

## 2012 Prior Authorization Requirements

BRAND NAME DRUG(S)	PRIOR AUTHORIZATION GROUP DESCRIPTION	COVERED USES	EXCLUSION CRITERIA	MEDICAL INFORMATION	AGE RESTRICTION	PRESCRIBER RESTRICTION	COVERAGE DURATION	OTHER CRITERIA
ABSTRAL, ACTIQ, FENTANYL CITRATE, FENTORA, ONSOLIS	FENTANYL CITRATE	All FDA-approved indications not otherwise excluded from Part D.				Oncologist must prescribe Fentanyl Citrate	12 Months	Meets the following criteria: For Breakthrough cancer pain. Tolerant to other opioid therapy: 60mg morphine daily or 25mcg transdermal fentanyl 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.
ACIPHEX, NEXIUM, PREVACID, PRILOSEC, PROTONIX, VIMOVO, ZEGERID	PPI AGENTS	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Plan requires a minimum 30 day trial and failure of two generic prescription strengths PPI drugs in the past 12 months such as Lansoprazole 30mg daily, Lansoprazole ODT 15mg or 30mg daily, Pantoprazole 40mg daily, Omeprazole 40mg daily, or Omeprazole/ Sodium bicarbonate 40mg/1.1g, daily.
ADAPALENE, ATRALIN, AVITA, TAZORAC, DIFFERIN, EPIDUO, RETIN-A, RETIN-A MICRO, TRETINOIN, TRETIN-X	VITAMIN A DERIV	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Claims for members less than 35 will not require prior authorization, others must meet the following criteria: Diagnosis of acne vulgaris, Diagnosis of psoriasis (tazorac only).

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ADCIRCA	TADALAFIL	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Meets the following criteria: Diagnosis of Pulmonary Hypertension.
AFINITOR	EVEROLIMUS	All FDA-approved indications not otherwise excluded from Part D.		Renal (Kidney) Cancer: 1. Diagnosis of advanced renal cell carcinoma. 2. Trial and failure of either Sunitinib (Sutent) or Sorafenib (Nexavar) or Pazopanib (Votrient). Brain Tumor: 1. Diagnosis of SEGA (subependymal giant cell astrocytoma) associated with tuberous sclerosis for which surgical resection is not a treatment option. Pancreatic Neuroendocrine Tumor: 1. Diagnosis of PNET (progressive neuroendocrine tumors) of pancreatic organ that is unresectable, locally advanced or metastatic		Oncologist has recommended Everolimus (Afinitor).	12 Months	
AMPYRA	DALFAMPRIDINE	All FDA-approved indications not otherwise excluded from Part D.	1. Hx of Seizures , 2. Moderate or severe renal impairment (CrCl equal to or less than 50ml per min).	Initial Therapy for Multiple Sclerosis (MS): 1. Diagnosis of MS 2. EDSS score between 4.5-6.5 Reauthorization for MS: After 16 weeks of therapy, documentation that patient has demonstrated at least 10% improvement in timed walking speed.		Neurologist must prescribe Ampyra.	Initial 16 weeks, renewal 12 Months.	Use of FDA approved dosing (10mg twice daily).
APLENZIN	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.

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ARANESP, PROCRIT, EPOGEN	ERYTHROPOIETIN AGENTS	All FDA-approved indications not otherwise excluded from Part D.		Treatment of anemia related to one of the following: Anemia due to Chronic Kidney Disease (Aranesp-Epogen-Procrit): 1. Hgb less than 10 gm per dl Anemia due to Chemotherapy/Cancer (Aranesp-Procrit): 1. Diagnosis of anemia due to chemotherapy for non-myeloid malignancy 2. Verification that the patient will be receiving chemotherapy 3. Verification of iron evaluation for adequate iron stores 4. Hgb less than 10 gm per dl. 5. Verification that other causes of anemia have been ruled out Anemia due to HIV related to Zidovudine therapy (Procrit): 1. Serum erythropoietin level is equal to or less than 500mU per ml 2. Verification that patient is receiving a dose of Zidovudine equal to or less than 4200mg per week. Reduction of Allogenic Blood Transfusion in surgery (Procrit): 1. Verification that patient is at high risk for transfusions with significant, anticipated blood loss and hemoglobin greater than 10 but less than or equal to 13 g/dl. Renewal Criteria for patients who have been receiving Procrit, Epogen or Aranesp: 1. Dosage should have been adjusted if Hgb has increased more than 1.0g/dl in any 2 week period and current Hgb is less than 12g/dl.			4 months	1. Erythropoietin Agents are subject to Part B vs. Part D review (Members on dialysis should be able to receive Erythropoietin under Part B). 2. For anemia due to Chronic Kidney Disease and Chemotherapy/Cancer plan requires trial of preferred agent (Procrit) prior to Aranesp therapy or contraindication to its use. Failure of Procrit is not required for patients who are continuing Aranesp therapy.
AVINZA, KADIAN, OPANA ER	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 generic controlled or extended release morphine within past 6 months. For Opana IR tried and failed a generic immediate release morphine with past 6 months.

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AVONEX ADMINIS- TRATION PACK, AVONEX, BETASERON, COPAXONE, EXTAVIA, REBIF	MS AGENTS	All FDA- approved indications not otherwise excluded from Part D.		Renal Cell Carcinoma: Diagnosis of advanced renal cell carcinoma.			12 Months	Must meet the following criteria: Confirmed diagnosis of Multiple Sclerosis. If requesting either Rebif or Copaxone (preferred agents), no other requirements need to be met. If requesting either Avonex or Betaseron or Extavia, must provide documentation of trial and failure of both Rebif and Copaxone (preferred agents) or documentation of prior use of either Avonex or Betaseron or Extavia for at least six months.
BOTOX	ONABOTULINUMTOXINA	All FDA- approved indications not otherwise excluded from Part D.		Chronic Migraine-Initial Therapy: 1) Submission of chart notes documenting diagnosis, meeting International Headache Classification (ICHD-2) diagnostic criteria for chronic migraine headache (example: migraines lasting at least four hours for at least 15 days per month, for at least 3 months), AND 2) complete evaluation of the patient and symptoms that persist despite adequate trials of at least 2 agents from different classes of medications used in the treatment of chronic migraine headaches, (example: antidepressants, antihypertensives and antiepileptics such as TCA, Beta blockers, CCB, divalproex sodium, topiramate). Reauthorization: 1) Submission of chart notes documenting migraine frequency has been reduced by at least 7 days per month OR 2) migraine headache duration has been reduced by at least 100 hours per month. Primary Axillary Hyperhidrosis: Initial Therapy: 1) Submission of chart notes documenting persistent primary axillary hyperhidrosis in adult patient with Score of 3 or 4 on the Hyperhidrosis Disease Severity Scale (HDSS), AND 2) History of failure to topical prescription strength drying agents. Reauthorization: 1) Submission of chart notes documenting at least a 2-point improvement in HDSS. Upper Limb Spasticity, Cervical Dystonia, Blepharospasm, and Strabismus- Initial therapy and Reauthorization: 1) Submission of chart notes documenting diagnosis, prior therapies, and outcome.			6 months	

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CARIMUNE NF NANOFIL-TERED, FLEBOGAMMA, HIZENTRA, GAMASTAN S-D, GAMMAGARD LIQUID, GAMMAPLEX, GAMUNEX, OCTAGAM, PRIVIGEN, VIVAGLOBIN	IV IMMUNE GLOBULIN	All FDA-approved indications not otherwise excluded from Part D.		Submission of chart notes documenting diagnosis, prior therapies and outcome.			12 Months	IVIG is subject to Part B vs D review (IVIG is covered under part B for treatment of primary immune deficiency in patient's home).
CIALIS	TADALAFIL (CIALIS)	All FDA-approved indications not otherwise excluded from Part D.		Benign Prostatic Hyperplasia(BPH): 1)Diagnosis of BPH, 2) males only, 3) Age of forty five (45) years old or older	Member must be at least 45 years old		12 Months	
CELEBREX	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 less 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.
CESAMET	NABILONE	All FDA-approved indications not otherwise excluded from Part D.				Prescribed by an Oncologist	4 Months	Meets the following criteria:1.Prescribed by an oncologist and 2.Prescribed for chemotherapy-induced nausea and vomiting and 3.Trial and failure of one of the following agents- emend, anzemet, marinol, kytril or zofran.

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CIMZIA	CERTOLIZUMAB	All FDA-approved indications not otherwise excluded from Part D.		Rheumatoid Arthritis (RA): 1. Diagnosis of moderate to severe active RA 2. Trial and failure or inadequate response to at least one or more DMARDs such as Methotrexate, Imuran, Ridaura, Plaquenil, Cuprimine, Azulfidine or Arava. Crohn's Disease: 1. Diagnosis of Crohn's disease 2. Trial and failure or inadequate response to at least one or more conventional therapies such as 5-ASA, systemic corticosteroids, or immunosuppressants such as azathioprine is required.		Rheumatologist must recommend therapy for RA. Gastroenterologist must recommend therapy for Crohn's.	12 Months	1. For all diagnosis: use of FDA approved dosing 2. For all Diagnosis: If patient is receiving a different TNF blocking agent, therapy must be discontinued prior to initiating new TNF agent Certolizumab (Cimzia). 3. Rheumatoid Arthritis (RA): Trial and failure or inadequate response to one preferred agent, Humira or Enbrel 4. Crohn's Disease: Trial and failure or inadequate response to preferred agent Humira.
DAYTRANA	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 OR Patient has diagnosis of narcolepsy and tried and failed an oral methylphenidate within the past six months.
EGRIFTA	TESAMORELIN	All FDA-approved indications not otherwise excluded from Part D.		Lipodystrophy: Diagnosis of excessive abdominal fat in HIV-infected patient with lipodystrophy. Reauthorization: 1. Diagnosis of excessive abdominal fat in HIV-infected patient with lipodystrophy 2. Patient had a reduction in visceral adipose tissue (VAT).			26 Weeks	
ENBREL	ETANERCEPT	All FDA-approved indications not otherwise excluded from Part D.		Rheumatoid Arthritis (RA): 1. Diagnosis of moderately to severe active RA , 2. Trial and failure or inadequate response to at least one or more DMARDs is required. Juvenile Idiopathic Arthritis (JIA): 1. Diagnosis of moderately to severe active polyarticular juvenile idiopathic arthritis, 2. Trial and failure or inadequate response to at least one or more DMARDs is required. Psoriatic Arthritis (PsA): 1. Diagnosis of active PsA, 2. Trial and failure or inadequate response to at least one or more DMARDs is required. Ankylosing Spondylitis (AS): 1. Diagnosis of AS , Plaque Psoriasis: 1. Diagnosis of chronic moderate to severe plaque psoriasis requiring systemic or phototherapy.		Rheumatologist or dermatologist must recommend/ requested therapy for RA, JRA, PsA, AS. Dermatologist must recommend therapy for Plaque Psoriasis.	12 Months	For all Diagnosis: If patient is receiving a different TNF blocking agent, therapy must be discontinued prior to initiating new TNF.

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ERIVEDGE	VISMODEGIB	All FDA-approved indications not otherwise excluded from Part D.		Skin Cancer: 1. Diagnosis of metastatic or locally advanced basal cell carcinoma that has recurred after surgery or cannot be treated by surgery or radiation		Oncologist has recommended Erivedge	12 Months	
FLECTOR	DICLOFENAC (FLECTOR)	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 and documented trial/failure with two prescription strength NSAIDs in past for acute pain. Flector will not be prescribed for more than 2 weeks.
FORTEO	TERIPARATIDE	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Meets the following criteria: Diagnosis of, 1. Male with primary or hypogonadal osteoporosis at high risk for fractures, or 2. Post menopausal 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 therapies (such as bisphosphonates, SERMs, calcitonin, calcium with vitamin D).

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GENOTROPIN, HUMATROPE, NORDITROPIN, NORDITROPIN NORDIFLEX, NUTROPIN AQ, NUTROPIN, OMNITROPE, SAIZEN, TEV-TROPIN	GROWTH HORMONE AGENTS	All FDA-approved indications not otherwise excluded from Part D.		<p>MEDICAL INFORMATION: ADULT with Diagnosis of: 1. Adult-onset growth hormone deficiency (GHD) due to hypothalamic-pituitary disease or history of cranial irradiation 2. Documented childhood-onset GHD who have been evaluated for other endocrine disorders and 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. Renewal (Adult): Monitoring of serum insulin-like growth factor (IGF-1). CHILDREN with Diagnosis of: 1. Isolated GHD/pituitary dwarfism a) With open bony epiphyses, b) Growth velocity less than the 10th percentile, c) Bone age less than chronological age d) Height less than the 5th percentile for chronological age e) Two documented failed stimulation test (peak serum growth hormone value of less than 10mcg/L after GH stimulation) f) Child's bone age less than 16 years for boys or less than 14 years for girls g) child's height velocity is 2.5 cm/year over the previous untreated rate h) Child has not reached the 25th percentile of normal adult height for sex. 2. Panhypopituitarism 3. Iatrogenic Pituitary Disorder 4. Chronic renal insufficiency prior to transplantation 5. Pituitary Tumor 6. Turner syndrome with short stature 7. Prader-Willi syndrome 8. Noonan syndrome in pre-pubertal children with short stature a) with height at least 2SDs below the mean for chronological age b) Sex and Growth velocity measured over 1 year prior to initiation of therapy of 1 or more SDs before the mean for age and sex. 9. Small for gestational age (SGA) defined as weight or length more than 2SDs below the mean for gestational age who have failed to reach catch-up age by age two. Renewal (child): 1. One of above diagnosis 2. For GHD: a) Child's bone age is less than 16 years for boys or less than 14 years for girls, and b) Child's height velocity is 2.5 cm/year over the previous untreated rate and C) Child has not reached the 25th percentile of normal adult height for sex.</p>			12 months	<p>1. For Pediatric and Adult GHD, Noonan Syndrome, Turner syndrome, and SGA a trial and failure of the preferred agent (norditropin) is required unless member has been on a non-preferred agent for greater than 6 months. 2. For all Pediatric Diagnosis patient should be evaluated for other causes of growth failure such as thyroid deficiency.</p>
GILENYA	MS AGENTS (GILENYA)	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Must meet the following criteria: Confirmed diagnosis of Multiple Sclerosis and previous trial and failure of both Rebif and Copaxone (preferred agents).

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GLEEVEC	IMATINIB MESYLATE	All FDA-approved indications not otherwise excluded from Part D.		<p>1.Chronic Myeloid Leukemia (CML):  a) Newly Diagnosed adult patients with Philadelphia Chromosome Positive (Ph+) chronic myeloid leukemia(CML) in chronic phase b) Diagnosis of Ph+CML in blast crisis(BC), accelerated phase(AP), or in chronic phase(CP) after failure of interferon-alpha therapy c) Pediatric patient with diagnosis of Ph+CML in chronic phase newly diagnosed or with disease recurrence after stem cell transplantation or interferon-alpha therapy. 2. Gastrointestinal stromal tumors (GIST): a) In patients with Kit (CD117) unresectable positive and/or metastatic malignant GIST b) Adjuvant treatment of adult patients following resection of Kit (CD117) positive GIST 3. Acute Lymphoblastic Leukemia (ALL): In adult patients diagnosed with relapsed or refractory Ph+ ALL or 4. Myelodysplastic/ Myeloproliferative Disease (MDS/MPD): in adult patient diagnosed with MDS/MPD associated with platelet-derived growth factor receptor gene rearrangements (PDGFR) 5. Aggressive Systemic Mastocytosis (ASM): In adult patient with ASM without the D816V c-Kit mutation or with c-kit mutation status unknown 6. Hypereosinophilic Syndrome (HES) and Chronic eosinophilic Leukemia (CEL): In adult patient diagnosed with HES and/or CEL who have FIP1L1-PDGFR-alpha fusion kinase or with FIP1L1-PDGFR-alpha fusion kinase negative or unknown 7. Dermatofibrosarcoma protuberans (DFSP): In adult patients diagnosed with unresectable, recurrent and/or metastatic DFSP.</p>		Oncologist has recommended Imatinib (Gleevec).	12 Months	

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HUMIRA	ADALIMUMAB	All FDA-approved indications not otherwise excluded from Part D.		Moderate to severe Rheumatoid Arthritis (RA): 1. Diagnosis of moderate-to-severe active rheumatoid arthritis. 2. Trial and failure/inadequate response to at least one or more DMARDs Juvenile Idiopathic Arthritis (JIA): 1. Diagnosis of moderate-to-severe active polyarticular juvenile idiopathic arthritis 2. Trial and failure or inadequate response to at least one or more DMARDs Psoriatic arthritis (PsA): 1. Diagnosis of active PsA 2. Trial and failure/inadequate response to at least one or more DMARDs Ankylosing spondylitis (AS): 1. Diagnosis of active Ankylosing Spondylitis Plaque Psoriasis: 1. Moderately to severely chronic plaque psoriasis 2. Failed phototherapy or systemic therapy Crohn's disease: 1. Diagnosis of moderate to severe active Crohn's Disease 2. Trial and failure of at least one or more conventional therapy such as 5-ASA, systemic corticosteroids or immunosuppressants such as azathioprine.		Rheumatologist or Dermatologist must recommend therapy for RA, JIA, AS, PsA. Dermatologist must recommend therapy for Plaque Psoriasis. Gastroenterologist must recommend therapy for Crohn's.	12 Months	For all Diagnosis: If patient is receiving a different TNF blocking agent, therapy must be discontinued prior to initiating new TNF.
INCIVEK	HEP C AGENTS (TELAPREVIR)	All FDA-approved indications not otherwise excluded from Part D.		Genotype, Baseline HCV-RNA (pre-treatment). HCV-RNA level at Treatment Week (TW) 4,12, 24 should be evaluated by physician for continuation of therapy per manufacturer guidelines.			Initial: 8 weeks of Incivek. Continuation: 4 weeks depending on therapy and clinical response.	For Initial treatment: In Incivek_Pegasys (preferred agent) or Peg-Intron (non-preferred)_ Ribavirin triple therapy plan requires the following: 1) Diagnosis of Hepatitis C, genotype-1, 2) Prior treatment and outcome if applicable, 3) must be naïve to Incivek and Victrelis therapy, 4) History of compensated liver disease (i.e. cirrhosis), 5) baseline (pre-treatment) HCV-RNA.(6) Labs and clinical documentation must be included with request. 7) Treatment with preferred agent (Pegasys) is required unless member is already receiving Peg-Intron, Note for initial treatment: In Peg-interferon_Ribavirin_Incivek triple therapy, Pegasys (preferred agent) or Peg-Intron (non-preferred) and Incivek are initially authorized for 8 weeks (Ribavirin does not require authorization) For Continuation Treatment with Incivek_Peg-interferon_Ribavirin, plan requires the following:

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INCIVEK <i>(Continued)</i>	HEP C AGENTS (TELAPREVIR)	All FDA- approved indications not otherwise excluded from Part D.		Genotype, Baseline HCV-RNA (pre-treatment). HCV-RNA level at Treatment Week (TW) 4,12, 24 should be evaluated by physician for continuation of therapy per manufacturer guidelines.			Initial: 8 weeks of Incivek. Continuation: 4 weeks depending on therapy and clinical response.	1) result of HCV-RNA levels at TW 4,12 and 24 to evaluate continuation or stopping of therapy per manufacturer guidelines. 2) HCV-RNA less than 1000 IU_ml at TW4 is required to continue therapy. 3) HCV-RNA level less than 1000IU_ml at TW12 is required to continue therapy, 4) HCV-RNA level undetectable at TW24 is required to continue therapy. Note for continuation treatment: Incivek may be renewed for additional 4 weeks depending on therapy and clinical response (maximum total length of therapy for Incivek is 12 weeks) and peg-interferon may be renewed for up to an additional 40 weeks (maximum total length of therapy for peg-interferon is 48 weeks) depending on therapy and clinical response.
INCRELEX	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:1.Diagnosis of growth failure due to severe primary IGF-1 deficiency (primary IGFD) or 2.Diagnosis of growth hormone gene deletion with neutralizing antibodies to growth hormone and 3.Other causes of growth failure have been ruled out and 4.Bone epiphyses is open and 5.Height standard deviation score is greater than or equal to -3.0 and 6.Basal IGF-1 standard deviation score is greater than or equal to -3.0 and 7.Growth hormone level is normal or elevated.
INLYTA	AXITINIB	All FDA- approved indications not otherwise excluded from Part D.		Renal (Kidney) Cancer: 1. Diagnosis of advanced renal cell carcinoma. 2. Trial and failure of nexavar, sutent or votrient		Oncologist has recommended Inlyta	12 Months	

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JAKAFI	RUXOLITINIB	All FDA-approved indications not otherwise excluded from Part D.		Myelofibrosis: Diagnosis of intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis		Hematologist or Oncologist must recommend Jakafi	12 Months	
KALYDECO	IVACAFTOR	All FDA-approved indications not otherwise excluded from Part D.		Cystic Fibrosis: 1. Diagnosis of cystic fibrosis, 2. G551D mutation confirmed using a FDA-approved test			12 Months	
KINERET	ANAKINRA	All FDA-approved indications not otherwise excluded from Part D.		Rheumatoid Arthritis (RA): 1. Diagnosis of moderate to severe active RA 2. Trial and failure or inadequate response to at least one or more DMARDs.		Rheumatologist must recommend therapy for RA	12 Months	If patient is receiving a different TNF blocking agent, therapy must be discontinued prior to initiating new TNF.
LANTUS, LANTUS SOLOSTAR	GLARGINE INSULIN	Hematologist or Oncologist must recommend Jakafi					12 Months	Meets the following criteria: 1. Patient has a diagnosis of diabetes, 2. Patient has tried and failed preferred drug Levemir. Approved if member has been on Lantus for more than 4 months.
LEUKINE	SARGRAMOSTIM	All FDA-approved indications not otherwise excluded from Part D.		If patient has received Leukine therapy within the past month then must meet following criteria: 1. Diagnosis of neutropenia (ANC less than 500) and 2. have complete CBC with differential and platelet count during therapy and 3. have no record of excessive leukocytosis. If new start, then meets one of the following criteria: 1. Acute myeloid leukemia and Receiving induction or consolidation chemo with CBC and platelet count before and during therapy. 2. Myeloid recovery after autologous or allogenic BMT with CBC and platelet count before and during therapy. 3. Allogenic or autologous BMT failure with engraftment delay or failure with CBC and platelet count before and during therapy. 4. Peripheral blood progenitor cell transplantation with CBC and platelet count before and during therapy .			4 Months	
LOVAZA	OMEGA-3 ACID	All FDA-approved indications not otherwise excluded from Part D.		TG LEVEL			12 Months	Meets the following criteria: Diagnosis of hypertriglyceridemia and TG level greater than 500mg/dL.

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NEULASTA	PEGFILGRASTIM	All FDA-approved indications not otherwise excluded from Part D.		I. New Start: 1. Diagnosis of Non-myeloid cancer receiving myelosuppressive chemo with CBC and platelet count before and during therapy, 2. documented Absolute Neutrophil Count (ANC LEVEL less than 500/mm <sup>3</sup> ) II. If patient has received Neulasta Therapy within the past month then meet the following criteria: 1. Diagnosis of neutropenia with Absolute Neutrophil Count (ANC less than 500/mm <sup>3</sup> ) or 2. have moderate to high risk for developing neutropenia based on chemotherapy regimen and patient characteristics and 3. have complete CBC with differential and platelet count during therapy and 4. No record of excessive leukocytosis.			4 Months	
NEUMEGA	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.
NEUPOGEN	FILGRASTIM	All FDA-approved indications not otherwise excluded from Part D.		I. NEW START with Diagnosis of: 1) Acute myeloid leukemia (AML) receiving induction or consolidation chemo with CBC and platelet count before and during therapy or 2) Non-myeloid cancer receiving myelosuppressive chemo with CBC and platelet count before and during therapy or 3) Severe chronic neutropenia with CBC and platelet count before and during therapy or 4) Non-myeloid cancer receiving myeloablative chemotherapy followed by a BMT with CBC and platelet count before and during therapy or 5) Peripheral blood progenitor cell transplantation with CBC and platelet count before and during therapy. II. If patient has received Neupogen Therapy within the past month then meet the following criteria: 1) Diagnosis of neutropenia with Absolute Neutrophil Count (ANC less than 500/mm <sup>3</sup> ) or 2) have moderate to high risk for developing neutropenia based on chemotherapy regimen and patient characteristics and 3) have complete CBC with differential and platelet count during therapy and 4) No record of excessive leukocytosis.			4 Months	

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NEXAVAR	SORAFENIB TOSYLATE	All FDA-approved indications not otherwise excluded from Part D.		Renal Cell Carcinoma: Diagnosis of advanced renal cell carcinoma or Hepatocellular Carcinoma: Diagnosis of unresectable hepatocellular carcinoma(HCC).		Oncologist has recommended Sorafenib (Nexavar)	12 Months	
NUVIGIL	ARMODAFINIL	All FDA-approved indications not otherwise excluded from Part D.		Narcolepsy: Submission of sleep study confirming the diagnosis of narcolepsy. Shift Work Sleep Disorder (SWSD): Symptoms of excessive sleepiness associated with SWSD. Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS): Symptom of excessive sleepiness associated with OSAHS treated with continuous positive airway pressure (CPAP).			12 Months	
ORENCIA SQ	ABATACEPT	All FDA-approved indications not otherwise excluded from Part D.		Adult Rheumatoid Arthritis (RA): 1) Diagnosis of moderate to severe active RA. 2) Trial and failure or inadequate response to at least one or more DMARDs such as Methotrexate, Imuran, Ridaura, Plaquenil, Cuprimine, Azulfidine or Arava. 3) A three month trial and failure of both preferred agents, Enbrel and Humira, is required by plan. 4) Must meet FDA approved dosing guideline 5) If patient is receiving a different TNF blocking agent, therapy must be discontinued		Rheumatologist must recommend Orencia SQ	12 Months	

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PEGASYS, PEGINTRON, PEGINTRON REDIPEN,	HEP C AGENTS	All FDA-approved indications not otherwise excluded from Part D.					Hep C: 48 weeks for Genotype 1, 4 and 24 weeks for Genotype 2,3,5, 6, Hep B: 48 weeks	For Chronic Hepatitis C initial authorization: Pegasys (preferred agent) or Peg-Intron (non-preferred), plan requires the following: 1) Diagnosis of Hepatitis C, 2) Genotype test result, 3) Prior treatment and outcome if applicable, 4) History of compensated liver disease (i.e. cirrhosis), 5) baseline (pre-treatment) HCV-RNA. 6) Labs and clinical documentation must be included with request. 7) Treatment with preferred agent (Pegasys) is required unless member is already receiving Peg-Intron. For all genotypes, initial authorization (if approved) is granted for 16 weeks only. HCV-RNA level should be evaluated at 12 weeks and results submitted with continuing authorization request. For Continuing authorization, plan requires the following: 1) result of HCV-RNA levels at week 12 to evaluate continuation or stopping of therapy per manufacturer guidelines (2 log drop in HCV-RNA at treatment week 12 is required to continue therapy, 2) Continuing authorization (if approved) is granted for a maximum of 32 additional weeks for genotype 1, 4, and 8 additional weeks for genotypes 2, 3, 5, 6 based on lab evaluation. For treatment of Hepatitis B with Pegasys only, length of authorization is 48 weeks.

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PENNSAID	DICLOFENAC SOLN(PENNSAID)	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Patient has a diagnosis of osteoarthritis and documented trial/failure with two prescription strength NSAIDs in the past six months for this condition.
PROVIGIL	MODAFINIL	All FDA-approved indications not otherwise excluded from Part D.		Narcolepsy: A diagnosis of narcolepsy as documented by a sleep study, Fatigue associated with multiple sclerosis: Symptom of fatigue associated with MS, Shift Work Sleep Disorder (SWSD): Symptom of excessive sleepiness associated with SWSD, Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS): Symptom of excessive sleepiness associated with OSAHS treated with continuous positive airway pressure (CPAP) treatment.			12 Months	
REVLIMID	LENALIDOMIDE	All FDA-approved indications not otherwise excluded from Part D.		1. Multiple Myeloma: 1. Diagnosis of multiple myeloma, 2. Myelodysplastic Syndrome (MDS): 1. Transfusion-dependent anemia due to myelodysplastic syndrome (MDS) associated with deletion 5q cytogenetic abnormalities 2. Diagnosis of low risk MDS without deletion 5q cytogenetic abnormalities.		Hematologist/Oncologist has recommended Lenalidomide (Revlimid).	12 Months	
SEROSTIM	SOMATROPIN (SEROSTIM)	All FDA-approved indications not otherwise excluded from Part D.		Initial therapy for AIDS associated cachexia or wasting: 1.Diagnosis of AIDS wasting and/or cachexia and 2. Continuing prescribed anti-viral therapy and 3.Evaluated for inadequate nutritional intake, malabsorption and/or hypogonadism. Renewal: 1. Continuing prescribed anti-viral therapy and 2. positive response to initial therapy/not continuing to lose weight.			12 Weeks initial tx, renew for 12 weeks, Maximum length of therapy is 24 weeks.	

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SIMPONI	GOLIMUMAB	All FDA-approved indications not otherwise excluded from Part D.		Rheumatoid Arthritis (RA): 1. Diagnosis of moderately to severely active rheumatoid arthritis 2. Must be used in combination with Methotrexate (MTX) 3. A trial and failure or inadequate response to at least one or more DMARDs such as MTX, Imuran, Ridaura, Plaquenil, Cuprimine, Azulfidine, or Arava Ankylosing Spondylitis (AS): 1. Diagnosis of active ankylosing spondylitis Psoriatic Arthritis (PsA): 1. Diagnosis of active Psoriatic arthritis. 2. A trial and failure or inadequate response to at least one or more DMARDs such as MTX, Imuran, Ridaura, Plaquenil, Cuprimine, Azulfidine, or Arava.		Rheumatologist or dermatologist must recommend/ requested therapy for RA, AS, PsA.	12 Months	1. If the member has been on Golimumab (Simponi) for six months or more with any plan, request will be approved. 2. For All diagnosis: Must use FDA approved dosage per indication. 3. For RA, PSA, and AS: Trial and failure or inadequate response to one preferred agent, Humira or Enbrel. 4. If patient is already receiving a different TNF blocking agent, therapy must be discontinued prior to treatment with Golimumab (Simponi).
SPRYCEL	DASATINIB	All FDA-approved indications not otherwise excluded from Part D.		Chronic Myeloid Leukemia (CML): 1. Diagnosis of chronic, accelerated or myeloid or lymphoid blast phase Philadelphia chromosome-positive (Ph+) CML Acute Lymphoblastic Leukemia (ALL): 1. Diagnosis of Philadelphia Chromosome-positive acute lymphoblastic leukemia (Ph+ALL) 2. Resistant or intolerant to prior therapy.		Hematologist/ Oncologist has recommended Dasatinib (Sprycel).	12 Months	
SUBOXONE & SUBUTEX	BUPRENORPHINE	All FDA-approved indications not otherwise excluded from Part D.		Meets the following criteria: 1) Daily dosage of buprenorphine does not exceed 32 mg, 2) diagnosis of opioid dependence, 3) Patient is receiving addiction counseling and/or other non-pharmacologic therapy and/or 12-step program such as Narcotics Anonymous (NA) or Alcoholics Anonymous (AA).			12 Months	Prescribing physician's valid DATA waiver and "X" DEA license number must be provided.
SUTENT	SUNITINIB MALATE	All FDA-approved indications not otherwise excluded from Part D.		Gastrointestinal Stromal Tumor (GIST): Diagnosis of progressive GIST that has failed or is intolerant to Gleevec or 2. Renal Cell Carcinoma: Diagnosis of advanced renal cell carcinoma.		Oncologist has recommended Sunitinib (Sutent).	12 Months	
SYLATRON	PEGINTERFERON (SYLATRON)	All FDA-approved indications not otherwise excluded from Part D.		Melanoma: Diagnosis of surgically resected melanoma with microscopic or gross nodal involvement		Oncologist must recommend Sylatron	12 months	

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SYMLIN, SYMLINPEN	PRAMLINTIDE ACETATE	All FDA-approved indications not otherwise excluded from Part D.		Type 1 Diabetes Mellitus: 1. Diagnosis of Type 1 diabetes, 2. concurrent use of insulin therapy Type 2 Diabetes Mellitus: 1. Diagnosis of Type 2 diabetes, 2. concurrent use of insulin therapy with or without a concurrent sulfonylurea agent and/or metformin.			12 Months	
TARCEVA	ERLOTINIB HCL	All FDA-approved indications not otherwise excluded from Part D.		Non-Small Cell Lung Cancer (NSCLC): 1. Diagnosis of locally advanced or metastatic NSCLC after trial and failure of at least one chemotherapy regimen Pancreatic Cancer: 1. Diagnosis of locally advanced, unresectable or metastatic pancreatic cancer 2. Used in combination with Gemcitabine (Gemzar).		Oncologist has recommended Erlotinib (Tarceva).	12 Months	
TASIGNA	NILOTINIB HYDROCHLORIDE	All FDA-approved indications not otherwise excluded from Part D.		Chronic Myeloid Leukemia (CML): Diagnosis of accelerated phase (AP) or chronic phase (CP) Philadelphia chromosome positive CML that has been resistant or intolerant to a prior therapy with Imatinib (Gleevec).		Oncologist has recommended Nilotinib (Tasigna).	12 Months	
THALOMID	THALIDOMIDE	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Meets the following criteria:1. Diagnosis of multiple myeloma or 2.Moderate to severe ENL and 3.Patient is not using as monotherapy for moderate to severe neuritis associated with ENL.
TYKERB	LAPATINIB DITOSYLATE	All FDA-approved indications not otherwise excluded from Part D.		Breast Cancer: 1. Diagnosis of HER2 receptor positive advanced or metastatic breast cancer and has tried and failed at least one chemotherapy regimen including an anthracycline, a taxane or trastuzumab (Herceptin) and will use in combination with Capecitabine (Xeloda). 2. Diagnosis of Postmenopausal with HER2 receptor positive metastatic breast cancer and will use in combination with Letrozole (Femara)		Oncologist has recommended Lapatinib (Tykerb).	12 Months	
VANDETANIB (CAPRELSA)	VANDETANIB	All FDA-approved indications not otherwise excluded from Part D.		Thyroid Cancer: Diagnosis of symptomatic or progressive medullary thyroid cancer that is unresectable locally advanced or metastatic		Oncologist or Endocrinologist has recommended Vandetanib.	12 Months	IVIG is subject to Part B vs D review (IVIG is covered under part B for treatment of primary immune deficiency in patient's home).

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VICTRELIS	HEP C AGENTS (BOCEPREVIR)	All FDA- approved indications not otherwise excluded from Part D.		Genotype, Baseline HCV-RNA (pre-treatment). HCV-RNA level at Treatment Week (TW) 4, 8, 12, 24 should be evaluated by physician for continuation of therapy per manufacturer guidelines.			Initial: 8 weeks Vectrelis. Continuation: 24 weeks depending on therapy and clinical response.	For Initial treatment: In Victrelis_Pegasys (preferred agent) or Peg-Intron (non-preferred)_ Ribavirin triple therapy plan requires the following: 1) Diagnosis of Hepatitis C, genotype-1. 2) Prior treatment and outcome if applicable, 3) must be naïve to Incivek and Victrelis therapy, 4) History of compensated liver disease (i.e. cirrhosis), 5) baseline (pre-treatment) HCV-RNA (6) Labs and clinical documentation must be included with request. 7) Treatment with preferred agent (Pegasys) is required unless member is already receiving Peg-Intron. Notes: Duration of initial therapy: In Peg-interferon_Ribavirin_Victrelis triple therapy, Pegasys (preferred agent) and Peg-Intron (non-preferred) is initially authorized for 12 weeks (Ribavirin does not require authorization). Authorization for Victrelis starts at week 5 of triple therapy. For Continuation Treatment with Victrelis_Peg-interferon_Ribavirin, plan requires the following: 1) result of HCV-RNA levels at TW 4, 8, 12 and 24 to evaluate continuation or stopping of therapy per manufacturer guidelines. 2) HCV-RNA less than 100 IU per ml at TW12 is required to continue therapy, 3) confirmed undetectable HCV-RNA at TW24 is required to continue therapy. Notes: Continuation Treatment: Maximum total length of therapy for Victrelis is 32 weeks. Peg-interferon may be renewed for additional 36 weeks, maximum total length of therapy for Peg-Interferon is 48 weeks, depending on therapy and clinical response.

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VOLTAREN	DICLOFENAC GEL(VOLTAREN)	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Patient has a diagnosis of osteoarthritis and documented trial/failure with two prescription strength NSAIDs in the past six months for this condition.
VOTRIENT	PAZOPANIB	All FDA-approved indications not otherwise excluded from Part D.		Renal Cell Carcinoma: Diagnosis of advanced renal cell carcinoma.		Oncologist must recommend Pazopanib (Votrient)	12 Months	
XALKORI	CRIZOTINIB	All FDA-approved indications not otherwise excluded from Part D.		Lung Cancer: 1)Diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC)· 2) Anaplastic lymphoma kinase (ALK) positive confirmed using a FDA-approved test.		Oncologist has recommend Xalkori	12 Months	
XEOMIN	INCOBOTULINUMTOXINA	All FDA-approved indications not otherwise excluded from Part D.		Cervical Dystonia-Initial therapy & Reauthorization: Submission of chart notes documenting diagnosis, prior therapies and outcome. Blepharospasm- Initial therapy and Reauthorization: Submission of chart notes documenting diagnosis, prior therapy and failure with onabotulinumtoxinA (Botox) and outcome.			6 months	
XOLAIR	OMALIZUMAB	All FDA-approved indications not otherwise excluded from Part D.		Allergic Asthma: 1. Diagnosis of moderate-severe persistent allergic asthma 2.Positive skin test with greater than or equal to 1 perennial aeroallergen 3. IgE level greater than or equal to 30 IU/ml and less than or equal to 700 IU/ml.			12 Months	
XYREM	SODIUM OXYBATE	All FDA-approved indications not otherwise excluded from Part D.		Narcolepsy: 1.Diagnosis of narcolepsy with excessive daytime sleepiness AND Trial and failure of a CNS stimulant such as methylphenidate or dextroamphetamine OR 2. Diagnosis of narcolepsy with cataplexy			12 Months	
ZELBORAF	VEMURAFENIB	All FDA-approved indications not otherwise excluded from Part D.		Melanoma: 1) Diagnosis of unresectable or metastatic melanoma. 2) BRAF V60E mutation confirmed using a FDA-approved test		Oncologist has recommend Zelboraf	12 Months	
ZOLINZA	VORINOSTAT	All FDA-approved indications not otherwise excluded from Part D.		Cutaneous T-cell Lymphoma (CTCL): Diagnosis of progressive, persistent or recurrent cutaneous T-cell lymphoma(CTCL) and has tried and failed two other systemic therapies for CTCL.		Oncologist has recommended Vorinostat (Zolinza).	12 Months	

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ZORBTIVE	SOMATROPIN (ZORBTIVE)	All FDA-approved indications not otherwise excluded from Part D.					12 Months	Meets the following criteria: Diagnosis of short bowel syndrome and Patient receiving specialized nutritional support.
ZYTIGA	ABIRATERONE	All FDA-approved indications not otherwise excluded from Part D.		Prostate Cancer: Diagnosis of metastatic castration-resistant prostate cancer in patients who received prior chemotherapy containing docetaxel.		Oncologist has recommended Zytiga.	12 Months	

**THE FOLLOWING DRUGS MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES.  
 INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.**

<p>ARANESP          AREDIA          ATGAM          AZASAN          AZATHIOPRINE SODIUM INJ          BONIVA          CALCIJEX          CALCITONIN-SALMON          CALCITRIOL          CARIMUNE NF          CARNITOR          CELLCEPT          CUBICIN          CYCLOSPORIN          CYCLOSPORIN MODIFIED          EMLA          EPOGEN</p>	<p>FLEBOGAMMA          FORTICAL          GAMASTAN S-D          GAMMAGARD LIQUID          GAMUNEX          GENGRAF          HECTORAL          HEPARIN SODIUM VIAL          IMURAN          LEVOCARNITINE          LIDOCAINE HCL TOPICAL          LIDOCAINE-PILOCARPINE TOPICAL          MIACALCIN          MYCOPHENOLATE MOFETIL          MYFORTIC          NEORAL          OCTAGAM</p>	<p>ORTHOCLONE OK T3          PAMIDRONATE DISODIUM          PRIVIGEN          PROCRT          PROGRAF          RAPAMUNE          ROCALTROL          SANDIMMUNE          SYNERA          TACROLIMUS          VANCOMYCIN HCL INJ          VIBATIV          VIVAGLOBIN          ZEMPLAR          ZENAPAX          ZORTRESS</p>
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