



**2012 Prior Authorization Criteria**

Prior Authorization Group	Affected Drugs	Covered Uses	Exclusions	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ESRD Therapy	Aranesp	All medically accepted uses not otherwise excluded from Part D	N/A	Hemoglobin less than 10 g/dl for patients receiving Cancer Chemotherapy and Hemoglobin less than 12 and Hematacrit less than 33 for other approved FDA indications in addition to supporting statement of diagnosis from physician	None	None	3 months	N/A
	Procrit							
Fentanyl	Fentanyl Patch	All medically accepted uses not otherwise excluded from Part D	N/A	Supporting statement of diagnosis from the physician	None	None	12/31/2012	N/A
	Fentora Tab							
Growth Hormone	Humatrope	All medically accepted uses not otherwise excluded from Part D	N/A	Supporting statement of diagnosis from the physician	None	None	12/31/2012	N/A
	Humatrope Combo Pack							
	Nutropin							
	Nutropin AQ							
	Saizen							
Saizen Click Easy								
Provigil	Provigil	All medically accepted uses not otherwise excluded from Part D	N/A	Supporting statement of diagnosis from the physician	None	None	12/31/2012	N/A
Revatio	Revatio	All medically accepted uses not otherwise excluded from Part D	N/A	Supporting statement of diagnosis from the physician	None	None	12/31/2012	N/A
Samsca	Samsca	All medically accepted uses not otherwise excluded from Part D	N/A	Supporting statement of diagnosis from the physician	None	None	12/31/2012	N/A
Tretinoin	Tretinoin Cream	All medically accepted uses not otherwise excluded from Part D	N/A	Supporting statement of diagnosis from the physician	None	None	12/31/2012	N/A
	Tretinoin Gel							

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Part B/D Drugs (A-C)	ALBUTEROL SULFATE	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.	N/A	N/A	N/A	N/A	N/A	N/A
	ALBUTEROL SULFATE/IPRATRO							
	AMINOSYN							
	AMINOSYN 8.5%/ELECTROLYTE							
	AMINOSYN II							
	AMINOSYN II 3.5%/DEXTROSE							
	AMINOSYN II 3.5%/DEXTROSE							
	AMINOSYN II 4.25%/DEXTROSE							
	AMINOSYN II 5%/DEXTROSE 25							
	AMINOSYN II 8.5%/ELECTROL							
	AMINOSYN II M 3.5%/DEXTRO							
	AMINOSYN M							
	AMINOSYN-HBC							
	AMINOSYN-HF							
	AMINOSYN-PF							
	AMINOSYN-PF 7%							
	AMPHOTERICIN B							
	AMPICILLIN 100 MG/ML /							
	SULBACTAM 50 MG/ML							
	ATGAM							
	AZATHIOPRINE							
	CALCITONIN-SALMON							
	CALCITRIOL							
	CARIMUNE NANOFILTERED							
	CELLCEPT							
	CELLCEPT INTRAVENOUS							
	CLINIMIX 2.75%/DEXTROSE 5							
	CLINIMIX 4.25%/DEXTROSE 1							
	CLINIMIX 4.25%/DEXTROSE 2							
	CLINIMIX 4.25%/DEXTROSE 5							
	CLINIMIX 5%/DEXTROSE 15%							
	CLINIMIX 5%/DEXTROSE 20%							
CLINIMIX 5%/DEXTROSE 25%								
CLINIMIX E 2.75%/DEXTROSE								
CLINIMIX E 4.25%/DEXTROSE								
CLINIMIX E 5%/DEXTROSE 15								
CLINIMIX E 5%/DEXTROSE 20								
CLINIMIX E 5%/DEXTROSE 25								
CLINISOL SF 15%								
CROMOLYN SODIUM								
CYCLOSPORINE								

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Part B/D Drugs (C-Z)	CYCLOSPORINE MODIFIED	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.	N/A	N/A	N/A	N/A	N/A	N/A
	DAUNOXOME 2MG/ML							
	DEXRAZOXANE 10 MG/ML INJ SOLN							
	DOXYCYCLINE 10 MG/ML INJECTABLE SOLUTION							
	DRONABINOL							
	FORTICAL							
	FREAMINE III							
	FREAMINE III 3%							
	GAMASTAN S/D							
	GAMMAGARD LIQUID							
	GANCICLOVIR 50MG/ML							
	GENGRAF							
	GRANISETRON HCL							
	HEPATAMINE							
	INVANZ 313 MG/ML INJ SOLN							
	IPRATROPIUM BROMIDE							
	JEVTANA 10 MG/ML							
	LEUCOVORIN INJ SOLN							
	LEVOCARNITINE							
	METHOTREXATE							
	METHOTREXATE SODIUM							
	MYCOPHENOLATE MOFETIL							
	NEPHRAMINE							
	ONDANSETRON HCL							
	ONDANSETRON ODT							
	ORTHOCLONE OKT3							
	PREMASOL							
	PROCALAMINE							
	PROGRAF							
	PULMICORT							
PULMOZYME INHALANT SOLN								
RAPAMUNE								
THYMOGLOBULIN								
TOBI								
TRAVASOL								
VANCOCIN HCL								
VANCOMYCIN HCL								
VENTAVIS 0.01 MG/ML INHALANT SOLN								
VIVAGLOBIN								
ZEMPLAR								
ZORTRESS								

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