Catheterization, 6 Minute Walk time	Ages approved in FDA labeling	Pulmonologist or cardiologist	12 months	Pulmonary hypertension must be diagnosed by heart catheterization ,Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral ,Coverage will be based on medical history/status, vasoreactivity tests, response to previous treatments, and the consideration of other therapeutic options including Revatio			
TRETINOIN 0.01% GEL *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications, treatment of photoaging, wrinkles	Diagnosis	Ages approved in FDA labeling		up to 12 months				
TRETINOIN 0.025% GEL *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications, treatment of photoaging, wrinkles	Diagnosis	Ages approved in FDA labeling		up to 12 months				

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TRETINOIN 0.025% CREAM *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications, treatment of photoaging, wrinkles	Diagnosis	Ages approved in FDA labeling		up to 12 months				
TRETINOIN 0.05% CREAM *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications, treatment of photoaging, wrinkles	Diagnosis	Ages approved in FDA labeling		up to 12 months				
TRETINOIN 0.1% CREAM *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications, treatment of photoaging, wrinkles	Diagnosis	Ages approved in FDA labeling		up to 12 months				
TRETINOIN 10MG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Hematologist/oncologist	12 months				
TYKERB 250MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, associated studies	Ages approved in FDA labeling	Oncologist/hematologist	up to 12 months	Patient is using in combination with capecitabine for HER/NEU + Metastatic breast CA, having failed an anthracycline, Herceptin and a taxane, or Patient must be using in combination with an aromatase inhibitor and have HER/NEU+ HR+ metastatic breast CA			
TYZEKA 600MG TAB *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, associated studies	Ages supported by medical literature		12 months				
VICTRELIS 200MG CAPSULE *	1	All FDA approved indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Infectious disease/ Gastroenterology	up to 44 weeks				

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VIMPAT 100MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Diagnosis	17 and older	Neurology	12 months				
VIMPAT 10MG/ML SOLN *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Diagnosis	17 and older	Neurology	12 months				
VIMPAT 150MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Diagnosis	17 and older	Neurology	12 months				
VIMPAT 200MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Diagnosis	17 and older	Neurology	12 months				
VIMPAT 50MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Diagnosis	17 and older	Neurology	12 months				
XALKORI 200MG CAPSULE *	1	All FDA approved indications not otherwise excluded from part D, locally advaced or metastatic ALK+ NSCLC	FDA labeled contraindications, NCLC which is Anaplastic Lymphoma Kinase negative, combination therapy with other antineoplastics/anti proliferatives	Diagnosis, documentation support ALK+ NSLC	Ages approved in FDA labeling	Hematology- oncology	6 months	Continuation will be based on lack of disease progresssion			

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XALKORI 250MG CAPSULE *	1	All FDA approved indications not otherwise excluded from part D, locally advaced or metastatic ALK+ NSCLC	FDA labeled contraindications, NCLC which is Anaplastic Lymphoma Kinase negative, combination therapy with other antineoplastics/anti proliferatives	Diagnosis, documentation support ALK+ NSLC	Ages approved in FDA labeling	Hematology-oncology	6 months	Continuation will be based on lack of disease progresssion			
XENAZINE 25MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Neurology	12 months	Patient must have moderate to severe chorea.			
XOLAIR 150MG INJ *	1	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical Notes, Previous treatment history, RAST and aeroallergens results, Ige values	Ages approved in FDA labeling	Pulmonologist/allergist	12 months	Patient Must Fail Combination LABA/ICS and LTA4 receptor antagonist			
YERVOY 50MG INJ *	1	All FDA approved indications not otherwise excluded from part D	Combination therapy with other antineoplastics, adjuvant treatment, previous intolerance to ipilimumab warranting discontinuation	Diagnosis, medical notes	Ages approved in FDA labeling	Hematology-oncology	6 months	Approval will be for up to 4 doses at 3mg/kg			
ZAVESCA 100MG CAP *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, associated studies	Ages approved in FDA labeling	Oncologist	12 months	Coverage will be based on medical history/status, response to previous treatments, and the consideration of other therapeutic options			

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ZELBORAF 240MG TABLET *	1	All medically accepted indications not otherwise excluded from part D, Metastatic Melanoma Stage IIIC unresectable or Stage IV	Absence of Braf V600E mutation, Combination therapy with other antineoplastic agents	Diagnosis, verification of a positive Braf V600e Mutation	Ages approved in FDA labeling	Oncology	3 months	Authorization for continuation past 90 days will be based on absence of disease progression.			
ZEMPLAR 1MCG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, CA PO4, iPTH	Ages approved in FDA labeling	Nephrologist/endocrinologist	12 months	Patient must fail or have contraindication to Calcitriol or phosphate binder if appropriate			
ZEMPLAR 2MCG CAPSULE *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical notes, previous treatment history, CA PO4, iPTH	Ages approved in FDA labeling	Nephrologist/endocrinologist	12 months	Patient must fail or have contraindication to Calcitriol or phosphate binder if appropriate			
ZOLINZA 100MG CAP *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Medical Notes	Ages approved in FDA labeling	Oncologist/hematologist/dermatologist	12 months	Failed minimum of two systemic treatments, one of which must be Targretin, unless contraindicated			
ZYPREXA 2.5MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/Neurology	12 months				
ZYPREXA 5MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/Neurology	12 months				
ZYPREXA 7.5MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/Neurology	12 months				
ZYPREXA 10MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/Neurology	12 months				

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ZYPREXA 15MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
ZYPREXA 20MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
ZYPREXA IM 10MG INJ *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
ZYPREXA ZYDIS 5MG TABLET *	0	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months				
ZYTIGA 250MG TABLET *	1	All medically accepted indications not otherwise excluded from part D	FDA labeled contraindications	Diagnosis	Ages approved in FDA labeling	Oncology	12 months	Patient Must have castrate resistant metastatic prostate cancer and have failed docetaxol	Ages approved in FDA labeling	Psychiatry/ Neurology	12 months
ZYVOX 100MG/5ML SUSPENSION *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Diagnosis, culture and sensitivity	Ages supported by medical literature		Up to 12 weeks	Coverage will be based on medical history/status, response to previous treatments, and the consideration of other therapeutic options, Culture and sensitivity must be submitted			
ZYVOX 600MG TABLET *	0	All FDA-approved indications not otherwise excluded from Part D	FDA labeled contraindications	Diagnosis, culture and sensitivity	Ages supported by medical literature		Up to 12 weeks	Coverage will be based on medical history/status, response to previous treatments, and the consideration of other therapeutic options, Culture and sensitivity must be submitted			