

Prior Authorization Criteria (Medicare-D) (effective January 2009)

Name of drug	Approval Criteria
Altabax®	<ul style="list-style-type: none"> • Documented diagnosis of impetigo in individuals 9 months of age or older • Documentation of a trial and failure of/contraindication/intolerance/allergy to mupirocin ointment
Alvesco®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of asthma in patients 12 years of age and older • Documentation of trial and failure of or contraindication/intolerance/allergy to two of following: <ul style="list-style-type: none"> o Fluticasone-containing inhalation product o Budesonide-containing inhalation product o Triamcinolone acetonide (Azmacort) MDI
Amevive®/Raptiva®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <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
<p>Angiotensin II Receptor Blockers (ARBs)</p> <p>(Atacand®/Atacand HCT® Avapro®/Avalide® Cozaar®/Hyzaar® Micardis®/Micardis HCT® Teveten®/Teveten HCT®)</p>	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <ul style="list-style-type: none"> • Documentation of a minimum 30-day trial and failure of or intolerance to Diovan AND Benicar-containing products AND one of the following: <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

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	<p>maleate, lisinopril, moexipril HCl, fosinopril sodium, benazepril HCl, captopril, quinapril HCl) or ramipril (Altace) within the past six months</p> <p>OR</p> <ul style="list-style-type: none"> •Diagnosis of Type 2 diabetes with renal insufficiency
Azor®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <ul style="list-style-type: none"> • Documentation of at least a 30-day trial of concurrent use of olmesartan/olmesartan HCT (Benicar®/Benicar HCT®) and an amlodipine-containing product (Benicar®/Benicar HCT® requires prior authorization) <p>AND</p> <ul style="list-style-type: none"> • Documentation of non-compliance with olmesartan/olmesartan HCT (Benicar®/Benicar HCT®) and an amlodipine-containing product
Benicar®/Diovan®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</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 <p>OR</p> <ul style="list-style-type: none"> • Diagnosis of Type 2 diabetes with renal insufficiency
BiDil®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <ul style="list-style-type: none"> •Diagnosis of heart failure •Documentation of trial and failure or contraindication or intolerance to a combination isosorbide dinitrate and hydralazine product

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Byetta®	<ul style="list-style-type: none"> • Documentation of Type 2 Diabetes Mellitus with concurrent use of one of the following: <ul style="list-style-type: none"> • Metformin • A sulfonylurea • A thiazolidinedione
Caduet®/Lipitor®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <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
Celebrex®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <ul style="list-style-type: none"> • Documentation of familial adenomatous polyposis (FAP) <p>OR</p> <ul style="list-style-type: none"> • Documentation of the failure of a meloxicam-containing product and one of the following: <ul style="list-style-type: none"> ○ Documentation of the trial and failure of two additional non-steroidal anti-inflammatory drugs (NSAIDs) ○ Documentation that the individual is 65 years of age or older ○ Documentation of concurrent warfarin use (within the last 90 days) ○ Documentation of a bleeding disorder ○ Documentation of concurrent systemic steroid treatment <p>OR</p> <ul style="list-style-type: none"> • Documentation of a history of gastrointestinal bleed, peptic ulcer, gastroesophageal reflux disease (GERD), or Barrett's esophagus.

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	<p>OR</p> <ul style="list-style-type: none"> Documentation of a concomitant condition in which celecoxib (Celebrex®) offers a significant advantage over non-COX-2 selective NSAIDs and meloxicam (Mobic®).
Cesamet®	<ul style="list-style-type: none"> Documentation of chemotherapy-induced nausea and vomiting <p>AND</p> <ul style="list-style-type: none"> Documentation of trial and failure of ondansetron containing product (Zofran®) and one of the following: granisetron HCL (Kytril®) or aprepitant (Emend®)
Cymbalta®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <ul style="list-style-type: none"> Documentation of Major Depressive Disorder (MDD) <ul style="list-style-type: none"> AND 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 Fluvoxamine Paroxetine Sertraline Venlafaxine (Effexor®) Venlafaxine extended-release (XR) <p>(Effexor® XR)</p> <p>OR</p> <ul style="list-style-type: none"> Documentation of Generalized Anxiety Disorder (GAD) <ul style="list-style-type: none"> AND Documentation of the failure or intolerance to two of the following agents: <ul style="list-style-type: none"> Bupropion

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	<p>Bupropion sustained-release (SR) Bupropion extended-release (XL) Citalopram Escitalopram (Lexapro®) Fluoxetine Fluvoxamine Paroxetine Sertraline Venlafaxine (Effexor®) Venlafaxine extended-release (XR) (Effexor® XR) OR</p> <ul style="list-style-type: none"> • Documentation of neuropathic pain associated with Diabetic Peripheral Neuropathy (DPN) secondary to diabetes with documented use of any diabetic medications. <p>OR</p> <ul style="list-style-type: none"> • Diagnosis of Fibromyalgia
Daytrana®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <ul style="list-style-type: none"> • Documented diagnosis of attention deficit hyperactivity disorder (ADHD) <p>AND</p> <ul style="list-style-type: none"> • 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®) <p>AND</p> <ul style="list-style-type: none"> • Patient age is at least 6 years

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Enbrel®	<ul style="list-style-type: none"> • Documentation of one of the following diagnoses: adult rheumatoid arthritis, polyarticular-course juvenile rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, adult plaque psoriasis, arthritis related to inflammatory bowel disease, arthritis related to Reiter's disease, arthritis related to other postinfectious syndromes • Patient age at least 2 years • Prescribed by a rheumatologist or dermatologist
Exforge®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <ul style="list-style-type: none"> • Documentation of at least a 30-day trial of concurrent therapy of Valsartan/Valsartan HCT (Diovan®/Diovan HCT®) and an amlodipine-containing product (Diovan®/Diovan HCT® requires prior authorization) <p>AND</p> <ul style="list-style-type: none"> • Documentation of non-compliance with valsartan/valsartan HCT (Diovan®/Diovan HCT®) and an amlodipine-containing product
Exjade®	<p>Deferasirox (Exjade®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of chronic iron overload due to blood transfusions • Individual is 2 years of age or older • Serum ferritin levels consistently greater than 1000 mcg/L (as demonstrated with at least two lab values within the previous two months)
Fentora®	<ul style="list-style-type: none"> • Documentation of a diagnosis of breakthrough pain in individuals with cancer who are already receiving opioid therapy <p>AND</p> <ul style="list-style-type: none"> • Documentation of tolerance to current opioid therapy (ie, adherence to one of the following

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	<p>regimens for one week or longer):</p> <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 <p>AND</p> <ul style="list-style-type: none"> • Documentation of a trial and failure of oral transmucosal fentanyl citrate (Actiq®) for at least one week or longer
Forteo®	<p>Documentation of primary (postmenopausal) or hypogonadal osteoporosis when all of the following criteria are met:</p> <ul style="list-style-type: none"> •The individual is receiving supplemental treatment with vitamin D and calcium. •The individual has osteoporotic fractures •Multiple risk factors for fractures <p>•The individual is intolerant of or failing to respond to at least one of the following therapies for osteoporosis:</p> <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®	<p>Imatinib mesylate (Gleevec®) is approved when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of acute lymphoblastic leukemia (ALL) • Documentation of a diagnosis of aggressive systemic mastocytosis (ASM)

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	<ul style="list-style-type: none"> • Documentation of a diagnosis of chronic myeloid leukemia (CML) • Documentation of a diagnosis of dermatofibrosarcoma protuberans (DFSP) • Documentation of a diagnosis of gastrointestinal stromal tumors (GIST) • Documentation of a diagnosis of hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL) • Documentation of a diagnosis of myelodysplastic/myeloproliferative diseases (MDS/MPD) • Documentation of a diagnosis of neoplastic disease with documentation of the failure of conventional therapy
Glumetza®	<ul style="list-style-type: none"> • Documentation of type 2 diabetes mellitus <p>AND</p> <ul style="list-style-type: none"> • Documentation of the trial and failure of or intolerance/allergy/contraindication to either metformin IR- or metformin ER-containing products
Growth Hormone	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p>
Humira®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <ul style="list-style-type: none"> •Patient is at least 4 years •Prescribed by a Rheumatologist, Dermatologist or Gastroenterologist
Increlex®	<ul style="list-style-type: none"> • Documented diagnosis of growth failure in children who have severe primary insulin-like growth factor-1 deficiency (primary IGFD) or growth failure in children who have growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH • The individual has a height standard deviation score of less than or equal to 3.0 SD scores below normal (growing at or below the third percentile for age and sex).

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	<ul style="list-style-type: none"> • The individual has a basal IGF-1 standard deviation score of less than or equal to 3.0 SD scores below normal (based on age and sex related reference ranges). • The individual has normal or elevated growth hormone (GH) (based on a GH stimulation testing) or (for children with GH gene deletion) measured titers of GH-neutralizing antibodies • The individual has open epiphyses (bone growth plates) (bone age less than 14 years for girls and less than 16 years for boys) • The individual is two years of age or older • The individual has been prescribed Increlex™ (mecasermin) by an endocrinologist or pediatric endocrinologist • Exclusion criteria: Individuals who have active or suspected neoplasia
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: <ul style="list-style-type: none"> ○ Aripiprazole (Abilify®) ○ Risperidone (Risperdal®) ○ Quetiapine fumarate (Seroquel®) ○ An olanzapine-containing product
Iressa®	<ul style="list-style-type: none"> • The individual was documented as previously benefiting from gefitinib (Iressa®) therapy before September 15, 2005 and has registered through the Iressa Access Program to continue therapy.
Janumet®/Januvia®	<ul style="list-style-type: none"> • Documentation of Type 2 Diabetes Mellitus (DM) • Documentation of one of the following: <ul style="list-style-type: none"> ○ Current concomitant therapy of both sitagliptin and metformin ○ Current treatment with metformin and trial/failure with one of the following: <ul style="list-style-type: none"> ▪ Thiazolidinedione

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	<ul style="list-style-type: none"> ▪ Sulfonylurea
Kineret®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <ul style="list-style-type: none"> • Patient is at least 18 years • Prescribed by a Rheumatologist
Lyrica®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <p>Pregabalin (Lyrica®) is approved when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of neuropathic pain that is associated with diabetic peripheral neuropathy (DPN) secondary to diabetes • Documentation of add-on therapy for partial onset epileptic seizures in adults with trial and failure or contraindication/intolerance/allergy to gabapentin • Documentation of diagnosis of postherpetic neuralgia with trial and failure or contraindication/intolerance/allergy to gabapentin • Documentation of diagnosis of fibromyalgia • Documentation of diagnosis of non-diabetic neuropathic pain with trial and failure or contraindication/intolerance/allergy to gabapentin and any three of the following medications: <ul style="list-style-type: none"> ○ An opioid containing product ○ Tramadol ○ A tricyclic antidepressant ○ A lidocaine-containing product ○ Carbamazepine ○ A venlafaxine-containing
Magnacet®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p>

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	<ul style="list-style-type: none"> Documentation of the trial and failure/intolerance to an oxycodone/acetaminophen-containing product with 325 mg of acetaminophen Documentation of the reason why an oxycodone/acetaminophen-containing product with greater than 400 mg of acetaminophen would not be appropriate
Mobic®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <ul style="list-style-type: none"> Documentation of the trial and failure/contraindication to generic meloxicam
Nexavar®	<p>Sorafenib (Nexavar®) is approved when one the following inclusion criteria is met:</p> <ul style="list-style-type: none"> Documentation of advanced renal cell carcinoma Documentation of unresectable hepatocellular carcinoma
Nexium®/Prevacid®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <ul style="list-style-type: none"> A documented trial and failure or contraindication/intolerance/allergy to a prescription generic omeprazole lasting at least 14 days
Noxafil®	<ul style="list-style-type: none"> Use in prophylaxis of invasive Aspergillus and Candida infections due to a severe immunocompromised state <p>OR</p> <ul style="list-style-type: none"> Use in the treatment of invasive Aspergillus and Candida infections due to a severe immunocompromised state after trial and failure of voriconazole (Vfend®) <p>OR</p> <ul style="list-style-type: none"> Diagnosis of oropharyngeal candidiasis with failed

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	<p>trials of itraconazole and fluconazole.</p>
<p>Omnaris®</p>	<ul style="list-style-type: none"> • Documentation that the individual is 6 years of age or older with a diagnosis of seasonal allergic rhinitis or perennial allergic rhinitis <p>AND</p> <ul style="list-style-type: none"> • Documentation of a trial and failure of or intolerance/contraindication/allergy to a fluticasone propionate containing nasal product <p>AND</p> <ul style="list-style-type: none"> • Documentation of a trial and failure of or intolerance/contraindication/allergy to one of the following: <ul style="list-style-type: none"> ○ Mometasone furoate monohydrate (Nasonex®) ○ Triamcinolone acetonide (Nasacort® AQ)
<p>Opana®</p>	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <ul style="list-style-type: none"> • Documentation of the trial and failure of or contraindication/allergy/intolerance to at least 2 of the following: <ul style="list-style-type: none"> ○ Oxycodone IR-containing product ○ Codeine phosphate ○ Hydromorphone ○ Morphine sulfate IR <p>OR</p> <ul style="list-style-type: none"> • Authorization for oxymorphone extended-release (ER) (Opana ER®)
<p>Opana ER®</p>	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <ul style="list-style-type: none"> • Documentation of the trial and failure of or contraindication/allergy/intolerance to both of the following:

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	<ul style="list-style-type: none"> ○ Oxycodone ER ○ Morphine sulfate sustained-release (SR) <p>OR</p> <ul style="list-style-type: none"> • Authorization for oxymorphone IR (Opana®)
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™	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <ul style="list-style-type: none"> • Documentation of allergic conjunctivitis • Documentation of trial and failure or contraindication to all of the following agents: <ul style="list-style-type: none"> ○ olopatadine hydrochloride ophthalmic solution (Patanol™) ○ azelastine hydrochloride ophthalmic solution (Optivar™)
Prevacid Naprapac®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p>
Pristiq™	<ul style="list-style-type: none"> • Documentation of a diagnosis of major depressive disorder • Documentation of a trial and failure/intolerance to two of the following agents: <ul style="list-style-type: none"> ○ A bupropion containing product ○ Citalopram ○ Escitalopram (Lexapro®) ○ Fluoxetine ○ Fluvoxamine ○ Paroxetine ○ Sertraline ○ A venlafaxine containing product
Proton Pump Inhibitors	<ul style="list-style-type: none"> • Documentation of any of the indications specified for

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(Aciphex®, Prevacid® Orally Disintegrating tablets, Prevacid Granules for Oral Suspension, Nexium® Oral Suspension, Protonix®, Pylera®, Zegerid®)	<p>the drug</p> <p>AND</p> <ul style="list-style-type: none"> • A documented trial and failure or contraindication/intolerance/allergy to a generic omeprazole lasting at least 14 days <p>AND</p> <ul style="list-style-type: none"> • A documented trial of products containing esomeprazole (Nexium®) and lansoprazole (Prevacid®)
Provigil®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <ul style="list-style-type: none"> • Diagnosis of narcolepsy, idiopathic hypersomnia, or obstructive sleep apnea/hypopnea syndrome with recommendation of modafinil (Provigil®) by a neurologist or sleep specialist and a report of a sleep study supporting such diagnosis <p>OR</p> <ul style="list-style-type: none"> • Diagnosis of shift work sleep disorder when all of the following inclusion criteria are met: <ul style="list-style-type: none"> ○ Patient has a primary complaint of insomnia or excessive sleepiness temporally associated with a work period that occurs during the habitual sleep phase OR Polysomnography and the multiple sleep latency test (MSLT) demonstrate loss of a normal sleep wake pattern ○ No medical or mental disorder accounts for the symptoms ○ The symptoms do not meet criteria for any other sleep disorder producing insomnia or excessive sleepiness (e.g. time-zone change [jet lag] syndrome. <p>OR</p> <ul style="list-style-type: none"> • Diagnosis of fatigue associated with multiple sclerosis with recommendation of modafinil (Provigil®) by a neurologist
Pylera®	<ul style="list-style-type: none"> • Documented diagnosis of <i>Helicobacter pylori</i>.
Qualaquin™	<ul style="list-style-type: none"> • Documentation of uncomplicated <i>Plasmodium falciparum</i> malaria

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Ranexa®	<ul style="list-style-type: none"> • Documentation of insufficient response, intolerance, or contraindication to at least one medication from each of the following: <ul style="list-style-type: none"> ○ Long-acting nitrates: Isosorbide dinitrate, Isosorbide mononitrate, Nitroglycerin patches ○ Beta-blockers: Atenolol, Acebutolol, Carvedilol, Penbutolol, Labetalol, Pindolol, Metoprolol, Nadolol, Betaxolol, Bisoprolol, Timolol, or Propranolol ○ Calcium channel blockers: Nifedipine, Felodipine, Amlodipine, Diltiazem, or Verapamil • Documentation of concurrent treatment with one of the following: <ul style="list-style-type: none"> ○ Amlodipine ○ Beta-blockers: Atenolol, Acebutolol, Carvedilol, Penbutolol, Labetalol, Pindolol, Metoprolol, Nadolol, Betaxolol, Bisoprolol, Timolol, or Propranolol ○ Long-acting nitrates: Isosorbide dinitrate, Isosorbide mononitrate, Nitroglycerin patches
Revatio®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of pulmonary arterial hypertension • No history of a nitrate prescription being filled within the last six months
Revlimid®	<p>Lenalidomide (Revlimid®) is approved for individuals who are registered with the RevAssist(SM) Program when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • 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

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	<p>or without additional cytogenetic abnormalities</p> <ul style="list-style-type: none"> • A diagnosis of multiple myeloma in combination with dexamethasone for individuals who received at least one prior therapy (eg, stem cell transplantation, thalidomide, dexamethasone, mephalan, doxorubicin, vincristine, cyclophosphamide, carmustine, velcade)
Seroquel XR®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <p>Quetiapine fumarate (Seroquel XR®) is approved when all of the following inclusion criteria are met:</p> <ul style="list-style-type: none"> • Documented diagnosis of schizophrenia or bipolar disorder • 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
Simcor®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <ul style="list-style-type: none"> • Documentation of a minimum 30 day trial of concurrent use of a prescription niacin product and a simvastatin-containing product • Documentation of non-compliance

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Singulair®	<ul style="list-style-type: none"> • Documentation of a diagnosis of asthma in individuals 12 months of age and older <p>OR</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of allergic rhinitis in individuals 6 months 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®], levocetirizine [Xyzal®]) ○ Over-the-counter nonsedating antihistamine (eg, loratadine [Claritin®, Alavert®], cetirizine [Zyrtec®]) ○ Intranasal corticosteroid (eg, beclomethasone [Vancenase®], budesonide [Rhinocort®], fluticasone [Flonase®], mometasone [Nasonex®], triamcinolone [Nasacort®])
<p>Sleep agents (Ambien CR®, Lunesta®, Rozerem®)</p>	<p>Ambien CR and Lunesta:</p> <ul style="list-style-type: none"> • Diagnosis of insomnia <p>AND</p> <ul style="list-style-type: none"> • Documentation of a trial and failure of an immediate-release zolpidem-containing product <p>Rozerem:</p> <ul style="list-style-type: none"> • Diagnosis of insomnia <p>AND</p> <ul style="list-style-type: none"> • Documentation of abuse potential to any drug
Sprycel®	<p>Dasatinib (Sprycel®) is approved when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of CML in any phase (chronic, accelerated, myeloid, or lymphoid blast phase) with resistance or intolerance to prior therapy,

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	<p>including imatinib mesylate (Gleevec®)</p> <ul style="list-style-type: none"> • Documentation of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL) with resistance or intolerance to prior therapy, including imatinib mesylate (Gleevec®)
Sutent®	<p>Sunitinib malate (Sutent®) is approved when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of a diagnosis of gastrointestinal stromal tumors (GIST) after disease progression on imatinib mesylate (Gleevec®) or documented intolerance to imatinib mesylate (Gleevec®) • 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 • Documentation of trial and failure of or contraindication/intolerance/allergy to concurrent use of a long-acting beta2-agonist and an inhaled corticosteroid
Symlin®	<ul style="list-style-type: none"> • Documentation of type 1 diabetes with concurrent insulin therapy <p>OR</p> <ul style="list-style-type: none"> • Documentation of type 2 diabetes with concurrent therapy with insulin AND trial and failure with one of the following medications: <ul style="list-style-type: none"> ○ Metformin-containing product ○ Sulfonylurea-containing product ○ Thiazolidinedione-containing product
Taclonex®	<ul style="list-style-type: none"> • Documentation of psoriasis vulgaris in adults 18 years of age or older

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	<p>AND</p> <ul style="list-style-type: none"> Documentation of the trial and failure of/intolerance to concurrent use of calcipotriene (Dovonex®) and a topical betamethasone product
Tarceva®	<ul style="list-style-type: none"> Documentation of a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) and documentation of at least one prior chemotherapy regimen that failed or is contraindicated <p>OR</p> <ul style="list-style-type: none"> Documentation of a diagnosis of locally advanced, unresectable, or metastatic pancreatic cancer in combination with gemcitabine (Gemzar®) as a first-line therapy.
Tasigna®	<ul style="list-style-type: none"> Documentation of a diagnosis of chronic-phase or accelerated-phase Philadelphia chromosome-positive chronic myelogenous leukemia (CML) <p>AND</p> <ul style="list-style-type: none"> Documentation of resistance to or intolerance to imatinib mesylate (Gleevec®)
Tekturna®/Tekturna HCT®	<ul style="list-style-type: none"> Documented diagnosis of hypertension <p>AND</p> <ul style="list-style-type: none"> Documentation of trial and failure of or contraindication/intolerance/allergy to an ACE inhibitor <p>AND</p> <ul style="list-style-type: none"> Documentation of trial and failure of or contraindication/intolerance/allergy to Diovan- or Benicar-containing products (Diovan/Diovan HCT and Benicar/Benicar HCT require prior

Name of drug	Approval Criteria
	<p>authorization)</p> <p>AND</p> <ul style="list-style-type: none"> • Documentation of trial and failure of or contraindication/intolerance/allergy to an amlodipine- containing product
Thalomid®	<ul style="list-style-type: none"> • Documentation of acute treatment of cutaneous manifestations of moderate-to-severe erythema nodosum leprosum (ENL) • Documentation of maintenance therapy for prevention and suppression of erythema nodosum leprosum (ENL) occurrence • Documentation of first-line therapy for multiple myeloma • Documentation of a diagnosis of neoplastic disease with documented failure of conventional therapy
Treximet®	<ul style="list-style-type: none"> • Documentation of a diagnosis of migraine • Documentation of a trial and failure of concurrent therapy with Imitrex® and a naproxen-containing product
Tykerb®	<ul style="list-style-type: none"> • Documentation of advanced or metastatic breast cancer <p>AND</p> <ul style="list-style-type: none"> • Documentation of a tumor with overexpression of HER2 <p>AND</p> <ul style="list-style-type: none"> • Documentation of prior therapy with all of the following: <ul style="list-style-type: none"> ○ An anthracycline ○ A taxane ○ Trastuzumab (Herceptin®)
Ultram ER®	<ul style="list-style-type: none"> • The individual is 18 years of age or more

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	<p>AND</p> <ul style="list-style-type: none"> • The individual failed or was intolerant to a trial of at least one preferred analgesic medication indicated for moderate to moderately severe pain, such as the following: <ul style="list-style-type: none"> ○ Propoxyphene/acetaminophen (APAP) ○ Non-steroidal anti-inflammatory agents/analgesics [NSAIDs] [diflunisal, naproxen sodium, flurbiprofen, etodolac, meclufenamate ibuprofen, fenoprofen calcium, ketoprofen, nabumetone, diclofenac sodium] ○ Opioid analgesics [oxycodone/APAP, morphine sulfate, codeine phosphate, codeine sulfate, meperidine, hydromorphone, methadone, fentanyl, hydrocodone/APAP, oxycodone, oxycodone/aspirin (ASA), codeine/APAP, hydrocodone/ibuprofen] <p>AND</p> <ul style="list-style-type: none"> • Documentation of a trial and failure of or intolerance to tramadol (Ultram®)
Veramyst®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <p>Documentation of a diagnosis of seasonal or perennial allergic rhinitis and one of the following:</p> <ul style="list-style-type: none"> • Documentation that the individual is 2 or 3 years of age, with documentation of trial and failure of or intolerance/contraindication/allergy to mometasone furoate monohydrate (Nasonex®) • Documentation that the individual is 4 or 5 years of age, with documentation of trial and failure of or intolerance/contraindication/allergy to fluticasone propionate-containing nasal product and mometasone furoate monohydrate (Nasonex®) • Documentation that the individual is 6 years of age or older, with documentation of trial and failure of or intolerance/contraindication/allergy

Name of drug	Approval Criteria
	<p>to fluticasone propionate containing nasal product and one of the following:</p> <ul style="list-style-type: none"> ○ Mometasone furoate monohydrate (Nasonex®) ○ Triamcinolone acetonide (Nasacort® AQ)
Vyvanse®	<p>Lisdexamfetamine dimesylate (Vyvanse®) is approved when there is documentation of a diagnosis of attention-deficit hyperactivity disorder (ADHD) and when one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of a trial and failure or contraindication/intolerance/allergy to any two of the following medications: <ul style="list-style-type: none"> ○ A methylphenidate containing product ○ A mixed amphetamine salts containing product (eg, amphetamine-dextroamphetamine [Adderall or Adderall XR]) ○ Atomoxetine hydrochloride (Strattera®) ○ A dextroamphetamine containing product ○ Methamphetamine hydrochloride (Desoxyn®) ○ A dexmethylphenidate containing product • Documentation of a history of or a potential for drug abuse among the individual or a member of the individual's household
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 • Individuals are at least 12 years old • Documentation of positive skin test or in vitro reactivity to a perennial aeroallergen • Documentation that symptoms are inadequately

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	<p>controlled with corticosteroids administered via inhaler</p>
Xyzal®	<ul style="list-style-type: none"> • Documented diagnosis of allergic rhinitis or urticaria • Documentation of age greater than or equal to 6 years • Documentation of a two-week trial and failure of, or contraindication to, two of the following medications: <ul style="list-style-type: none"> ○ Loratadine-containing products ○ Cetirizine-containing products ○ Fexofenadine-containing products
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®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <ul style="list-style-type: none"> • Documentation of contraindication to one generic formulations of azithromycin
Zolinza®	<ul style="list-style-type: none"> • Documentation of a diagnosis of cutaneous T-cell lymphoma (CTCL) • Documentation of the trial and failure of, or contraindication to, at least two systemic therapies
Zyvox®	<p>Covered Use(s): all FDA-approved indications not otherwise excluded from Part D.</p> <p>Linezolid (Zyvox®) is approved when at least one of the following inclusion criteria is met:</p> <ul style="list-style-type: none"> • Documentation of a current diagnosis of vancomycin-resistant Enterococcus faecium (VRE) infection, methicillin-resistant Staphylococcus aureus (MRSA) or methicillin-

Name of drug	Approval Criteria
	<p>resistant Staphylococcus epidermis (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> <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: <ul style="list-style-type: none"> ○ At least one of the penicillins or cephalosporins ○ At least one of the macrolides or a ketolide ○ At least one of the fluoroquinolones ○ Trimethoprim and sulfamethoxazole ○ At least one of the tetracyclines ○ Clindamycin • Coverage duration: 28 days