

Medicare Part D Prior Authorization Criteria (effective January 2008)

Name of drug/class	Approval Criteria
Amevive [®] /Raptiva [®]	<ul style="list-style-type: none"> •Documentation of moderate-to-severe chronic plaque psoriasis •Failure, medical contraindication, or intolerance to two or more treatment modalities, including topical steroids, antipsoriatic agents, retinoids, and phototherapy •Prescribed and/or administered by a dermatologist or rheumatologist •Age of at least 18 years.
Angiotensin II Receptor Blockers (Benicar [®] /Benicar HCT [®]) Diovan [®] /Diovan HCT [®] Atacand [®] /Atacand HCT [®] Avapro [®] /Avalide [®] Cozaar [®] /Hyzaar [®] Micardis [®] /Micardis HCT [®] Teveten [®] /Teveten HCT [®]	<p>DIOVAN/DIOVAN HCT, BENICAR/BENICAR HCT:</p> <ul style="list-style-type: none"> •Documentation of a minimum 30-day trial and failure of or intolerance to at least one angiotensin converting enzyme (ACE) inhibitor-containing product (eg, enalapril maleate, lisinopril, moexipril HCl, fosinopril sodium, benazepril HCl, captopril, quinapril HCl) or ramipril (Altace) within the past six months •Diagnosis of Type 2 diabetes with renal insufficiency <p>AVAPRO/AVALIDE, ATACAND/ATACAND HCT, COZAAR/HYZAAR, MICARDIS/MICARDIS HCT, TEVETEN/TEVETEN HCT:</p> <ul style="list-style-type: none"> •Documentation of a minimum 30-day trial and failure of or intolerance to valsartan (Diovan)- AND olmesartan (Benicar)-containing products (<i>Diovan/Diovan HCT and Benicar/Benicar HCT require prior authorization.</i>) <p>In addition, one of the following inclusion criteria must also be met in order for treatment with irbesartan (Avapro, Avalide), candesartan (Atacand/Atacand HCT), losartan (Cozaar, Hyzaar), telmisartan (Micardis/Micardis HCT), eprosartan (Teveten/Teveten HCT) to be approved:</p> <ul style="list-style-type: none"> •Documentation of a minimum 30-day trial and failure of or intolerance to at least one ACE inhibitor-containing product (eg, enalapril maleate, lisinopril, moexipril HCl, fosinopril sodium, benazepril HCl, captopril, quinapril HCl) or ramipril (Altace) within the past six months •Diagnosis of Type 2 diabetes with renal insufficiency <p>NOTE: Requests for any of the following angiotensin II receptor blockers (ARBs): irbesartan (Avapro, Avalide), candesartan (Atacand/Atacand HCT), losartan (Cozaar, Hyzaar), telmisartan (Micardis/Micardis HCT), eprosartan (Teveten/Teveten HCT) that have documentation of a minimum 30-day trial and failure of an ACE inhibitor-containing product within the past six months will receive an authorization for both valsartan (Diovan/Diovan HCT) and olmesartan (Benicar/Benicar HCT).</p>
BiDil [®]	<ul style="list-style-type: none"> •Diagnosis of heart failure •Documentation of trial and failure or contraindication or

Name of drug/class	Approval Criteria
	intolerance to a combination isosorbide dinitrate and hydralazine product
Botox [®] /Myobloc [®]	Documentation of cervical dystonia, strabismus, blepharospasm, facial nerve disorders, focal and segmental limb dystonias, hemifacial spasm, focal hyperhydrosis, spastic hemiplegia, cerebral palsy, voice and speech disorders (abductor spasmodic dysphonia, adductor spasmodic dysphonia, laryngeal spasm, stuttering and vocal tremor).
Byetta [®]	<ul style="list-style-type: none"> •Documentation of concurrent use of metformin, a sulfonylurea, or combination of metformin and sulfonylureaAND •Documentation of Type 2 Diabetes Mellitus
Cesamet [®]	<ul style="list-style-type: none"> •Documentation of chemotherapy-induced nausea and vomiting AND •Documentation of trial and failure of ondansetron containing product (Zofran[®]) and one of the following: granisetron HCL (Kytril[®]) or aprepitant (Emend[®])
COX-2 inhibitors (Celebrex [®] , Mobic [®])	<ul style="list-style-type: none"> •Documentation of familial adenomatous polyposis (FAP) [for celecoxib (Celebrex[®]) only] <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> •Documentation of failure of generic meloxicam and one of the Following: <ul style="list-style-type: none"> • The patient has a documented trial and failure of two non-steroidal anti-inflammatory drugs (NSAIDs). • The patient is 65 years of age or older. • The patient has concurrent warfarin use (within the last 90 days). • The patient has a bleeding disorder • The patient is on concurrent systemic steroid treatment • The patient has a history of gastrointestinal bleed, peptic ulcer, GERD, or Barrett's esophagus • The patient has a documented concomitant condition in which COX-2 inhibitors or brand meloxicam (Mobic[®]) offers a significant advantage over non-COX-2 selective NSAIDs.
Cymbalta [®]	<ul style="list-style-type: none"> •Documentation of MDD OR GAD <p style="text-align: center;">And</p> <ul style="list-style-type: none"> •Documentation of the failure or intolerance to two of the following agents: <ul style="list-style-type: none"> Bupropion Bupropion sustained-release (SR) Bupropion extended-release (XL) Citalopram Escitalopram (Lexapro[®]) Fluoxetine

Name of drug/class	Approval Criteria
	Fluvoxamine Paroxetine Sertraline Venlafaxine (Effexor®) Venlafaxine extended-release (XR) (Effexor® XR) • Documentation of neuropathic pain associated with DPN secondary to diabetes with documented use of any diabetic medications.
Daytrana®	<ul style="list-style-type: none"> • Documented diagnosis of attention deficit hyperactivity disorder (ADHD) • Documented trial and failure of or contraindication/intolerance/allergy to two of the following agents: <ul style="list-style-type: none"> ○ Amphetamine-dextroamphetamine (Adderall XR®) ○ A long-acting methylphenidate product ○ Atomoxetine (Strattera®) ○ A long-acting dextroamphetamine-containing product ○ Methamphetamine hydrochloride (Desoxyn®)
Enbrel®	<ul style="list-style-type: none"> • Use in rheumatoid or psoriatic arthritis and rheumatoid variant conditions AND • Prescribed by a rheumatologist or dermatologist (for psoriatic arthritis) AND • Patient age at least 4 years
Erectile Dysfunction drugs (Viagra®, Caverject®, Edex®, MUSE®, Levitra®, Cialis®)	<ul style="list-style-type: none"> • Documentation for erectile dysfunction in a male AND • Absence of nitrate use during previous 6 months AND • For males less than 55 years old, one of the following: Concomitant conditions such as: diabetes; treatment for prostate cancer; pelvic surgery or radiation (i.e., colon cancer); spinal cord injury; or neurologic disease. <p>OR</p> <p>Documented normal testosterone level</p>
Exforge®	<ul style="list-style-type: none"> • Documentation of non-compliance with a 30-day concurrent therapy of DIOVAN/DIOVAN HCT (with prior authorization) and Amlodipine containing product
Exjade®	<ul style="list-style-type: none"> • Members age 2 years and older AND • The diagnosis of chronic iron overload due to blood transfusions. AND • Serum ferritin levels consistently greater than 1000mcg/L (as demonstrated with at least two lab values within the previous two months) AND

Name of drug/class	Approval Criteria
	<ul style="list-style-type: none"> Evidence of failure/contraindication to deferoxamine injection.
Exubera®	<ul style="list-style-type: none"> Documentation of assessment of pulmonary function test with FEV₁ ≥70%, AND Documentation of smoking abstinence or history of smoking greater than 6 months prior to treatment initiation, AND Documentation of no current diagnosis of asthma, COPD, unstable or poorly controlled lung disease AND one of the following: <ul style="list-style-type: none"> Treatment of adult Type I DM in combination with longer-acting insulin (NPH/ Lantus) or Treatment of adult Type II DM
Fentora®	<ul style="list-style-type: none"> Diagnosis of breakthrough pain in patients with cancer who are already receiving opioid therapy Tolerance to current opioid therapy (therapy is defined as one of the following regimens for one week or longer): <ul style="list-style-type: none"> At least 25 mcg of transdermal fentanyl hourly At least 30 mg of oxycodone daily At least 60 mg of oral morphine daily At least 8 mg of oral hydromorphone daily An equianalgesic dose of another opioid Trial and failure of either brand or generic oral transmucosal fentanyl citrate (Actiq®) for at least one week or longer
Forteo®	<ul style="list-style-type: none"> Individual who is 18 years of age or over and has documentation of primary (postmenopausal) or hypogonadal osteoporosis when all of the following criteria are met: <ul style="list-style-type: none"> The T score of the individual's bone mineral density (BMD) is at least -2.5 standard deviations below the young adult mean. The individual is receiving supplemental treatment with vitamin D and calcium. The individual has osteoporotic fractures, or Multiple risk factors for fractures (See Risk Assessment chart in the Policy Guidelines section.) or The individual is intolerant of or failing to respond to at least one of the following therapies for osteoporosis: <ul style="list-style-type: none"> Bisphosphonates (eg, Boniva®, Fosamax®, Actonel®) Hormone replacement therapy Selective-estrogen receptor modulators (SERMs) (eg, Evista®) Calcitonin-salmon (Miacalcin®)
Gleevec®	<ul style="list-style-type: none"> Philadelphia chromosome-positive chronic myeloid leukemia (Ph+CML) in blast crisis phase, accelerated phase, or chronic phase after failure of interferon-alpha therapy. Kit-positive unresectable and/or metastatic malignant

Name of drug/class	Approval Criteria
	gastrointestinal stromal tumors (GISTs) <ul style="list-style-type: none"> • Acute lymphoblastic leukemia (ALL) • Aggressive systemic mastocytosis (ASM) • Dermatofibrosarcoma protuberans (DFSP) • Hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL) • Myelodysplastic/myeloproliferative diseases (MDS/MPD)
Glumetza®	<ul style="list-style-type: none"> • Documentation of a trial and failure of or intolerance/allergy/contraindication to either metformin IR- or metformin ER-containing products • Documentation of Type 2 diabetes mellitus
Growth Hormone	Documentation of the following diagnoses: Growth Hormone (GH) deficiency in children, Chronic Renal insufficiency, Turner Syndrome, Prader-Willi Syndrome, SGA, GH deficiency in adults with adult/childhood-onset hypothalamic or pituitary disease, AIDS wasting, hypopituitarism in childhood, Neonates with suspected GH deficiency manifested by hypoglycemia, children with ISS with documentation of required laboratory tests.
Humira®	Adalimumab (Humira®) is considered medically necessary and, therefore, covered for the following FDA-approved indications when prescribed by a rheumatologist or dermatologist: <ul style="list-style-type: none"> • Arthritis, rheumatoid For reducing signs and symptoms, inducing major clinical response, inhibiting the progression of structural damage, and improving physical function in individuals 18 years of age or older with moderately to severely active RA • Arthritis, psoriatic For reducing signs and symptoms in individuals with active psoriatic arthritis • Ankylosing spondylitis For reducing signs and symptoms in individuals with active ankylosing spondylitis • Arthritis associated with other conditions For reducing signs and symptoms of arthritis associated with any of the following conditions: <ul style="list-style-type: none"> ○ Inflammatory bowel disease ○ Crohn's disease ○ Reiter's syndrome ○ Other post-infectious syndromes ○ • Crohn's disease For reducing signs and symptoms of disease, and inducing and maintaining clinical remission in adults with moderately to severely active Crohn's disease who have

Name of drug/class	Approval Criteria
	<p>had an inadequate response to conventional therapy, or who no longer respond to or are intolerant to infliximab (Remicade®).</p> <p>EXPERIMENTAL/INVESTIGATIONAL All other uses for anakinra (Kineret®) and/or adalimumab (Humira®) are considered experimental/investigational and, therefore, not covered because the safety and/or efficacy of these drugs for those uses cannot be established by a review of the available published medical literature.</p> <p>The use of adalimumab (Humira®) with other TNF-blocking agents (eg, infliximab [Remicade®], etanercept [Enbrel®]) or interleukin-1 (IL-1) inhibitors (eg, anakinra [Kineret®]) is considered experimental/investigational and, therefore, not covered because the safety and/or efficacy of this regimen cannot be established by a review of the available published medical literature.</p>
Invega®	<ul style="list-style-type: none"> • Documented diagnosis of schizophrenia • Documentation of a trial and failure of, or contraindication to, at least one of the following medications: Aripiprazole (Abilify®) Risperidone (Risperdal®) Quetiapine fumarate (Seroquel®) Olanzapine (Zyprexa®)
Iressa®	<ul style="list-style-type: none"> • Individuals who were documented as previously benefiting from gefitinib (Iressa®) therapy prior to September 15, 2005 and have registered through the Iressa Access Program to continue therapy.
Januvia®	<ul style="list-style-type: none"> • Documentation of type 2 Diabetes Mellitus • Documentation of trial and failure or contraindication to metformin and either a thiazolidinedione (TZD) or a sulfonylurea
Kineret®	<p>Anakinra (Kineret®) is considered medically necessary and, therefore, covered for the following FDA-approved indication when prescribed by a rheumatologist:</p> <ul style="list-style-type: none"> • Arthritis, rheumatoid For reducing signs and symptoms and slowing the progression of structural damage in moderately to severely active rheumatoid arthritis (RA) in individuals 18 years of age or older who have failed one or more disease-modifying antirheumatic drugs (DMARDs). Anakinra (Kineret®) can be used alone or in combination with DMARDs other than tumor necrosis factor (TNF)-blocking agents. • Arthritis associated with other conditions

Name of drug/class	Approval Criteria
	<p>For reducing signs and symptoms of arthritis associated with any of the following conditions:</p> <ul style="list-style-type: none"> ○ Inflammatory bowel disease ○ Crohn's disease ○ Reiter's syndrome ○ Other post-infectious syndromes <p>EXPERIMENTAL/INVESTIGATIONAL All other uses for anakinra (Kineret®) and/or adalimumab (Humira®) are considered experimental/investigational and, therefore, not covered because the safety and/or efficacy of these drugs for those uses cannot be established by a review of the available published medical literature.</p>
Lipitor® and Caduet®	<ul style="list-style-type: none"> • Documentation of a minimum 30-day trial and failure or contraindication/intolerance/allergy to one of the following agents: <ul style="list-style-type: none"> ○ Lovastatin-containing product ○ Pravastatin-containing product ○ Simvastatin-containing product
Lyrica®	<ul style="list-style-type: none"> • Documentation of neuropathic pain that is associated with diabetic peripheral neuropathy • Diagnosis of Fibromyalgia • Add-on therapy for partial onset epileptic seizures in adults after trial and failure or contraindication/intolerance/allergy to Gabapentin • Diagnosis of post herpetic neuralgia with trial and failure or contraindication/intolerance/allergy to Gabapentin • Documentation of non diabetic neuropathic pain with a trial and failure or contraindication/intolerance/allergy to Gabapentin and at least one medication from three (3) of the following five (5) groups: <ul style="list-style-type: none"> ○ An opioid containing product ○ Tramadol ○ A tricyclic antidepressant ○ Lidoderm Patch or a form of topical lidocaine ○ Carbamazepine
Migraine agent quantity edit (Amerge® , Axert® , Frova® , Imitrex® , Maxalt® , Migranal® , Relpax® , Stadol® , Zomig®)	<ul style="list-style-type: none"> • There is a documented diagnosis of migraine headaches. • There has been a trial of prophylactic treatment with beta blockers, calcium channel blockers, tricyclic antidepressants, valproic acid, methylsergide, cyproheptadine, etc. • The requested quantity does not exceed the manufacturer-recommended maximum daily doses. • The individual has been examined by a neurologist within the past three years.

Name of drug/class	Approval Criteria
Nexavar [®]	<ul style="list-style-type: none"> • A diagnosis of advanced renal cell carcinoma
Noxafil [®]	<p>Individual who is 13 years of age or older and when either one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Use in prophylaxis of invasive Aspergillus and Candida infections due to a severe immunocompromised state • Use in the treatment of invasive Aspergillus and Candida infections due to a severe immunocompromised state after trial and failure of voriconazole (Vfend[®]) • Diagnosis of oropharyngeal candidiasis with failed trials of itraconazole and fluconazole.
Nulev [®]	<ul style="list-style-type: none"> •Documentation of intolerance to the standard dosage forms, or conditions that make swallowing tablets and liquid dosage forms difficult
Opana [®] /Opana ER [®]	<ul style="list-style-type: none"> •A trial and failure of all generic immediate-release scheduled II analgesic medications for oxymorphone (Opana[®]) requests and all extended-release scheduled II analgesic medications for oxymorphone ER (Opana ER[®]) requests indicated for moderate to severe pain .
Oracea [®]	<ul style="list-style-type: none"> •Documentation of diagnosis of Rosacea •Documentation of trial and failure or contraindication/intolerance/allergy to topical metronidazole and one other formulation of oral doxycycline
Pataday [™]	<ul style="list-style-type: none"> •Documentation of allergic conjunctivitis And •Documentation of trial and failure or contraindications to all of the following agents: olopatadine hydrochloride ophthalmic solution (Patanol[™]), azelastine hydrochloride ophthalmic solution (Optivar[™]), and ketotifen fumarate ophthalmic solution
Paxil CR [®]	<ul style="list-style-type: none"> • Documentation of a six-week trial occurring within the last six months that resulted in: Failure of or intolerance to one or more of the following generic selective serotonin reuptake inhibitors (SSRIs): Citalopram Fluoxetine Fluvoxamine Paroxetine Sertraline AND Failure of or intolerance to one or more of the following medications: Lexapro Effexor/Effexor XR

Name of drug/class	Approval Criteria
	A generic antidepressant agent
Proton Pump Inhibitors (Aciphex [®] , Prevacid [®] /Prevacid Naprapac [®] , Nexium [®] , Protonix [®] , Pylera [®] .)	<p>ESOMEPRAZOLE (NEXIUM[®]) AND LANSOPRAZOLE (PREVACID[®])</p> <ul style="list-style-type: none"> •Documentation of any of the indications specified for the drug •A documented trial and failure or contraindication/intolerance/allergy to a prescription generic omeprazole lasting at least 14 days <p>ESOMEPRAZOLE (NEXIUM[®]) FOR DELAYED-RELEASE ORAL SUSPENSION, LANSOPRAZOLE (PREVACID[®]) ORALLY DISINTEGRATING TABLETS, AND LANSOPRAZOLE (PREVACID[®]) GRANULES FOR ORAL SUSPENSION</p> <ul style="list-style-type: none"> •The individual is under 12 years of age with documentation of any of the indications specified for the drug •Documentation of the inability to swallow capsules/tablets (eg, dysphagia, gastrointestinal [GI] tubes) along with documentation of any of the indications specified for the drug <p>LANSOPRAZOLE/NAPROXEN (PREVACID NAPRAPAC[®])</p> <ul style="list-style-type: none"> •Documentation of any of the indications specified for lansoprazole/naproxen (Prevacid Naprapac[®]). <p>RAPEPRAZOLE (ACIPHEX[®]) AND PANTOPRAZOLE (PROTONIX[®])</p> <ul style="list-style-type: none"> •A documented trial of products containing esomeprazole (Nexium[®]) and lansoprazole (Prevacid[®]) •Documentation of any of the indications specified for the drug •A documented trial and failure or contraindication/intolerance/allergy to a generic omeprazole lasting at least 14 days <p>BISMUTH SUBCITRATE POTASSIUM, METRONIDAZOLE, AND TETRACYCLINE HYDROCHLORIDE (PYLERA[®])</p> <ul style="list-style-type: none"> •Documented diagnosis of <i>Helicobacter pylori</i>.
Provigil [®]	<p>Prescribed or recommended by a neurologist or sleep specialist, AND one of the following diagnoses with appropriate labs/clinical evaluations:</p> <p>Diagnosis of:</p> <ul style="list-style-type: none"> • Narcolepsy, idiopathic hypersomnolence with documentation of a supporting-sleep study • Documentation of fatigue associated with multiple sclerosis • Diagnosis of shift work sleep disorder and clinical evaluation demonstrating the presence of a shift work schedule likely to result in sleepiness AND Failure of patient counseling regarding techniques for reducing the negative effects of shift work

Name of drug/class	Approval Criteria
Ranexa®	<ul style="list-style-type: none"> • Documentation of insufficient response, intolerance, or contraindication to at least one medication from each of the following: Long-acting nitrates (eg, isosorbide dinitrate, isosorbide mononitrate) Atenolol, metoprolol, nadolol, or propranolol Nifedipine XL or amlodipine AND • Documentation of concurrent treatment with one of the following: Amlodipine Beta-blocker Long-acting nitrate
Reclast®	<ul style="list-style-type: none"> • Documentation of Paget’s disease with any of the following conditions: <ul style="list-style-type: none"> ○ An individual is symptomatic ○ An individual is at risk for complications from the disease ○ Elective surgery planned for a pagetic site (e.g. hip replacement surgery) ○ Serum alkaline phosphatase elevations that are two times or higher than the upper limit of the age specific normal reference range (20-130 IU/L or 0.33-2.17 mckat/L) <p>OR</p> <ul style="list-style-type: none"> • Documentation of osteoporosis in postmenopausal women with any of the following conditions: <ul style="list-style-type: none"> ○ Contraindication to oral bisphosphonates ○ Failure with adequate trial of two oral bisphosphonates ○ Difficulty swallowing oral medications or inability to sit upright for 30 to 60 minutes ○ History of esophagitis, gastritis, gastric ulcer, esophageal stricture or esophageal motility disorder <p>All other indications for zoledronic acid (Reclast®) are considered experimental or investigational and, therefore, not covered.</p>
Revatio®	<ul style="list-style-type: none"> • Documentation of pulmonary arterial hypertension and history of no nitrate prescriptions within the last six months.
Revlimid®	<ul style="list-style-type: none"> • Patients must be registered with RevAssistSM Program AND • A diagnosis of transfusion-dependent anemia, due to low-or intermediate-1-risk myelodysplastic syndromes that are associated with a deletion 5q cytogenetic abnormality, with or without additional cytogenetic abnormalities OR • A diagnosis of multiple myeloma in combination with dexamethasone for patients who had received at least one prior therapy (such as stem cell transplantation, thalidomide, dexamethasone, mephalan, doxorubicin, vincristine).

Name of drug/class	Approval Criteria
	cyclophosphamide, carmustine, Velcade)
Schedule II Oral Tablet/Capsule/Lozenge Quantity Level Limit	<ul style="list-style-type: none"> Documentation of appropriate diagnosis upon visit with a qualified specialist, and evidence to support medical necessity of the requested dose.
Seroquel XR®	<ul style="list-style-type: none"> Documented diagnosis of schizophrenia <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> Documented diagnosis of bipolar disorder <p style="text-align: center;">And</p> <ul style="list-style-type: none"> Documentation of a trial and failure of, or contraindication to at least one of the following medications: <ul style="list-style-type: none"> Aripiprazole (Abilify®) Risperidone (Risperdal®) Quetiapine fumarate immediate release (Seroquel®) An Olanzapine containing product (Zyprexa or Symbyax)
Singulair®	<ul style="list-style-type: none"> Documentation of a diagnosis of asthma in individuals 12 months of age and older <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> Documentation of a diagnosis of seasonal allergic rhinitis in individuals 2 years of age and older with documented failure of at least one of the following: <ul style="list-style-type: none"> Prescription nonsedating antihistamine (eg, fexofenadine [Allegra®], desloratadine [Clarinex®], cetirizine [Zyrtec®]) Over-the-counter nonsedating antihistamine (eg, loratadine [Claritin®, Alavert®]) Intranasal corticosteroid (eg, beclomethasone [Vancenase®], budesonide [Rhinocort®], fluticasone [Flonase®], mometasone [Nasonex®], triamcinolone [Nasacort®])
Sleep agents (Ambien CR®, Lunesta®, Rozerem®)	<ul style="list-style-type: none"> Diagnosis of insomnia And Documentation of a trial and failure of a zolpidem tartrate immediate-release-containing product for a minimum of 14 days within the past six months
Sprycel®	<ul style="list-style-type: none"> Documentation of chronic myeloid leukemia (CML) in any

Name of drug/class	Approval Criteria
	<p>phase (chronic, accelerated, or myeloid or lymphoid blast phase) with resistance or intolerance to prior therapy, including Gleevec®* (imatinib mesylate).</p> <p>OR</p> <ul style="list-style-type: none"> • Documentation of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL) with resistance or intolerance to prior therapy.
Sutent®	<ul style="list-style-type: none"> • A diagnosis of gastrointestinal stromal tumors (GIST) after disease progression on or documented intolerance to imatinib mesylate (Gleevac®). • A diagnosis of advanced renal cell carcinoma (RCC)
Symbicort®	<ul style="list-style-type: none"> • Documentation of a diagnosis of asthma in patients 12 years of age and older.
Symlin®	<ul style="list-style-type: none"> • Documentation of type 1 diabetes with concurrent use of insulin therapy • Documentation of type 2 diabetes with concurrent therapy with insulin or with a sulfonylurea agent and/or metformin with insulin
Tekturna®	<ul style="list-style-type: none"> • Aliskiren (Tekturna) is approved when all of the following inclusion criteria are met: <ul style="list-style-type: none"> ○ Documented diagnosis of hypertension ○ Documentation of trial and failure of or contraindication/intolerance/allergy to an ACE inhibitor ○ Documentation of trial and failure of or contraindication/intolerance/allergy to Diovan-or Benicar-containing products (<i>Diovan/Diovan HCT and Benicar/Benicar HCT require prior authorization.</i>) ○ Documentation of trial and failure of or contraindication/intolerance/allergy to an amlodipine- containing product
Thalomid®	<ul style="list-style-type: none"> • Diagnosis of erythema nodosum leprosum or moderate to severe neuritis (not as monotherapy). • Multiple Myeloma and Neoplastic diagnosis with documentation of failure of conventional therapy.
Tarceva®	<ul style="list-style-type: none"> • The individual is diagnosed with locally advanced or metastatic non-small cell lung cancer (NSCLC) and has documentation of at least one prior chemotherapy regimen that failed or is contraindicated. • The individual is diagnosed with locally advanced, unresectable or metastatic pancreatic cancer in combination

Name of drug/class	Approval Criteria
	with gemcitabine as a first-line therapy.
Tykerb [®]	<ul style="list-style-type: none"> • A diagnosis of advanced or metastatic breast cancer whose tumors overexpress HER2 • Documentation of concurrent therapy with capecitabine (Xeloda[®]) • Documentation of a trial and/or failure/contraindication/intolerance/allergy to prior therapy including all of the following: an anthracycline, a taxane, and trastuzumab
Veramyst [®]	<ul style="list-style-type: none"> • Documentation of a diagnosis of seasonal or perennial allergic rhinitis and any of the following: • Documentation that the individual is 2 or 3 years of age and documentation of trial and failure or intolerance/contraindication/allergy to mometasone furoate monohydrate (Nasonex[®]) <p>OR</p> <ul style="list-style-type: none"> • Documentation that the individual is 4 or 5 years of age and documentation of trial and failure or intolerance/contraindication/allergy to fluticasone propionate-containing nasal product and mometasone furoate monohydrate (Nasonex[®]) <p>OR</p> <ul style="list-style-type: none"> • Documentation that the individual is 6 years of age or older and documentation of trial and failure or intolerance/contraindication/allergy to fluticasone propionate containing nasal product and one of the following: <ul style="list-style-type: none"> o mometasone furoate monohydrate (Nasonex[®]) o triamcinolone acetonide (Nasacort[®] AQ)
Vyvanse [®]	<ul style="list-style-type: none"> • Documentation of a diagnosis of attention-deficit/ hyperactivity disorder (ADHD). And When one of the following inclusion criteria is met: • Documentation of a trial and failure or contraindication/intolerance/allergy to any 2 of the following medications: <ul style="list-style-type: none"> o A methylphenidate containing product o A mixed amphetamine salts containing product (Adderall or Adderall XR) o Strattera o A dextroamphetamine containing product o Desoxyn o A dexmethylphenidate containing product <p>OR</p> <ul style="list-style-type: none"> • Documentation of a history of or potential for drug abuse among patient or member of the household

Name of drug/class	Approval Criteria
Ultram ER [®]	<ul style="list-style-type: none"> • Trial and failure of tramadol AND at least one other generic analgesic medication indicated for moderate to moderately severe pain AND • Age 18 years or older
Xolair [®]	<ul style="list-style-type: none"> • Omalizumab (Xolair[®]) treatment should be initiated by an allergist or pulmonologist. An allergist, pulmonologist, or primary care physician (PCP) can then prescribe omalizumab (Xolair[®]) as maintenance therapy. • Diagnosis of moderate to severe allergic asthma AND • Individuals who are at least 12 years old AND • Documentation of positive skin test or in vitro reactivity to a perennial aeroallergen AND • Documentation that symptoms are inadequately controlled with corticosteroids administered via inhaler
Zavesca [®]	<ul style="list-style-type: none"> • Documentation of mild to moderate type 1 (non-neuronopathic) Gaucher disease.
Zelapar [®]	<ul style="list-style-type: none"> • Documentation of Parkinson's disease • Documentation of the trial and failure of, intolerance to, or contraindication to other oral non-disintegrating formulations of selegiline HCl
Zmax [®]	<ul style="list-style-type: none"> • Documentation of contraindication or intolerance to all other generic formulations of azithromycin
Zolinza [®]	<ul style="list-style-type: none"> • Documentation of diagnosis of T-Cell Lymphoma with cutaneous manifestations • Documentation of trial and failure or contraindication to at least two systemic therapies
Zyvox [®]	<ul style="list-style-type: none"> • Documentation of a CURRENT diagnosis of vancomycin-resistant <i>Enterococcus faecium</i> (VRE) infection, methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) or methicillin-resistant <i>Staphylococcus epidermis</i> (MRSE) infection prescribed by an infectious disease (ID) specialist or prescribed with ID consultation (telephone consultation is acceptable) including name of the ID specialist and date of the consultation within the last 60 days <p>OR</p> <ul style="list-style-type: none"> • Documentation of a CURRENT bacterial infection with trial and failure of at least one drug from TWO of the following groups within the last 60 days: <ol style="list-style-type: none"> 1. At least one of the penicillins or cephalosporins 2. At least one of the macrolides or a ketolide 3. At least one of the fluoroquinolones 4. Trimethoprim and sulfamethoxazole 5. At least one of the tetracyclines 6. Clindamycin

Name of drug/class	Approval Criteria