

**Drugs That Require Prior Authorization (PA)
Before Being Approved for Coverage**

You will need authorization by SecureCareHMO / Secure ChoicePPO before filling prescriptions for the drugs shown in the chart below. SecureCareHMO / Secure ChoicePPO will only provide coverage after it determines that the drug is being prescribed according to the criteria specified in the chart. You, your appointed representative, or your prescriber can request prior authorization by calling The Health Plan / THP Insurance Company at 1-800-624-6961, Ext. 7914, Monday through Friday 8:00 a.m.- 5:00 p.m. Customer Service is available in English and other languages. TTY/TDD users should call 1-800-622-3925.

<u>PRIOR AUTHORIZATION MEDICATIONS</u>	
<u>ACTIMMUNE</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>AFINITOR</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Combination use with sorafenib or sunitinib.
Required Medical Info	Coverage is provided after failure of treatment with sunitinib or sorafenib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>ALFA INTERFERONS</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Additional off-label uses covered are Essential thrombocythemia, Philadelphia chromosome (Ph) positive chronic phase myelogenous leukemia (CML) in a patient who is minimally pretreated (e.g., within 1 year of diagnosis), and Renal cell carcinoma.
Exclusion Criteria	For chronic hepatitis: contraindications such as decompensated liver disease or when used in combination with another interferon product

Required Medical Info	For Hepatitis C: positive hepatitis C viral load. For Kaposi sarcoma: T cell count is less than 400/mm ³ or in the presence of an opportunistic infection.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For treatment of condylomata acuminata: at least ONE conventional therapy such as, (but not limited to) topical imiquimod (Aldara), podofilox (Condylox) or liquid nitrogen cryotherapy, has failed to treat the patient.
Excluded Drug Criteria	
<u>ALFA INTERFERONS PEGYLATED</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	For chronic hepatitis C: contraindications such as decompensated liver disease or is using in combination with another Interferon product
Required Medical Info	Coverage for chronic hepatitis C is provided in the presence of a positive viral load
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>ANDROGENS</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Coverage for the prescribed testosterone product is provided for females for the palliative treatment of breast cancer. Coverage for androgens (testosterone drug) is provided for males for delayed puberty or the treatment of hypogonadism in situations where the patient has a baseline (pre-treatment) serum testosterone level of less than or equal to 300 ng/dL (less than 10.4 nmol/L).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	All indications 5 years, except delayed puberty: 6 months
Other Criteria	
Excluded Drug Criteria	
<u>APOKYN</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	

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Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>BUTORPHANOL NASAL SPRAY</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for the treatment of migraine headache pain.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months for migraine pain / 3 month for acute pain
Other Criteria	Coverage for acute pain is provided in situations where the use of oral opioid therapy is not warranted or therapy with a rapid-acting agent is desirable. Coverage for migraine headache pain is provided in situations where the use serotonin agonists or ergotamine derivatives are not warranted as determined by the prescriber.
Excluded Drug Criteria	
<u>CHANTIX</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for Chantix (varenicline) use in combination with bupropion or other nicotine replacement products.
Required Medical Info	The patient must be enrolled in a behavioral support/ modification program (e.g., community program, manufacturer sponsored program, counseling by the physician, internet, or telephone quitline).
Age Restrictions	The patient must be 18 years of age or older
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Excluded Drug Criteria	
<u>CNS STIMULANTS - DEXMETHYLPHENIDATE</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for long term (greater than 2 months) combination therapy with Strattera for ADD/ADHD. Coverage is not provided in situations in which the patient has any of the following contraindications to its use: uncontrolled cardiovascular disease (for example, uncontrolled hypertension or the presence of arrhythmias or structural cardiac abnormalities), hyperthyroidism, narrow-angle glaucoma, agitated states including psychosis and/or schizophrenia, history of drug abuse or the use of a MAO inhibitor concurrently or within the previous 14 days.

Required Medical Info	Coverage for ADD/ADHD is provided in situations in which the diagnosis of ADD/ADHD has been confirmed using established criteria such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) or other criteria deemed appropriate by the prescriber.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>CNS STIMULANTS - DEXTROAMPHETAMINE AND SALT COMBO</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for depression.
Exclusion Criteria	Coverage is not provided for long term (greater than 2 months) combination therapy with Strattera for ADD/ADHD. Coverage is not provided in situations in which the patient has any of the following contraindications to its use: uncontrolled cardiovascular disease (for example, uncontrolled hypertension or the presence of arrhythmias or structural cardiac abnormalities), hyperthyroidism, narrow-angle glaucoma, agitated states including psychosis and/or schizophrenia, history of drug abuse or the use of a MAO inhibitor concurrently or within the previous 14 days.
Required Medical Info	Coverage for ADD/ADHD is provided in situations in which the diagnosis of ADD/ADHD has been confirmed using established criteria such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) or other criteria deemed appropriate by the prescriber. Coverage for narcolepsy is provided in situations in which there are no conditions contributing to or worsening symptoms of narcolepsy (e.g., nocturnal myoclonus, sedating drugs or drugs interfering with sleep, substance abuse, or chronic voluntary or involuntary sleep deprivation) or in situations in which the underlying conditions have been have been addressed or treated.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>CNS STIMULANTS - METHAMPHETAMINE</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for long term (greater than 2 months) combination therapy with Strattera for ADD/ADHD. Coverage is not provided in situations in which the patient has any of the following contraindications to its use: uncontrolled cardiovascular disease (for example, uncontrolled hypertension or the presence of arrhythmias or structural cardiac abnormalities), hyperthyroidism, narrow-angle glaucoma, agitated states including psychosis and/or schizophrenia, history of drug abuse or the use of a MAO inhibitor concurrently or within the previous 14 days.

Required Medical Info	Coverage for ADD/ADHD is provided in situations in which the diagnosis of ADD/ADHD has been confirmed using established criteria such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) or other criteria deemed appropriate by the prescriber.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>CNS STIMULANTS - METHYLPHENIDATE</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for depression, narcolepsy, and idiopathic hypersomnolence.
Exclusion Criteria	Coverage is not provided for long term (greater than 2 months) combination therapy with Strattera for ADD/ADHD. Coverage is not provided in situations in which the patient has any of the following contraindications to its use: uncontrolled cardiovascular disease (for example, uncontrolled hypertension or the presence of arrhythmias or structural cardiac abnormalities), hyperthyroidism, narrow-angle glaucoma, agitated states including psychosis and/or schizophrenia, history of drug abuse or the use of a MAO inhibitor concurrently or within the previous 14 days.
Required Medical Info	Coverage for ADD/ADHD is provided in situations in which the diagnosis of ADD/ADHD has been confirmed using established criteria such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) or other criteria deemed appropriate by the prescriber. Coverage for narcolepsy is provided in situations in which there are no conditions contributing to or worsening symptoms of narcolepsy (e.g., nocturnal myoclonus, sedating drugs or drugs interfering with sleep, substance abuse, or chronic voluntary or involuntary sleep deprivation) or in situations in which the underlying conditions have been have been addressed or treated. Coverage for idiopathic hypersomnolence is provided in situations in which the diagnosis of idiopathic hypersomnolence has been confirmed by sleep studies (polysomnography) in order to rule out disorders such as narcolepsy, obstructive sleep apnea or posttraumatic hypersomnia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>COLONY STIMULATING FACTORS</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for neutropenia due to other drugs, AIDS/HIV, and myelodysplasia.
Exclusion Criteria	Combination therapy with Neulasta, Neupogen or Leukine.

Required Medical Info	Patient has experienced neutropenia from previous chemotherapy OR for patient is considered to be at high risk for the development of neutropenia. Absolute Neutrophil Count (ANC). That is, coverage is provided for: AIDS/HIV when ANC is less than or equal to 500/mm ³ , Myelodysplasia when ANC is less than or equal to 1000/mm ³ , Severe chronic neutropenia (i.e., Neutropenic disorder, cyclic neutropenia) when ANC is less than or equal to 1500/mm ³ , bone marrow transplant when ANC is less than or equal to 1000/mm ³ , Current or post peripheral blood progenitor cell (PBPC) mobilization/transplantation (i.e., harvesting of peripheral blood stem cells) when ANC is less than or equal to 1500/mm ³
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>COLONY STIMULATING FACTORS PEGYLATED</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Combination therapy with Neulasta, Neupogen or Leukine. Patients who weigh less than or equal to 45kg, prescriber indicates that the patient is able to receive daily injections of either Neupogen (Filgrastim) or Leukine (Sargramostim).
Required Medical Info	Patient has experienced neutropenia from previous chemotherapy OR for patient is considered to be at high risk for the development of neutropenia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>CRINONE</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Additional coverage for off-label use is provided to support established pregnancy
Exclusion Criteria	Coverage is not provided for infertility
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	9 months for support of established pregnancy, 12 months for secondary amenorrhea
Other Criteria	
Excluded Drug Criteria	
<u>DARBEPOETIN ALFA</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	

Required Medical Info	Treatment of anemia secondary to chronic renal failure or chronic renal insufficiency is covered when Hg is less than or equal to 11 g/dL OR patient is symptomatic or has required transfusion and for cancer-chemotherapy when patient is currently receiving myelosuppressive chemotherapy OR it has been 6 weeks or less following the completion of the final dose of myelosuppressive chemotherapy AND Hg is less than or equal to 10 g/dL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	2 months for anemia due to cancer-chemotherapy, 12 months for CRF or CRI
Other Criteria	
Excluded Drug Criteria	
<u>ENBREL</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Coverage is not provided for use of Enbrel in combination with other biologics e.g., Humira, Kineret or Remicade.
Required Medical Info	Coverage is provided in situations where the patient has been evaluated and screened for the presence of latent TB infection, where warranted, prior to initiating treatment with Enbrel.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For the treatment of moderate to severe rheumatoid arthritis or psoriatic arthritis: coverage is provided when Enbrel is used in combination with methotrexate or when the patient has had an inadequate response to treatment with methotrexate unless the patient is unable to receive methotrexate. Enbrel is covered for the treatment of ankylosing spondylitis in situations where the patient has experienced inadequate symptom relief from treatment with at least two NSAIDs or COX2 inhibitors unless the patient is unable to receive NSAIDs or COX2 inhibitors.
Excluded Drug Criteria	
<u>EPOETIN ALFA</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for anemia secondary to HIV infection or HIV drug therapy, myelodysplasia, and chronic hepatitis C treatment from ribavirin and interferon therapy.
Exclusion Criteria	

Required Medical Info	The treatment of anemia secondary to chronic renal failure or chronic renal insufficiency is covered when Hg is less than or equal to 11 g/dL OR patient is symptomatic or has required transfusion and for cancer-chemotherapy when patient is currently receiving myelosuppressive chemotherapy OR it has been 6 weeks or less following the completion of the final dose of myelosuppressive chemotherapy AND Hg is less than or equal to 10 g/dL. Erythropoietin is covered for Reducing the need for allogeneic blood transfusions in surgery patients when therapy is for elective non-vascular or non-cardiac surgery AND patient refuses or cannot undergo autologous donation prior to surgery AND Hg is less than or equal to 13 g/dL, for the treatment of anemia secondary to: HIV infection or HIV drug therapy when Hg is less than or equal to 11 g/dL OR patient is symptomatic or has required transfusion AND erythropoietin level is less than or equal to 500 units/L, and Myelodysplasia and Chronic Hepatitis C treatment from ribavirin and interferon therapy when Hg is less than or equal to 11 g/dL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month- allogeneic blood transfusions, 2 months- anemia due to chemotherapy, 12 months- others
Other Criteria	
Excluded Drug Criteria	
<u>FENTANYL TRANSMUCOSAL</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Coverage is not provided for patients who are not already receiving and who not are tolerant to opioid therapy
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>GROWTH HORMONES</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for adult growth hormone deficiency, growth failure in children small for gestational age or with intrauterine growth retardation, idiopathic short stature, GH deficiency associated with Turner Syndrome, growth failure secondary to chronic renal failure/insufficiency in children who have not received a renal transplant, short stature associated with Noonan Syndrome, short bowel syndrome, and for the treatment of Prader-Willi Syndrome.
Exclusion Criteria	Coverage is not provided for constitutional delayed growth

Required Medical Info	For pediatric growth hormone deficiency: patient's height must be below the third percentile for their age and gender related height, growth velocity subnormal greater than or equal 2 standard deviations from the age related mean, delayed skeletal maturation greater than or equal 2 standard deviations below the age/gender related mean, epiphyses confirmed as open in patients greater than or equal 10 years of age, growth hormone deficiency confirmed by any 2 provocative tests OR by insulin growth factor-1 (IGF-1) a.k.a. somatomedin C, or IGF binding protein-3 (IGFBP-3) levels, a growth response of greater than or equal 4.5 cm/yr (pre-pubertal growth phase) or greater than or equal 2.5 cm/yr (post-pubertal) must occur for continuation of coverage. For idiopathic short stature: height must be less than or equal - 2.25 standard deviations from the mean and epiphyses must be confirmed as open in patients greater than or equal 10 years of age. Coverage is provided for pediatric growth failure due to chronic renal failure (in situations where the patient has not undergone a renal transplant) (provocative tests not required), growth failure in children born small for gestational age (SGA) who fail to manifest catch up
Age Restrictions	7 years of age or older for Idiopathic short stature
Prescriber Restrictions	Pediatric endocrinologist for ISS
Coverage Duration	1 month for short bowel syndrome, 12 months for other indications
Other Criteria	
Excluded Drug Criteria	
<u>HUMIRA</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for use of Humira in combination with other biologics e.g., Enbrel, Kineret or Remicade.
Required Medical Info	Coverage is provided in situations where the patient has been evaluated and screened for the presence of latent TB infection, where warranted, prior to initiating treatment with Humira.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For the treatment of moderate to severe rheumatoid arthritis or psoriatic arthritis: coverage is provided when Humira is used in combination with methotrexate or when the patient has had an inadequate response to treatment with methotrexate unless the patient is unable to receive methotrexate. Humira is covered for the treatment of ankylosing spondylitis in situations where the patient has experienced inadequate symptom relief from treatment with at least two NSAIDs or COX2 inhibitors unless the patient is unable to receive NSAIDs or COX2 inhibitors.
Excluded Drug Criteria	
<u>IMMUNE GLOBULINS</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for post bone marrow transplantation, post transfusion purpura, autoimmune hemolytic anemia, Guillain-Barre syndrome, chronic inflammatory demyelinating polyneuropathy, pediatric HIV infection, and myasthenia gravis.

Exclusion Criteria	For BMT, benefit not covered in patients concurrently receiving CMV immune globulin.
Required Medical Info	Coverage is provided for primary humoral immunodeficiency OR B-cell chronic lymphocytic leukemia (CLL) when patient has serum IgG concentration less than 600 mg/dL AND patient must have history of a recurrent bacterial infection or a single life-threatening bacterial infection. Coverage is provided for idiopathic thrombocytopenic purpura (ITP) when platelet count is less than 30,000/mm ³ . Coverage is provided for bone marrow transplantation when bone marrow transplant performed within the previous 100 days.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>INCRELEX</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided in the presence of: Concurrent treatment with growth hormone or Pharmacologic doses of corticosteroids
Required Medical Info	Patient's height standard deviation score must be less than or equal -3.0 AND the basal IGF-1 score must be below the lower limits of normal for the reporting lab AND the patient must have normal or elevated growth hormone (except for patients with growth hormone gene deletion) AND epiphyses must be confirmed as open in patients greater than or equal 10 years of age.
Age Restrictions	
Prescriber Restrictions	Coverage is provided in situations where the diagnosis of IGF-1 deficiency has been made by an endocrinologist.
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>LIDODERM</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for neuropathic pain (from etiologies other than a herpes zoster outbreak).
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months

Other Criteria	For the FDA-labeled indication of post-herpetic neuralgia, no additional criteria are required to be met. For OTHER types of off-labeled neuropathic pain: the patient must have previous use and inadequate response or intolerance to any ONE neuropathic pain medication, including (but not limited to) Cymbalta and Lyrica that are labeled for neuropathic pain.
Excluded Drug Criteria	
<u>MULTIPLE SCLEROSIS THERAPY</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for treatment at the time of a first demyelinating event.
Exclusion Criteria	Treatment of primary progressive MS is not covered. Combination therapy with a beta interferon product and Copaxone is not covered.
Required Medical Info	For relapsing forms of multiple sclerosis: Patient must still either be able to walk at least a few steps or alternatively must have some functional arm/ hand use consistent with performing activities of daily living.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>NEUMEGA</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has experienced severe thrombocytopenia (e.g., platelet count less than equal to 20,000/mcL) from previous chemotherapy OR for patient is considered to be at high risk for the development of severe thrombocytopenia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>NEXAVAR</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	

OXANDROLONE

Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	
Excluded Drug Criteria	

OXYMETHOLONE

Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Coverage is provided for anemia due to conditions such as acquired aplastic anemia, anemia of chronic renal failure, pure red cell aplasia, Fanconi's anemia or myelosuppression due to chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months for anemia or 5 years for cachexia/AIDS wasting
Other Criteria	
Excluded Drug Criteria	

PAGET'S DISEASE AGENTS

Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	

PROMACTA

Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided when used in combination with Nplate.
Required Medical Info	Renewal is provided for patients who continue to have a response to therapy (for example, platelet count has increased).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months

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Other Criteria	Patients have had an inadequate response or have been intolerant to treatment with corticosteroids, immunoglobulins, or splenectomy.
Excluded Drug Criteria	
<u>PROVIGIL</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Coverage is provided for the off-label use of idiopathic hypersomnolence and depression associated with fatigue and/or sleepiness.
Exclusion Criteria	
Required Medical Info	For narcolepsy, the prescriber must confirm that the patient does not have underlying conditions that may contribute to excessive sleepiness (e.g., nocturnal myoclonus, current drug therapy which affects sleep or contributes to daytime sedation, or chronic voluntary or involuntary sleep deprivation through shift-work). Coverage is provided for SWSD when: (1) Prescriber must confirm that the patient is a night worker and (2) has complaints of persistent and frequent excessive sleepiness and/or falling asleep while at work and (3) any medical conditions known to cause or contribute to sleepiness have been considered and treated. Coverage is provided for idiopathic hypersomnolence that is confirmed by polysomnography where excessive sleepiness is not due to other sleep disorders such as narcolepsy, obstructive sleep apnea or posttraumatic hypersomnia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For OSAHS, coverage is provided for patients who are receiving nasal continuous positive airway pressure therapy (CPAP) or who are not candidates for CPAP. Coverage is provided for depression associated with fatigue and/or sleepiness when the patient is receiving antidepressant therapy
Excluded Drug Criteria	
<u>REGRANEX</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Coverage is provided for the following off-label use: treatment of severe pressure ulcers that are unresponsive to other measures.
Exclusion Criteria	
Required Medical Info	Regranex must be used as an adjunct to good ulcer wound care (e.g., debridement, infection control and/or pressure relief).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 months
Other Criteria	For the off-label use- treatment of severe pressure ulcers ONLY: prescriber must indicate that wound has been unresponsive to at least ONE other measure (may include but is not limited to the following: nutritional supplementation, pressure relief, debridement, proteolytic enzymes, epidermal growth factor).
Excluded Drug Criteria	

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REMICADE

Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for use of Remicade in combination with other biologics e.g., Enbrel, Kineret or Humira
Required Medical Info	Coverage is provided in situations where the patient has been evaluated and screened for the presence of latent TB infection prior to initiating treatment with Remicade.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Coverage is provided for mild ulcerative colitis when the patient has had an inadequate response to at least one conventional treatment (for example: sulfasalazine, olsalazine, mesalamine, etc.), and for ankylosing spondylitis when the patient has experienced inadequate symptom relief from at least one other treatment such as NSAIDs, COX2 inhibitors, or methotrexate, unless the patient is unable to receive treatment with these drugs.
Excluded Drug Criteria	

RIBAVIRIN

Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	

RITUXAN

Covered Uses	All FDA approved indications not otherwise excluded from Part D. Additional coverage for off-label use is provided for relapsed or refractory chronic lymphoid lymphoma and relapsed or refractory Waldenstrom's macroglobulinemia.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	For rheumatoid arthritis: 18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 month for rheumatoid arthritis, 12 months for other indications
Other Criteria	For rheumatoid arthritis: inadequate response to at least one TNF inhibitor or been intolerant to treatment with at least two TNF inhibiting drugs.
Excluded Drug Criteria	

SMOKING DETERRENTS

Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for Chantix (varenicline) use in combination with bupropion or other nicotine replacement products. Coverage is provided for one nicotine replacement product with or without concurrent use of bupropion SR (Zyban). Bupropion sustained-release tablet (Zyban) coverage is not provided in the presence of any of the following: Concurrent use with any other form of bupropion, Seizure disorder (epilepsy), Eating disorder (bulimia or anorexia nervosa), Concurrent or recent MAO inhibitor use (within the previous 14 days)
Required Medical Info	The patient must be enrolled in a behavioral support/ modification program (e.g., community program, manufacturer sponsored program, counseling by the physician, internet, or telephone quitline).
Age Restrictions	The patient must be 18 years of age or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>SOMAVERT</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Coverage is provided when patients have had an inadequate response to surgery, radiation, or other medical therapies or in situations where the patient is not a candidate for other therapies.
Excluded Drug Criteria	
<u>SUTENT</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Additional coverage for off-label use is provided for neuroendocrine tumors.
Exclusion Criteria	Combination use with sorafenib (Nexavar).
Required Medical Info	For neuroendocrine tumors -patient must have inadequate response to octreotide and systemic chemotherapy, if indicated
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>TARCEVA</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.

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Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	

THALIDOMIDE

Covered Uses	All FDA approved indications not otherwise excluded from Part D. Additional coverage for off-label uses include Crohn's disease, aphthous ulcers in the presence of HIV or AIDS, prostate cancer, malignant melanoma, myelofibrosis, and myelodysplastic syndromes.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For ENL with moderate to severe neuritis: is provided in situations in which corticosteroids are used concurrently with thalidomide.
Excluded Drug Criteria	

TORISEL

Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided when used in combination with Sutent or Nexavar.
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	

VACCINES

Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Coverage is provided through Part D when the vaccine is NOT being administered to treat an injury or as a result of the patient's direct exposure to a disease or condition. Coverage for Hepatitis B vaccine is provided for low risk patients through Part D.
Age Restrictions	

Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>VACCINES HPV</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Coverage for Gardasil provided for patients 9 through 26 years of age. Coverage for Cervavix is provided for females between 10 and 25 years of age.
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>VACCINES SHINGLES</u>	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Coverage is provided for patients 60 years of age and older.
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	
<u>XYREM</u>	
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Excluded Drug Criteria	

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.

CMS Material ID: H3672_H5151_H8604_10_063

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Drug Name	Route of Administration / Dosage Form
A-METHAPRED	INJECTION SOLUTION RECONSTITUTED
ACETYLCYSTEINE	INHALATION SOLUTION
ALBUTEROL SULFATE	INHALATION NEBULIZATION SOLUTION
ALDURAZYME	INJECTION SOLUTION
AMPHOTERICIN B	INJECTION SOLUTION RECONSTITUTED
AZATHIOPRINE	ORAL TABLET
AZATHIOPRINE SODIUM	INJECTION SOLUTION RECONSTITUTED
BUDESONIDE	INHALATION SUSPENSION
CELLCEPT	ORAL CAPSULE
CELLCEPT	ORAL SUSPENSION RECONSTITUTED
CELLCEPT	ORAL TABLET
CEREZYME	INJECTION SOLUTION RECONSTITUTED
CHLORPROMAZINE HCL	ORAL TABLET
CROMOLYN SODIUM	INHALATION NEBULIZATION SOLUTION
CYCLOPHOSPHAMIDE	ORAL TABLET
CYCLOSPORINE	ORAL CAPSULE
CYCLOSPORINE	INJECTION SOLUTION
CYCLOSPORINE MODIFIED	ORAL CAPSULE
CYCLOSPORINE MODIFIED	ORAL SOLUTION
CYTOVENE	INJECTION SOLUTION RECONSTITUTED
DEPO-MEDROL	INJECTION SUSPENSION
DRONABINOL	ORAL CAPSULE
EMEND	ORAL CAPSULE
FABRAZYME	INJECTION SOLUTION RECONSTITUTED
FOSCARNET SODIUM	INJECTION SOLUTION
GENGRAF	ORAL CAPSULE
GENGRAF	ORAL SOLUTION
GRANISETRON HCL	ORAL TABLET
HYDROXYZINE HCL	ORAL SYRUP
HYDROXYZINE HCL	ORAL TABLET
IPRATROPIUM BROMIDE	INHALATION SOLUTION
IPRATROPIUM BROMIDE/ALBUTEROL SULFATE	INHALATION SOLUTION

Drug Name	Route of Administration / Dosage Form
METHOTREXATE	ORAL TABLET
METHYLPREDNISOLONE	ORAL TABLET
METHYLPREDNISOLONE ACETATE	INJECTION SUSPENSION
METHYLPREDNISOLONE SODIUMSUCCINATE	INJECTION SOLUTION RECONSTITUTED
MYCOPHENOLATE MOFETIL	ORAL CAPSULE
MYCOPHENOLATE MOFETIL	ORAL TABLET
MYFORTIC	ORAL TABLET DELAYED RELEASE
NEBUPENT	INHALATION SOLUTION RECONSTITUTED
NEORAL	ORAL CAPSULE
NEORAL	ORAL SOLUTION
NITROGLYCERIN	INJECTION SOLUTION
ONDANSETRON HCL	ORAL SOLUTION
ONDANSETRON HCL	ORAL TABLET
ONDANSETRON ODT	ORAL TABLET DISPERSIBLE
PERFORMIST	INHALATION NEBULIZATION SOLUTION
PERPHENAZINE	ORAL TABLET
PREDNISOLONE	ORAL SYRUP
PREDNISOLONE SODIUM PHOSPHATE	ORAL SOLUTION
PREDNISON	ORAL SOLUTION
PREDNISON	ORAL TABLET
PREDNISON INTENSOL	ORAL CONCENTRATE
PROCHLORPERAZINE MALEATE	ORAL TABLET
PROGRAF	ORAL CAPSULE
PROGRAF	INJECTION SOLUTION
PROMETHAZINE HCL	ORAL SYRUP
PROMETHAZINE HCL	ORAL TABLET
PULMICORT	INHALATION SUSPENSION
PULMOZYME	INHALATION SOLUTION
RAPAMUNE	ORAL SOLUTION
RAPAMUNE	ORAL TABLET

Drug Name	Route of Administration / Dosage Form
RHEUMATREX	ORAL TABLET
SANDIMMUNE	ORAL CAPSULE
SANDIMMUNE	INJECTION SOLUTION
SANDIMMUNE	ORAL SOLUTION
SOLU-MEDROL	INJECTION SOLUTION RECONSTITUTED
TACROLIMUS	ORAL CAPSULE
TOBI	INHALATION NEBULIZATION SOLUTION
ZORTRESS	ORAL TABLET