

PART D 2009 PRIOR AUTHORIZATION DESCRIPTIONS
 (For use with Part D Open & Closed 2009 Part D Formularies)



PA Group Description	Drug Name(s)	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restrictions	Coverage Duration	Other Criteria
5HT3 ANTI-NAUSEA AGENT BVD DETERMINATION	ANZEMET GRANISETRON HCL GRANISOL KYTRIL ONDANSETRON HCL ONDANSETRON ODT ZOFRAN ZOFRAN ODT	THIS DRUG 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.						
ALDARA	ALDARA	EXTERNAL GENITAL AND PERIANAL WARTS/CONDYLOMA ACUMINATA, NONHYPERKERATOTIC, NONHYPER TROPHIC ACTINIC KERATOSES ON THE FACE OR SCALP, PRIMARY SUPERFICIAL BASAL CELL CARCINOMA.	ACTINIC KERATOSIS: NOT PRESCRIBED OR SUPERVISED BY DERMATOLOGIST. SUPERFICIAL BASAL CELL CARCINOMA: NOT PRESCRIBED OR SUPERVISED BY DERMATOLOGIST OR ONCOLOGIST.	PERINEAL GENITAL WARTS: FAILED/CONTRAINDICATION TO CONDYLOX. ACTINIC KERATOSIS: NON-HYPERKERATOTIC, NON-HYPERTROPHIC ACTINIC KERATOSES ON THE FACE OR SCALP, AND PATIENT IS GREATER THAN OR EQUAL TO 18 YEARS OF AGE, IMMUNOCOMPETENT, SUPERVISED BY DERMATOLOGIST, AND HAS FAILED OR HAS CONTRAINDICATION TO TOPICAL 5-FLUOROURACIL. SUPERFICIAL BASAL CELL CARCINOMA: NO GREATER THAN 2CM IN SIZE, NOT ON THE FACE, AND THE MEDICATION HAS BEEN PRESCRIBED OR IS CURRENTLY BEING	ACTINIC KERATOSIS: GREATER THAN OR EQUAL TO 18 YEARS OF AGE	ACTINIC KERATOSIS : DERMATOLOGIST ONLY. SUPERFICIAL BASAL CELL CARCINOMA: DERMATOLOGIST OR ONCOLOGIST ONLY.	4 MONTHS	CRITERIA APPLIES TO NEW STARTS ONLY

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				SUPERVISED BY A DERMATOLOGIST OR ONCOLOGIST				
ANTIEMETICS	SANCUSO	CHEMOTHERAPY-INDUCED NAUSEA AND VOMITING	NOT TRIED AND FAILED ANOTHER FORMULARY ANTIEMETIC DRUG, NOT ON MODERATE TO HIGHLY EMETOGENIC CHEMOTHERAPY FOR 2 DAYS, OR ABLE TO TOLERATE ORAL THERAPY	CHEMOTHERAPY EMETOGENICITY AND THE DURATION OF CHEMOTHERAPY TREATMENT			UP TO 12 MONTHS	
ARANESP	ARANESP ALBUMIN FREE ARANESP ALBUMIN FREE SURE	ANEMIA ASSOCIATED WITH CHRONIC RENAL FAILURE OR ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CHEMOTHERAPY.	HEMOGLOBIN GREATER THAN OR EQUAL TO 12GM/DL	ANEMIA ASSOCIATED WITH CHRONIC RENAL FAILURE OR ANEMIA DUE TO THE EFFECT OF CONCOMITANTLY ADMINISTERED CHEMOTHERAPY: HEMOGLOBIN LESS THAN 12GM/DL			RENAL FAILURE: 1 YEAR. CANCER CHEMOTHERAPY: COURSE OF TREATMENT BASED ON CHEMOTHERAPY CYCLE.	
ARIXTRA	ARIXTRA	PREVENTION (PROPHYLAXIS) OF DEEP VEIN THROMBOSIS (DVT) AFTER HIP FRACTURE SURGERY, HIP REPLACEMENT SURGERY, KNEE REPLACEMENT SURGERY, OR PREVENTION OF VENOUS THROMBOEMBOLISM (VTE) IN		FOR TREATMENT OF DVT/PE INDICATION ONLY: NOT CURRENTLY STABILIZED ON WARFARIN OR HAS NOT ESTABLISHED AN ORAL ANTICOAGULANT EFFECT			HIP REPLACEMENT/FRACTURE SURGERY UP TO 30 DAYS	

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		PATIENTS UNDERGOING ABDOMINAL SURGERY. OUTPATIENT TREATMENT OF ACUTE DVT OR ACUTE PULMONARY EMBOLISM (PE) ADMINISTERED IN CONJUNCTION WITH WARFARIN		WITH A THERAPEUTIC INR BETWEEN 2 TO 3.			KNEE/ABDOMINAL SURGERY/ DVT/PE TREATMENT UP TO 14 DAYS	
ELTROMBOPAG	PROMACTA	CHRONIC IMMUNE THROMBOCYTOPENIC PURPURA WHO HAVE HAD AN INSUFFICIENT RESPONSE TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR SPLENECTOMY	INITIAL: ADEQUATE RESPONSE TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR SPLENECTOMY, RENEWAL: NO CLINICAL RESPONSE DEFINED BY GREATER THAN OR EQUAL TO 50 X10 ⁹ /L AT THE MAX DOSE OF 10 MCG/KG FOR 4 WEEKS			PRESCRIBE R ENROLLED IN PROMACTA CARES PROGRAM	INITIAL: ONE MONTH, RENEWAL: 12 MONTHS	
EMEND BVD DETERMINATION	EMEND	THIS DRUG 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.						
ERYTHROPOIETIN AGENTS	EPOGEN PROCRIT	ANEMIA OF CHRONIC RENAL FAILURE, ANEMIA RELATED TO AZT THERAPY, ANEMIA IN CANCER PATIENT RECEIVING CHEMOTHERAPY, REDUCTION OF ALLOGENIC BLOOD TRANSFUSION IN PATIENT	CHRONIC RENAL FAILURE: HEMOGLOBIN EQUAL TO OR GREATER THAN 10 GM/DL IF NOT UNDERGOING DIALYSIS OR GREATER THAN OR EQUAL TO 12 IF ON	CHRONIC RENAL FAILURE: HEMOGLOBIN LESS THAN 10GM/DL IF NOT UNDERGOING DIALYSIS OR LESS THAN OR EQUAL TO 12 IF ON DIALYSIS. ANEMIA RELATED TO AZT			ANEMIA FROM CHRONIC RENAL FAILURE/AZT /CHEMOTH	

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		UNDERGOING ELECTIVE SURGERY	DIALYSIS. PATIENTS WITH ANEMIA RELATED TO AZT THERAPY/ANEMIA DUE TO CONCOMITANTLY ADMINISTERED CHEMOTHERAPY: HEMOGLOBIN EQUAL TO OR GREATER THAN 12 GM/DL. PATIENTS SCHEDULED FOR ELECTIVE, NONCARDIAC SURGERY, NONVASCULAR SURGERY: HEMOGLOBULIN GREATER THAN 13 GM/DL.	THERAPY/ANEMIA DUE TO CONCOMITANTLY ADMINISTERED CHEMOTHERAPY: HEMOGLOBIN LESS THAN 12 GM/DL PATIENT SCHEDULED FOR ELECTIVE, NONCARDIAC, NONVASCULAR SURGERY: HEMOGLOBIN LEVEL GREATER THAN 10MG/DL AND LESS THAN OR EQUAL TO 13 GM/DL			ERAPY: 1 YEAR ANEMIA FROM ELECTIVE SURGERY: 14 DAYS	
FENTANYL TRANSDERMAL PATCH	FENTANYL	CHRONIC PAIN		CHRONIC PAIN (E.G. SUCH AS THAT ASSOCIATED WITH CANCER): PATIENT RECEIVING DAILY, AROUND-THE-CLOCK PAIN MEDICATION FOR AT LEAST ONE WEEK OR A PATIENT UNABLE TO TAKE OR INTOLERANT TO ORAL LONG-ACTING OPIOID NARCOTIC ANALGESICS.			12 MONTHS	
FENTANYL TRANSMUCOSAL AGENTS	FENTANYL CITRATE ORAL TRANSMUCOSAL FENTORA	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D FOR PATIENTS WITH A DIAGNOSIS OF		CANCER: ON A MAINTENANCE DOSE OF CONTROLLED- RELEASE PAIN MEDICATION, OR			6 MONTHS	

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		CANCER		EITHER A TRIAL AND FAILURE 1 IMMEDIATE-RELEASE ORAL PAIN AGENT OR DIFFICULTY SWALLOWING TABLETS/CAPSULES				
GROWTH HORMONE AGENTS	GENOTROPIN GENOTROPIN MINIQUICK HUMATROPE HUMATROPE COMBO PACK NORDITROPIN CARTRIDGE NORDITROPIN NORDIFLEX PEN NUTROPIN NUTROPIN AQ NUTROPIN AQ PEN OMNITROPE SAIZEN SAIZEN CLICK.EASY SEROSTIM TEV-TROPIN ZORBTIVE	PEDIATRIC GROWTH HORMONE DEFICIENCY, GROWTH FAILURE DUE TO CHRONIC RENAL INSUFFICIENCY, GROWTH FAILURE DUE TO SMALL FOR GESTATIONAL AGE OR INTRAUTERINE GROWTH RETARDATION, SHORT STATURE ASSOCIATED WITH TURNER SYNDROME, PRADER-WILLI SYNDROME, ADULT GROWTH HORMONE DEFICIENCY, HIV/AIDS-WASTING SYNDROME, SHORT-BOWEL SYNDROME AND NOONAN SYNDROME	IDIOPATHIC SHORT STATURE, NOT PRESCRIBED BY SPECIALIST, CLOSED EPIPHYSIS, RENAL TRANSPLANTATION, GROWTH HORMONE DEFICIENCIES NOT CONFIRMED BY ONE SUBNORMAL PROVACTIVE STIMULATION TEST, HIV PATIENTS NOT ON ANTIVIRAL THERAPY	FOR ALL DIAGNOSES: SPECIALITY PHYSICIAN REQUIRED FOR ALL PEDIATRIC GROWTH FAILURES, PRADER-WILLI SYNDROME (INITIAL AND RENEWAL): EPIPHYSIS MAY NOT BE CLOSED AND PATIENT MUST NOT HAVE REACHED FINAL HEIGHT PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD) INITIAL:SUBNORMAL PROVOCATIVE STIMULATION TEST, DIAGNOISIS CONFIRMED BY SPECIFIED CRITERIA PEDIATRIC (GHD) RENEWAL:POSITIVE RESPONSE TO THE FIRST 6 MONTHS OF THERAPY FOR GROWTH FAILURE DUE TO (CRI INITIAL): THE PATIENT HAS NOT UNDERGONE A RENAL TRANSPLANT, PATIENT'S HEIGHT AT LEAST 2 STANDARD DEVIATIONS		ONLY PEDIATRIC ENDOCRINOLOGIST OR ENDOCRINOLOGIST CAN PRESCRIBE FOR THE FOLLOWING DIAGNOSES: PEDIATRIC GROWTH HORMONE DEFICIENCY/GROWTH FAILURE DUE TO SMALL FOR GESTATION AGE OR INTRAUTERINE GROWTH RETARDATI	HIV/AIDS: 3 MONTHS SHORT BOWEL: 4 WEEK ONCE. ALL OTHER DIAGNOSES: INITIAL 6 MONTHS, RENEW 12 MONTHS.	

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				(SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER, RENEWAL FOR GROWTH FAILURE DUE TO (CRI) : ABSENCE OF LACK OF RESPONSE OR NOT ELIGIBLE FOR RENEWAL IF PATIENT HAS REACHED 50TH PERCENTILE FOR TARGET HEIGHT FOLLOWING GROWTH HORMONE THERAPY GROWTH FAILURE DUE TO SMALL FOR GESTATIONAL AGE OR INTRAUTERINE GROWTH RETARDATION INITIAL: BIRTH WEIGHT (LESS THAN 2.5KG AT GESTATION AGE OF 37 WEEKS) OR BIRTH LENGTH/WEIGHT BELOW THIRD PERCENTILE FOR GESTATION AGE, HEIGHT AT LEAST 2 SD BELOW MEAN HEIGHT FOR NORMAL CHILDREN OF SAME AGE/GENDER RENEWAL: POSITIVE RESPONSE TO FIRST 6 MONTHS OF GH THERAPY. TURNER SYNDROME, PRADER-WILLI SYNDROME		ON/SHORT STATUE ASSOCIATED WITH TURNER'S SYNDROME /PRADER-WILLI SYNDROME . ONLY NEPHROLOGISTS CAN PRESCRIBE FOR THE FOLLOWING DIAGNOSIS : GROWTH FAILURE DUE TO CHRONIC RENAL INSUFFICIENCY. ONLY ENDOCRINOLOGISTS CAN PRESCRIBE FOR THE FOLLOWING DIAGNOSIS : ADULT GROWTH		

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				INITIAL: SHORT STATURE, EPIPHYSIS NOT CLOSED, RENEWAL: RESPONSE TO FIRST 6 MONTHS OF THERAPY FOR ADULT GHD INITIAL: EITHER HYPOPITUITARISM DUE TO PITUITARY DISEASE, HYPOTHALMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA OR CHILDHOOD-ONSET GHD WITH SUBNORMAL PROVOCATIVE STIMULATION TEST. RENEWAL: IGF-1 NORMALIZATION OR IMPROVEMENT IN BODY COMPOSITION OR CLINICAL ASSESSMENT OF PATIENT FOCUSING ON IMPROVEMENT OF QUALITY OF LIFE ISSUES FOR HIV/AIDS INITIAL: ANTIRETROVIRAL THERAPY, MEETS SPECIFIED CRITERIA OF WEIGHT LOSS/BODY CELL MASS/BMI, INADEQUATE RESPONSE TO PREVIOUS THERAPY, RENEWAL: INCREASE IN MUSCLE MASS AND WEIGHT FROM GH REPLACEMENT		HORMONE DEFICIENCY.		

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				(RENEWAL ONLY). FOR SHORT-BOWEL SYNDROME: CURRENTLY ON SPECIALIZED NUTRITIONAL SUPPORT				
HEPATITIS A VACCINE (INACTIVATED) BVD DETERMINATION	HAVRIX VAQTA	THIS DRUG 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.						
HEPATITIS B VACCINE BVD DETERMINATION	ENGERIX-B RECOMBIVAX HB	THIS DRUG 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.						
IMMUNE GLOBULIN BVD DETERMINATION	CARIMUNE NANOFILTERED FLEBOGAMMA GAMASTAN S/D GAMMAGARD LIQUID GAMUNEX IVEEGAM EN OCTAGAM PANGLOBULIN NF POLYGAM S/D VIVAGLOBIN	THIS DRUG 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.						

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IMMUNOSUPPRESSANT BVD DETERMINATION	AZASAN AZATHIOPRINE AZATHIOPRINE SODIUM CELLCEPT CELLCEPT INTRAVENOUS CYCLOSPORINE CYCLOSPORINE MODIFIED GENGRAF IMURAN MYCOPHENOLATE MOFETIL MYFORTIC NEORAL ORTHOCLONE OKT3 PROGRAF RAPAMUNE SANDIMMUNE SIMULECT ZENAPAX	THIS DRUG 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.						
INFUSIBLE DRUG BVD DETERMINATION	ABELCET ACYCLOVIR SODIUM ADRIAMYCIN AMBISOME AMPHOTEC AMPHOTERICIN B BLENOXANE BLEOMYCIN SULFATE CLADRIBINE CYTARABINE CYTARABINEAQUEOUS CYTOVENE DOXIL DOXORUBICIN HCL	THIS DRUG 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.						

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	FLUOROURACIL FOSCARNET SODIUM FOSCAVIR LEUSTATIN REMICADE REMODULIN VINBLASTINE SULFATE VINCASAR PFS VINCRISTINE SULFATE							
LOW MOLECULAR WEIGHT HEPARIN AGENTS	INNOHEP	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D IF THE PATIENT IS CURRENTLY ON WARFARIN AND SCHEDULED FOR MINOR PROCEDURE/SURGERY, FOR PREVENTION OF THROMBOSIS FOLLOWING SURGERY OR PREVENTION OF ISCHEMIC COMPLICATIONS OF UNSTABLE ANGINA AND NON-Q WAVE, FOR OUTPATIENT TREATMENT OF ACUTE DEEP VEIN THROMBOSIS (DVT), WITHOUT PULMONARY EMBOLISM (PE) AND ADMINISTERED IN CONJUNCTION WITH WARFARIN.		CURRENTLY ON WARFARIN AND SCHEDULED FOR MINOR SURGERY OR MAJOR SURGERY OR FOR PREVENTION OF THROMBOSIS FOLLOWING SURGERY: PATIENT DOES NOT HAVE THERAPEUTIC INR (GREATER THAN 2 FOR AT LEAST 2 DAYS), FOR OUTPATIENT TREATMENT OF ACUTE DEEP VEIN THROMBOSIS (DVT) WITHOUT PULMONARY EMBOLISM (PE): CONCURRENT TREATMENT WITH ORAL WARFARIN FOR CANCER PATIENTS WHO REQUIRE DALTEPARIN TO REDUCE THE REOCCURRENCE OF VTE (VENOUS			CANCER:LI FETIME HIP REPLACEMENT/FRACTURE SURGERY UP TO 30 DAYS OTHER FDA INDICATIONS UP TO 17 DAYS	

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				THROMBOEMBOLISM: DVT AND/OR PE. PREVENTION OF THROMBOSIS FOLLOWING SURGERY (ABDOMINAL, KNEE OR HIP REPLACEMENT) OR FOR THE PREVENTION OF ISCHEMIC COMPLICATIONS OF UNSTABLE ANGINA AND NON-Q WAVE M				
MEASLES VIRUS LIVE VACCINE BVD DETERMINATION	ATTENUVAX	THIS DRUG 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.						
METHYLNALTREX ONE	RELISTOR	OPIOID-INDUCED CONSTIPATION IN PATIENTS WITH ADVANCED ILLNESS WHO ARE RECEIVING PALLIATIVE CARE	NOT ON PALLIATIVE CARE OR LIFE EXPECTANCY OF GREATER THAN 6 MONTHS	CONSTIPATION DUE TO OPIOIDS			UP TO 6 MONTHS	
PROTOPIC	PROTOPIC	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D	PROTOPIC 0.03%: PATIENT AGE LESS THAN 2 YEARS OLD. PROTOPIC 0.1%: PATIENT AGE LESS THAN 15 YEARS OLD BUT GREATER THAN OR EQUAL TO 2 YEARS OLD		PROTOPIC 0.03%: PATIENT AGE GREATER THAN OR EQUAL TO 2 YEARS OLD.		12 MONTHS	

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					PROTOPIC 0.1%: PATIENT AGE GREATER THAN OR EQUAL TO 15 YEARS OLD			
PROVIGIL	PROVIGIL	SHIFT WORK SLEEP DISORDER, OBSTRUCTIVE SLEEP APNEA/HYPOAPNEA SYNDROME,, EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH NARCOLEPSY, CHRONIC FATIGUE SYNDROME RELATED TO MULTIPLE SCLEROSIS.		SHIFT WORK DISORDER. OBSTRUCTIVE SLEEP APNEA/HYPOAPNEA SYNDROME: TRIAL OF CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) AND RECOMMENDED OR INITIATED BY A PHYSICIAN WHO SPECIALIZES IN SLEEP DISORDER. NARCOLEPSY: TRIED/FAILED OR CONTRAINDICATION TO AMPHETAMINE, DEXTROAMPHETAMINE AND/OR METHYLPHENIDATE.			1 YEAR	
QUALAQUIN	QUALAQUIN	MALARIA					1 YEAR	

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RABIES VACCINE BVD DETERMINATION	IMOVAX RABIES (H.D.C.V.) RABAVERT	THIS DRUG 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.						
RANEXA	RANEXA	CHRONIC ANGINA	PATIENTS TAKING QTC-PROLONGING DRUGS, POTENT/ MODERATELY POTENT CYP3A INHIBITORS, HIV PROTEASE INHIBITORS, MACROLIDES, PATIENT HAS NOT TRIED/FAILED OR HAVE CONTRAINDICATION TO 1 ANTI-ANGINA AGENT, RANEXA USED AS SINGLE THERAPY.	CHRONIC ANGINA: NO CONCURRENT USE OF QT PROLONGING AGENTS, POTENT/ MODERATELY POTENT CYP3A INHIBITORS, HIV PROTEASE INHIBITORS, OR MACROLIDES, AND HAVE TRIED/FAILED/HAVE A CONTRAINDICATION TO AT LEAST 1 ANTI-ANGINAL AGENT. RANEXA MUST BE USED IN COMBINATION WITH ANOTHER ANTI-ANGINAL AGENT, AMLODIPINE, ISOSORBIDE OR LONG-ACTING NITROGLYCERIN.			12 MONTHS	
REGRANEX	REGRANEX	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D IF THE PATIENT IS DIAGNOSED WITH DIABETES MELLITUS	DIAGNOSED NEOPLASM, NECROTIC TISSUE, INFECTION OR OSTEOMYELITIS AT SITE OF APPLICATION, NOT WRITTEN BY VASCULAR SURGEON, PODIATRIST,	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D IF THE PATIENT IS DIAGNOSED WITH DIABETES MELLITUS:		VASCULAR SURGEON, PODIATRIST, ENDOCRINOLOGIST OR	3 MONTHS	

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			ENDOCRINOLOGIST OR PHYSICIAN PRACTICING IN A SPECIALTY WOUND CLINIC	PRESCRIPTION WRITTEN OR CURRENTLY SUPERVISED BY A VASCULAR SURGEON, PODIATRIST, ENDOCRINOLOGIST OR PHYSICIAN PRACTICING IN A SPECIALTY WOUND CLINIC, PATIENT WITHOUT A DIAGNOSED NEOPLASM/NECROTIC TISSUE/INFECTION/OSTEO MYELITIS AT SITE OF APPLICATION		PHYSICIAN PRACTICING IN A SPECIALTY WOUND CLINIC ONLY		
RESTASIS	RESTASIS	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D IF PRESCRIBED BY AN OPHTHALMOLOGIST, OPTOMETRIST, OR RHEUMATOLOGIST, KERATOCONJUNCTIVITIS SICCA, DRY EYE DISEASE	KERATOCONJUNCTIVITIS SICCA (KCS) OR DRY EYE DISEASE: HAS NOT FAILED A TRIAL OF ARTIFICIAL TEARS AND/OR LACRISERT	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D: PRESCRIBED BY AN OPHTHALMOLOGIST, OPTOMETRIST, OR RHEUMATOLOGIST. DIAGNOSIS OF KERATOCONJUNCTIVITIS SICCA/DRY EYE DISEASE.		OPHTHALMOLOGIST, OPTOMETRIST, RHEUMATOLOGIST	1 YEAR	
SAPROPTERIN	KUVAN	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D	INITIAL: PRESCRIBER NOT AN ENDOCRINOLOGIST, PATIENT LESS THAN 4 YEARS OLD , HAS NOT TRIED DIETARY MODIFICATIONS RENEWAL: PATIENT HAS	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D INITIAL: TREATMENT BY AN ENDOCRINOLOGIST AND AGE 4 YEARS OR OLDER, AND PATIENT	4 YEARS OF AGE OR OLDER	ENDOCRINOLOGIST ONLY	INITIAL USE: 4 WEEKS. CONTINUED USE: 6 MONTHS	

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			NOT ACHIEVED AT LEAST 20% REDUCTION IN BLOOD PHE WITH INITIAL TREATMENT	FAILED TO ACHIEVE ADEQUATE REDUCTION OF PHE LEVELS WITH DIETARY MODIFICATIONS. RENEWAL: PATIENT ACHIEVED AT LEAST 20% REDUCTION IN BLOOD PHE WITH INITIAL TREATMENT				
TESTOSTERONE AGENTS	ANDRODERM ANDROGEL ANDROGEL PUMP TESTIM TESTOSTERONE CYPIONATE TESTOSTERONE ENANTHATE	HYPOGONADISM (PRIMARY OR SECONDARY), DELAYED PUBERTY AND METASTATIC BREAST CANCER	LABORATORY CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL EQUAL TO OR GREATER THAN 250NG/DL (8.7NMOL/L) OBTAINED WITHIN 90 DAYS OR A LABORATORY CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL NOT BETWEEN 250NG/DL AND 350NG/DL (12NMOL/L) AND A FREE SERUM TESTOSTERONE LEVEL OF EQUAL OR GREATER THAN 50NG/L (174 PMOL/L)	HYPOGONADISM: MALE AGE 12 YEARS OF AGE OR OLDER, A LABORATORY CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL OF LESS THAN 250NG/DL (8.7NMOL/L) OBTAINED WITHIN 90 DAYS OR A LABORATORY CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL BETWEEN 250NG/DL AND 350NG/DL (12NMOL/L) AND A FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 50NG/L (174 PMOL/L).	12 YEARS OF AGE OR OLDER		1 YEAR	
TETANUS TOXOID VACCINE BVD DETERMINATION	TETANUS TOXOID ADSORBED	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND						

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PA Group Description	Drug Name(s)	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restrictions	Coverage Duration	Other Criteria
		SETTING OF THE DRUG TO MAKE THE DETERMINATION.						
TOTAL PARENTARAL NUTRITION AGENT BVD DETERMINATION	AMINOSYN AMINOSYN 7%/ELECTROLYTES AMINOSYN 8.5%/ELECTROLYTE S AMINOSYN II AMINOSYN II 3.5%/DEXTROSE25% AMINOSYN II 3.5%/DEXTROSE5% AMINOSYN II 3.5/DEXTROSE25% AMINOSYN II 4.25/DEXTROSE10% AMINOSYN II 4.25/DEXTROSE20% AMINOSYN II 4.25/DEXTROSE25% AMINOSYN II 5/DEXTROSE 25 AMINOSYN II 8.5%/ELECTROLYTE S AMINOSYN II M 3.5%/DEXTROSE 5% AMINOSYN II M 4.25/DEXTROSE 10% AMINOSYN M AMINOSYN-HBC AMINOSYN-HF AMINOSYN-PF AMINOSYN-PF 7% CLIMIMIX E	THIS DRUG 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.						

PART D 2009 PRIOR AUTHORIZATION DESCRIPTIONS
 (For use with Part D Open & Closed 2009 Part D Formularies)



PA Group Description	Drug Name(s)	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restrictions	Coverage Duration	Other Criteria
	4.25%/DEXTROSE 5% CLINIMIX 2.75%/DEXTROSE 5% CLINIMIX 4.25%/DEXTROSE 10% CLINIMIX 4.25%/DEXTROSE 20% CLINIMIX 4.25%/DEXTROSE 25% CLINIMIX 4.25%/DEXTROSE 5% CLINIMIX 5%/DEXTROSE 15% CLINIMIX 5%/DEXTROSE 20% CLINIMIX 5%/DEXTROSE 25% CLINIMIX E 2.75%/DEXTROSE 10% CLINIMIX E 2.75%/DEXTROSE 5% CLINIMIX E 4.25%/DEXTROSE 25% CLINIMIX E 5%/DEXTROSE 15% CLINIMIX E 5%/DEXTROSE 20% CLINIMIX E 5%/DEXTROSE 25% CLINIMIX E 5%/DEXTROSE 35% CLINISOL SF 15% DEXTROSE 10%/NACL 0.45%							

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PA Group Description	Drug Name(s)	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restrictions	Coverage Duration	Other Criteria
	DEXTROSE 10% DEXTROSE 10%/NAACL 0.2% FREAMINE HBC 6.9% FREAMINE III 3% HEPATAMINE HEPATASOL INTRALIPID INTRALIPID 20% NEPHRAMINE NOVAMINE PREMASOL PROCALAMINE PROSOL RENAMIN TRAVASOL TRAVASOL 2.75%/DEXTROSE 10% TRAVASOL 2.75%/DEXTROSE 5% TRAVASOL 3.5%/ELECTROLYTE S TRAVASOL 4.25%/DEXTROSE 10% TRAVASOL 4.25%/DEXTROSE 25% TRAVASOL 5.5%/DEXTROSE 10% TRAVASOL 5.5%/DEXTROSE 20% TRAVASOL 5.5%/ELECTROLYTE S TRAVASOL 8.5%/DEXTROSE 10% TRAVASOL							

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PA Group Description	Drug Name(s)	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restrictions	Coverage Duration	Other Criteria
	8.5%/DEXTROSE 20% TRAVASOL 8.5%/DEXTROSE 50% TRAVASOL 8.5%/ELECTROLYTE S TROPHAMINE							
XOLAIR	XOLAIR	MODERATE TO SEVERE ASTHMA (DAILY ASTHMA SYMPTOMS, DAILY USE OF INHALED SHORT-ACTING BETA 2 AGONIST E.G., ALBUTEROL, EXACERBATIONS GREATER OR EQUAL TO 2 TIMES A WEEK, NIGHTTIME SYMPTOMS GREATER THAN 1 TIME A WEEK, FEV1 OR PEF LESS THAN 80% PREDICTED, OR PEF VARIABILITY GREATER THAN 30%)		ADULTS AND ADOLESCENTS (12YEARS OF AGE AND ABOVE) WITH MODERATE TO SEVERE PERSISTENT ASTHMA WITH A POSITIVE SKIN TEST OR IN VITRO REACTIVITY TO A PERENNIAL AEROALLERGEN WHOSE SYMPTOMS ARE INADEQUATELY CONTROLLED WITH INHALED CORTICOSTEROIDS.	PATIENT 12 YEARS OF AGE OR OLDER	SPECIALIST IN ALLERGY OR PULMONARY MEDICINE ONLY	1 YEAR	