

Prior Authorization Group Description	Covered Uses	Exclusion Criteria	Required Medical	Age Restriction	Prescriber Restrictions	Coverage Duration	Other Criteria
ADALIMUMAB	All FDA-approved indications not otherwise excluded from Part D.				Rheumatologist or dermatologist must recommend/ requested therapy for RA, JRA, PsA, AS, psoriasis. Gastroenterologist must have recommended/requested therapy for Crohn's.	12 Months	Has at least one of the following diagnosis: Moderately or severely active polyarticular course juvenile arthritis. Moderately to severely active rheumatoid arthritis. Moderately to severely active plaque psoriasis requiring systemic or phototherapy active ankylosing spondylitis. Psoratic arthritis. Crohn's disease For RA, JRA and PsA a trial and failure/inadequate response to at least one or more DMARDs is required. For Crohn's disease a trial and failure of conventional therapies is required. If patient is receiving a TNF blocking agent, therapy must be discontinued. Rheumatologist or dermatologist must recommend/ requested therapy for RA, JRA, PsA, AS, psoriasis. Gastroenterologist must have recommended/requested therapy for Crohn's.
ANAKINRA	All FDA-approved indications not otherwise excluded from Part D.				Rheumatologist must recommend therapy for RA	12 Months	Meets the following criteria:Has diagnosis of moderately to severely active rheumatoid arthritis.A trial and failure/inadequate response to at least one or more DMARDs is required.If patient is receiving a TNF blocking agent, therapy must be discontinued.Rheumatologist must recommend therapy for RA.
CELECOXIB	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Patient greater or equal to 60 years of age will not require prior authorization. Patient greater than 60 years of age must meet one of the following 2 criteria and not receiving concurrent GI protective agent and not receiving ASA therapy:1-Current treatment with oral corticosteroids, anticoagulants, or antiplatelets. 2-Documented trial/failure with two prescription strength NSAIDs in the past six months for this condition with those meds listed on form.
DASATINIB	All FDA-approved indications not otherwise excluded from Part D.				Hematologist/Oncologist has recommended Sprycel.	12 Months	Meets the following criteria: Diagnosis of chronic, accelerated or myeloid or lymphoid blast phase chronic myeloid leukemia that has been resistant or intolerant to prior therapy including Gleevec or Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia that has been resistant or intolerant to prior therapy. Hematologist/Oncologist has recommended Sprycel.
DICLOFENAC EPOLAMINE	All FDA-approved indications not otherwise excluded from Part D.					1 Month	Meets the following criteria: Patient has acute pain due to minor strains, sprains or contusions. Documented trial/failure with two prescription strength NSAIDs in past for acute pain.
ERLOTINIB HCL	All FDA-approved indications not otherwise excluded from Part D.				Oncologist has recommended Tarceva	12 Months	Meets the following criteria: Diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) that has tried and failed at least one chemotherapy regimen or Diagnosis of locally advanced, unrectable or metastatic pancreatic cancer and is receiving Gemzar. Oncologist has recommended Tarceva.
ERYTHROPOIETIN AGENTS	All FDA-approved indications not otherwise excluded from Part D.		lab: hematocrit and hemoglobin			4 months	Anemia related to one of the following: Chronic kidney disease (hematocrit less 33%, hemoglobin less 11). Trial of Procrit first (aranesp requests only). Not receiving dialysis (Medicare only). Zidovudine (AZT) in HIV-patient for Procrit only (serum erythropoietin less than 500mU/ml, AZT dose less than 4200mg/week. Cancer patient on chemo for Procrit and Aranesp only (non-myeloid malignancy with anemia due to chemo, receiving chemo greater than or equal to 2 months and , Hematocrit less than 33% , hemoglobin less than 11).Trial of Procrit first (Aranesp requests only).Reduction of the number of allogenic blood transfusions in surgery for Procrit only (anemic, at high risk for transfusions with significant, anticipated blood loss. Dosage, frequency and duration are within labeling for all indications. If patient has been receiving procrit,epogen or aranesp. Hgb should not have increased more than 1.0g/dl in any 2 week period.Hgb should not exceed 12g/dl.
ETANERCEPT	All FDA-approved indications not otherwise excluded from Part D.				Rheumatologist or dermatologist must recommend/ requested therapy for RA, JRA, PsA, AS, psoriasis.	12 Months	Has at least one of the following diagnosis: Moderately or severely active polyarticular course juvenile arthritis, Moderately to severely active rheumatoid arthritis, Moderately to severely active plaque psoriasis requiring systemic or phototherapy, Active ankylosing spondylitis, Psoratic arthritis. For RA, JRA and PsA a trial and failure/inadequate response to at least one or more DMARDs is required.If patient is receiving a TNF blocking agent, therapy must be discontinued. Rheumatologist or dermatologist must recommend/ requested therapy for RA, JRA, PsA, AS, psoriasis.
EXENATIDE	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Diagnosis of DM, type 2.Currently on either a thiazolidinedione(TZDI), or metformin and/or a sulfonylurea.
FENTANYL CITRATE	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Meets the following criteria:For Breakthrough cancer pain.Tolerant to other opioid therapy: 60mg morphine daily or 25mcg transdermalfentanyl per hour or at least 30mg of oxycodone daily, or at least 8mg oral hydromorphone daily or equianalgesic dose of another opioid for greater than or equal to one week.

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FILGRASTIM	All FDA-approved indications not otherwise excluded from Part D.		ANC LEVEL			4 Months	If received Neulasta therapy within the past month:Diagnosis of neutropenia (ANC less than 500).Complete CBC with differential and platelet count during therapy. No record of excessive leukocytosis. If new start, then meets one of the following: Non-myeloid cancer receiving myelosuppressive chemo: CBC and platelet count before and during therapy .
GROWTH HORMONE AGENTS	All FDA-approved indications not otherwise excluded from Part D.		Height, IGF-1 level,GH level			12 months	Meets the following criteria: ADULT- A diagnosis of adult-onset evidence of hypothalamic-pituitary disease or history of cranial irradiation, or documented childhood-onset growth hormone deficiency. Has been evaluated for other endocrine disorders. Has a failed stimulation test (peak serum growth hormone value of less than 5mcg/ml by RIA or less than 3.5mcg/L by IRMA, or less than 3mcg/L during hypoglycemia after GH stimulation) for documented childhood-onset growth hormone deficiency only. Trial and failure of the preferred agent (norditropin) unless member has been on a non-preferred agent for greater than 6 months. Renewal: Monitoring of serum insulin-like growth factor (IGF-1).CHILD-A diagnosis of either isolated growth hormone deficiency/pituitary dwarfism, panhypopituitarism, iatrogenic pituitary disorder, chronic renal insufficiency, pituitary tumor, Turner syndrome, Prader-Willi syndrome or small for gestational age (SGA) .Open bony epiphyses (GHD only). Bone age less than chronological age (GHD only). Height less than the 5th percentile for chronological age (GHD only). Growth velocity less than the 10th percentile (GHD only). Has a failed stimulation test (peak serum growth hormone value of less than 10mcg/L after GH stimulation) (GHD only) Has been evaluated for other causes of growth failure. Trial and failure of the preferred agent (norditropin) unless member has been on a non-preferred agent for greater than 6 month-for all indications. Patient born SGA defined as Weight or length more than two SD below mean gestational age and failure to achieve catch-up growth by age 2 years for SGA only. Renewal: Child's bone age is less than 16 years for boys or less than 14 years for girls: Child's height velocity is 2.5 cm/year over the previous untreated rate, Child has not reached the 25th percentile of normal adult height for sex.
HEP C AGENTS	All FDA-approved indications not otherwise excluded from Part D.		Genotype			Genotype 1: 12 months	Confirmed Diagnosis of Hepatitis C Appropriate Length of therapy based on genotype
IGF-1 HORMONES	All FDA-approved indications not otherwise excluded from Part D.		Height, IGF-1 level,GH level			12 Months	Meets the following criteria: Diagnosis of growth failure due to severe primary IGF-1 deficiency (primary IGFD) OR Diagnosis of growth hormone gene deletion with neutralizing antiobiotics to growth hormone Other causes of growth failure have been ruled out. Bone epiphyses is open. Height is more than 3 standard deviation below the mean for a normal child of that age. IGF-1 level is low Growth hormone level is normal or elevated.
IMATINIB MESYLATE	All FDA-approved indications not otherwise excluded from Part D.				Oncologist has recommended Gleevec	12 Months	Meets the following criteria: Newly Diagnosed with Ph+ chronic myeloid leukemia in chronic phase (CML) or Diagnosis of Ph+ CML in blast crisis, accelerated phase, or in chronic phase or (CD117) positive unresectable and/or metastatic gastrointestinal stromal tumor or Adult patient with relapsed or refractory Ph+ ALL or Adult patient with MDS,MPD associated PDGFR or Adult patient with ASM without the c-Kit mutation status or with the status unknown or Adult patient with HES and,or chronic CEL who have FIP1L1-PDGFR-alpha fusion kinase or with the status negative or unknown or Adult patient with unresectable, recurrent and, or metastatic DFSP or pediatric patient with diagnosis of Ph+ chronic phase CML newly diagnosed or with disease recurrence after stem cell transplantation or interferon-alpha therapy.
LAPATINIB DITOSYLATE	All FDA-approved indications not otherwise excluded from Part D.				Oncologist has recommended Tykerb	12 Months	Meets the following criteria: Diagnosis of locally advanced or metastatic breast cancer Tumor is HER2 receptor positive. Has tried and failed at least one chemotherapy regimen including an anthracycline, taxane or herceptin. Oncologist has recommended Tykerb.
LENALIDOMIDE	All FDA-approved indications not otherwise excluded from Part D.				Hematologist/ Oncologist has recommended Revlimid	12 Months	Meets the following criteria:Diagnosis of multiple myeloma and has failed other therapies or Transfusion-dependent anemia due to myelodysplastic syndrome (MDS) associated with deletion 5q cytogenetic abnormalities or Diagnosis of low risk MDS without deletion 5q cytogenetic abnormalities. Hematologist/Oncologist has recommended Revlimid.
METHYLPHENIDATE	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Meets one of the following:Patient has diagnosis of ADD or ADHD and tried and failed an oral methylphenidate within the past six months.Patient has diagnosis of narcolepsy and tried and failed an oral methylphenidate within the past six months.
MODAFINIL	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Patient has one of the following: A diagnosis of narcolepsy as documented by a sleep study or Fatigue associated with multiple sclerosis or Excessive sleepiness associated with Shift Work Sleep Disorder (SWSD) or Excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome treated with continuous positive airway pressure (CPAP) treatment

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MORPHINE DERIVATIVES	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Meet all of the following Criteria for Avinza, Kadian and Opana ER tried and failed a controlled or extended release morphine within past 6 months. For Opana IR tried and failed an immediate release morphine with past 6 months
MS AGENTS	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Physician must provide dosage then patient will be enrolled into the MS Care program administered by McKesson HealthCare and physician will be contacted.
NABILONE	All FDA-approved indications not otherwise excluded from Part D.				Prescribed by an Oncologist	4 Months	Meets the following criteria: Prescribed by an oncologist. Prescribed for chemotherapy-induced nausea and vomiting. Trial and failure one of the following agents- emend, anzemet, marinol, kytril or zofran.
NILOTINIB HYDROCHLORIDE	All FDA-approved indications not otherwise excluded from Part D.				Oncologist has recommended Tasigna	12 Months	Meets the following criteria: Diagnosis of accelerated or chronic phase chronic myeloid leukemia that has been resistant or intolerant to prior therapy including Gleevec or Oncologist has recommended Tasigna.
OMALIZUMAB	All FDA-approved indications not otherwise excluded from Part D.		IgE LEVEL, SKIN TEST RESULT			12 Months	Diagnosis of moderate-severe persistent allergic asthma. Positive skin test with greater than or equal to 1 perennial aeroallergen. IgE level greater than or equal to 30 and less than or equal to 700 IU/ml.
OMEGA-3 ACID	All FDA-approved indications not otherwise excluded from Part D.		TG LEVEL			12 Months	Meets the following criteria: Diagnosis of hypertriglyceridemia. TG level greater than 500mg/dL.
OPRELVEKIN	All FDA-approved indications not otherwise excluded from Part D.					4 Months	Meets the following criteria: Patient has a diagnosis of non-myeloid cancer. Receiving myelosuppressive chemo. At risk for severe thrombocytopenia. Patient is not going to be receiving myeloblastic chemotherapy-not indicated.
PEGFILGRASTIM	All FDA-approved indications not otherwise excluded from Part D.		ANC LEVEL			4 Months	If received Neupogen therapy within the past month: Diagnosis of neutropenia-ANC less than 500. Complete CBC with differential and platelet count during therapy. No record of excessive leukocytosis. If new start, then meets one of the following: Acute myeloid leukemia: Receiving induction or consolidation chemo, CBC and platelet count before and during therapy. Non-myeloid cancer receiving myelosuppressive chemo: CBC and platelet count before and during therapy. Severe chronic neutropenia: CBC and platelet count before and during therapy. Non-myleoid cancer receiving myeloblastic chemotherapy followed by a BMT: CBC and platelet count before and during therapy. Peripheral blood progenitor cell transplantation: CBC and platelet count before and during therapy.
PPI AGENTS	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Meets the following criteria: Minimum 30 day trial and failure of a preferred PPI drug in the last six months: pantoprazole (Protonix) 40mg daily Failure due to adverse reaction should have description and/or medwatch response attached.
PRAMLINTIDE ACETATE	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Meets the following criteria: Diagnosis of DM, types 1 or 2. Currently on either insulin and metformin and/or a sulfonylurea.
SARGRAMOSTIM	All FDA-approved indications not otherwise excluded from Part D.					4 Months	If received Leukine therapy within the past month: Diagnosis of neutropenia (ANC less than 500), Complete CBC with differential and platelet count during therapy, No record of excessive leukocytosis. If new start, then meets one of the following: Acute myeloid leukemia: Receiving induction or consolidation chemo, CBC and platelet count before and during therapy. Myeloid recovery after autologous or allogenic BMT: CBC and platelet count before and during therapy. Allogenic or autologous BMT failure with engraftment delay or failure: CBC and platelet count before and during therapy. Peripheral blood progenitor cell transplantation: CBC and platelet count before and during therapy .
SOMATROPIN (ZORBTIVE)	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Meets the following criteria: Diagnosis of short bowel syndrome. Patient receiving specialized nutritional support
SOMATROPIN (SEROSTIM)	All FDA-approved indications not otherwise excluded from Part D.					12 Weeks initial tx, renew for 12 weeks	Meets the following criteria: Diagnosis of AIDS wasting and/or cachexia, Continuing prescribed anti viral therapy. Evaluated for inadequate nutritional intake, malabsorption and/or hypogonadism. Initial length of PA is 12 weeks and Renewal at 12 weeks of therapy; If continuing prescribed anti-viral therapy, not continuing to lose weight and requesting treatment for additional 12 weeks or less.
SORAFENIB TOSYLATE	All FDA-approved indications not otherwise excluded from Part D.				Oncologist has recommended Nexavar	12 Months	Meets the following criteria: Diagnosis of advanced renal cell carcinoma or diagnosis of unresectable hepatocellular carcinoma and Oncologist has recommended Nexavar.
SUNITINIB MALATE	All FDA-approved indications not otherwise excluded from Part D.				Oncologist has recommended Sutent	12 Months	Meets the following criteria: Diagnosis of progressive gastrointestinal stromal tumor (GIST) that has failed or is intolerant to Gleevec or Diagnosis of advanced renal cell carcinoma Oncologist has recommended Sutent.

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TERIPARATIDE	All FDA-approved indications not otherwise excluded from Part D.					12 months	Meets the following criteria: 1. Male with primary or hypogonadal osteoporosis at high risk for fractures or 2. Postmenopausal woman with osteoporosis at high risk for fractures or 3. Patient with glucocorticoid-induced osteoporosis at high risk for fractures, and failed or intolerant to traditional osteoporosis therapy such as bisphosphonates, SERMs, calcitonin, calcium with vitamin D.
THALIDOMIDE	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Meets the following criteria:Diagnosis of multiple myeloma or refractory Crohn's disease, or moderate to severe ENL. Patient is not using as monotherapy for moderate to severe neuritis associated with ENL.
VITAMIN A DERIV	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Claims for members less than 26 will not require prior authorization, others must meet the following criteria: Diagnosis of acne vulgaris, acne rosacea, or actinic keratosis. Trial and failure of any 2 formulary medications from the following categories: Topical antibiotics(i.e. clindamycin, erythromycin) Benzoyl Peroxide Gels, or oral antibiotics (i.e. erythromycin, minocycline, tetracycline)
VORINOSTAT	All FDA-approved indications not otherwise excluded from Part D.				Oncologist has recommended Zolanza	12 Months	Meets the following criteria: Diagnosis of progressive, persistent or recurrent cutaneous T-cell lymphoma(CTCL) and has tried and failed other systemic therapies. Oncologist has recommended Zolanza.
BUPROPION	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Meets the following criteria:Diagnosis of Major Depressive Disorder (MDD), Documented 2 months trial and failure of either Wellbutrin, Wellbutrin SR, Wellbutrin XL or bupropion for this condition.
EVEROLIMUS	All FDA-approved indications not otherwise excluded from Part D.				Oncologist has recommended Afinitor	12 Months	Meets the following criteria: 1. Diagnosis of advanced renal cell carcinoma, 2. Trial and failure of either sunitinib or nexavar. 3. Oncologist has recommended Afinitor
GOLIMUMAB	All FDA-approved indications not otherwise excluded from Part D.				Rheumatologist or dermatologist must recommend/ requested therapy for RA, AS, PsA	12 Months	Meets the following criteria: •Has at least one of the following diagnosis for: 1. moderately to severely active rheumatoid arthritis. For RA, Simponi must be used in combination with MTX and Simponi dose for RA is 50mg once a month. 2. Active ankylosing spondylitis and Simponi dose for AS is 50mg every month. 3. Psoriatic arthritis and Simponi dose for PsA is 50mg every month • For RA, AS and PsA a trial and failure/inadequate response to at least one or more DMARDs is required. •Plan requires trial and Failure of 2 preferred agents (Enbrel and Humira) prior to Simponi use. •If patient is receiving a TNF blocking agent, therapy must be discontinued. •Rheumatologist or Dermatologist must recommend/ requested therapy for RA, AS and PsA. • If the member has been on the requested drug for six months or more (either with CareFirst or another plan) approve.