

Prior Authorization Drugs

Certain drugs require you to get prior authorization (prior approval) which means that your doctor or health care provider will need to contact CareSource before you fill your prescription. Without the necessary information on the Prior Authorization request, we may not cover the drug. Please refer to your Evidence of Coverage for details on how to request a Prior Authorization.

To see if one or more of the drugs you are taking requires prior authorization, type the name of the drug in the Search box below.

5HT3 ANTI-NAUSEA AGENT BVD DETERMINATION

Drug Name: GRANISETRON HCL, GRANISOL, ONDANSETRON HCL, ONDANSETRON ODT

Covered Uses: 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.

APREPITANT BVD DETERMINATION

Drug Name: EMEND

Covered Uses: 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.

BECAPLERMIN

Drug Name: REGRANEX

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria: NON-DIABETIC. KNOWN NEOPLASM AT APPLICATION SITE. PRESSURE OR VENOUS STASIS ULCERS. ULCER DOES NOT EXTEND THROUGH DERMIS.

Prescriber Restrictions: VASCULAR SURGEON, PODIATRIST, ENDOCRINOLOGIST OR PHYSICIAN PRACTICING IN A SPECIALTY WOUND CLINIC ONLY

Coverage Duration: 3 MONTHS

BENZYL ALCOHOL

Drug Name: ULESFIA

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

Age Restrictions: 6 MONTHS AND OLDER

Coverage Duration: 1 MONTH

Other Criteria: UP TO 2724 GRAMS

CALCINEURIN INHIBITORS

Drug Name: ELIDEL, PROTOPIC

Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria: NOT TRIED/FAILED OR INTOLERABLE ADVERSE EFFECTS TO TOPICAL CORTICOSTEROIDS

Age Restrictions: PROTOPIC 0.03%: PATIENT AGE GREATER THAN OR EQUAL TO 2 YEARS OLD. PROTOPIC 0.1%: PATIENT AGE GREATER THAN OR EQUAL TO 15 YEARS OLD

Coverage Duration: 12 MONTHS

CYCLOSPORINE OPHTHALMIC

Drug Name: RESTASIS

Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

Required Medical Information: KERATOCONJUNCTIVITIS SICCA (KCS) OR DRY EYE DISEASE

Prescriber Restrictions: OPHTHALMOLOGIST, OPTOMETRIST, RHEUMATOLOGIST

Coverage Duration: 12 MONTHS

DALFAMPRIDINE

Drug Name: AMPYRA

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Prescriber Restrictions: NEUROLOGIST

Coverage Duration: 12 MONTHS

DARBEPOETIN

Drug Name: ARANESP

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria: ANEMIA ASSOCIATED WITH CHRONIC RENAL FAILURE: HEMOGLOBIN GREATER THAN OR EQUAL TO 12G/DL. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CHEMOTHERAPY: HEMOGLOBIN GREATER THAN OR EQUAL TO 10G/DL

Coverage Duration: RENAL FAILURE:12 MONTHS CANCER CHEMOTHERPY:COURSE OF TREATMENT BASED ON CHEMOTHERAPY CYCLE.

ELTROMBOPAG

Drug Name: PROMACTA

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria: INITIAL: ADEQUATE RESPONSE TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR SUFFICIENT RESPONSE TO SPLENECTOMY, RENEWAL: NO CLINICAL RESPONSE AS DEFINED BY AN INCREASE IN PLATELET COUNT OF GREATER THAN OR EQUAL TO $50 \times 10^9/L$ AT THE MAX DOSE OF 75MG PER DAY FOR 4 WEEKS

Coverage Duration: INITIAL:1 MONTH RENEWAL: NO RESPONSE AFTER INITIAL:1 MONTH AT MAX DOSE, IF RESPONSE: 12 MONTHS.

EPOETIN ALFA

Drug Name: EPOGEN, PROCRIT

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria: CHRONIC RENAL FAILURE: HEMOGLOBIN EQUAL TO OR GREATER THAN 10 G/DL IF NOT UNDERGOING DIALYSIS OR GREATER THAN OR EQUAL TO 12 IF ON DIALYSIS. PATIENTS WITH ANEMIA RELATED TO AZT THERAPY: HEMOGLOBIN EQUAL TO OR GREATER THAN 12 G/DL. ANEMIA DUE TO CONCOMITANTLY ADMINISTERED CHEMOTHERAPY: HEMOGLOBIN EQUAL TO OR GREATER THAN 10 G/DL. PATIENTS SCHEDULED FOR ELECTIVE, NONCARDIAC SURGERY, NONVASCULAR SURGERY: HEMOGLOBULIN GREATER THAN 13 G/DL

Coverage Duration: ANEMIA FROM CHRONIC RENAL FAILURE/AZT/CHEMOTHERAPY:12 MONTHS, ANEMIA FROM ELECTIVE SURGERY: 21 DAYS

FENTANYL TRANSDERMAL PATCH

Drug Name: FENTANYL

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria: PATIENT ABLE TO TAKE OR HAS NOT FAILED ORAL LONG-ACTING OPIOID NARCOTIC ANALGESICS.

Required Medical Information: PATIENT IS RECEIVING DAILY, AROUND-THE-CLOCK PAIN MEDICATION FOR AT LEAST ONE WEEK

Coverage Duration: 12 MONTHS

FENTANYL TRANSMUCOSAL AGENTS

Drug Name: FENTANYL CITRATE, FENTORA, ONSOLIS

Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

Required Medical Information: CANCER: ON A MAINTENANCE DOSE OF CONTROLLED- RELEASE PAIN MEDICATION, AND EITHER A TRIAL AND FAILURE OF 1 IMMEDIATE-RELEASE ORAL PAIN AGENT OR DIFFICULTY SWALLOWING TABLETS/CAPSULES

Coverage Duration: 6 MONTHS

FONDAPARINUX

Drug Name: ARIXTRA

Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria: ACUTE DVT/PE TREATMENT: IS STABILIZED ON WARFARIN AND HAS ESTABLISHED AN ORAL ANTICOAGULANT EFFECT WITH A THERAPEUTIC INR BETWEEN 2 TO 3.

Coverage Duration: HIP REPLACEMENT/FRACTURE SURGERY UP TO 33 DAYS KNEE/ABDOMINAL SURGERY/DVT/PE TREATMENT UP TO 14 DAYS

HEPATITIS A VACCINE (INACTIVATED) BVD DETERMINATION

Drug Name: HAVRIX, VAQTA

Covered Uses: 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

Drug Name: ENGERIX-B, RECOMBIVAX HB

Covered Uses: 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.

IMIQUIMOD

Drug Name: IMIQUIMOD

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria: PERIANAL GENITAL WARTS: PATIENT HAS NOT TRIED/FAILED CONDYLOX. NON-HYPERKERATOTIC, NON-HYPERTROPHIC ACTINIC KERATOSES ON THE FACE OR SCALP: HAS NOT TRIED/FAILED OR CONTRAINDICATION TO TOPICAL 5-FLUOROURACIL. SUPERFICIAL BASAL CELL CARCINOMA: GREATER THAN 2CM IN SIZE AND ON THE FACE

Age Restrictions: EXTERNAL GENITAL OR PERIANAL WARTS: GREATER THAN OR EQUAL TO 12 YEARS OF AGE. ACTINIC KERATOSIS: GREATER THAN OR EQUAL TO 18 YEARS OF AGE

Prescriber Restrictions: ACTINIC KERATOSIS: DERMATOLOGIST ONLY. SUPERFICIAL BASAL CELL CARCINOMA: DERMATOLOGIST OR ONCOLOGIST ONLY.

Coverage Duration: 4 MONTHS

Other Criteria: CRITERIA APPLIES TO NEW STARTS ONLY

IMMUNE GLOBULIN BVD DETERMINATION

Drug Name: CARIMUNE NF NANOFILTERED, FLEBOGAMMA DIF, GAMASTAN S-D, GAMMAGARD LIQUID, GAMUNEX, OCTAGAM, POLYGAM S-D, PRIVIGEN, VIVAGLOBIN

Covered Uses: 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.

IMMUNOSUPPRESSANT BVD DETERMINATION

Drug Name: AZATHIOPRINE, AZATHIOPRINE SODIUM, CELLCEPT, CYCLOSPORINE, CYCLOSPORINE MODIFIED, GENGRAF, MYCOPHENOLATE MOFETIL, MYFORTIC, ORTHOCLONE OKT-3, PROGRAF, RAPAMUNE, SIMULECT, TACROLIMUS, TORISEL, ZENAPAX

Covered Uses: 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

Drug Name: ABELCET, ACYCLOVIR SODIUM, ADRIAMYCIN, AMBISOME, AMPHOTEC, AMPHOTERICIN B, BLEOMYCIN SULFATE, CLADRIBINE, CYCLOPHOSPHAMIDE, CYTARABINE, CYTOVENE, DOXIL, DOXORUBICIN HCL, FLUOROURACIL, FOSCARNET SODIUM, HERCEPTIN, IFOSFAMIDE, IFOSFAMIDE-MESNA, METHOTREXATE, MITOMYCIN, REMICADE, REMODULIN, VINBLASTINE SULFATE, VINCRISTINE SULFATE

Covered Uses: 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.

LOW MOLECULAR WEIGHT HEPARIN AGENTS

Drug Name: INNOHEP

Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria: ALL LMWH: CURRENTLY ON WARFARIN AND SCHEDULED FOR MINOR SURGERY OR MAJOR SURGERY AND HAS A THERAPEUTIC INR (GREATER THAN 2 FOR AT LEAST 2 DAYS).

Required Medical Information: ALL AGENTS: PREGNANCY TEST, INR.

CANCER:LIFETIME HIP REPLACEMENT/FRACTURE SURGERY UP TO 30 DAYS OTHER FDA INDICATIONS UP TO 17 DAYS

MEASLES VIRUS LIVE VACCINE BVD DETERMINATION

Drug Name: ATTENUVAX VACCINE WITH DILUENT

Covered Uses: 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.

METHYLNALTREXONE

Drug Name: RELISTOR

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria: NOT ON PALLIATIVE CARE OR LIFE EXPECTANCY OF GREATER THAN 6 MONTHS

Required Medical Information: CONSTIPATION DUE TO OPIOIDS

Coverage Duration: UP TO 6 MONTHS

MODAFINIL

Drug Name: PROVIGIL

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CHRONIC FATIGUE SYNDROME RELATED TO MULTIPLE SCLEROSIS.

Exclusion Criteria: OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME: NO TRIAL OF CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP). NARCOLEPSY: NO TRIAL/FAILURE OF OR CONTRAINDICATION TO AMPHETAMINE, DEXTROAMPHETAMINE AND/OR METHYLPHENIDATE.

Coverage Duration: 12 MONTHS

MODAFINIL AND ARMODAFINIL

Drug Name: NUVIGIL

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria: OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME: NO TRIAL OF CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP). NARCOLEPSY: NO TRIAL/FAILURE OR CONTRAINDICATION TO AMPHETAMINE, DEXTROAMPHETAMINE AND/OR METHYLPHENIDATE.

Coverage Duration: 12 MONTHS

OFATUMUMAB

Drug Name: ARZERRA

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria: CHRONIC LYMPHOCYTIC LEUKEMIA: NO FAILED TREATMENT WITH FLUDARABINE AND ALEMTUZUMAB

Coverage Duration: 6 MONTHS

OMALIZUMAB

Drug Name: XOLAIR

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

Required Medical Information: INITIAL: PATIENT MEETS THE CRITERIA OF MODERATE TO SEVERE ASTHMA, POSITIVE SKIN PRICK OR RAST TEST, NON-SMOKER, FEV1 LESS THAN 80%, DEMONSTRATED INADEQUATELY CONTROLLED SYMPTOMS ON INHALED CORTICOSTEROIDS AND SECOND ASTHMA CONTROLLER, BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30 IU/ML. RENEWAL: PATIENT REDUCED EXACERBATIONS BY AT LEAST 25% FROM BASELINE, REDUCTION IN ORAL OR INHALED CORTICOSTEROID USE FROM BASELINE.

Age Restrictions: PATIENT 12 YEARS OF AGE OR OLDER

Prescriber Restrictions: SPECIALIST IN ALLERGY OR PULMONARY MEDICINE ONLY

Coverage Duration: 12 MONTHS

PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

Drug Name: ADCIRCA, REVATIO

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

Required Medical Information: PULMONARY ARTERIAL HYPERTENSION: WHO CLASS I-IV SYMPTOMS

Prescriber Restrictions: CARDIOLOGIST OR PULMONOLOGIST

Coverage Duration: 12 MONTHS

Other Criteria: 2 TABLETS PER DAY PER MONTH

PLERIXAFOR

Drug Name: MOZOBIL

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

Required Medical Information: USE IN COMBINATION WITH GRANULOCYTE-COLONY STIMULATING FACTOR (G-CSF) TO MOBILIZE HEMATOPOIETIC STEM CELLS TO THE PERIPHERAL BLOOD FOR COLLECTION AND SUBSEQUENT AUTOLOGOUS TRANSPLANTATION IN PATIENTS WITH NON-HODGKIN'S LYMPHOMA AND MULTIPLE MYELOMA

Prescriber Restrictions: HEMATOLOGIST OR ONCOLOGIST

Coverage Duration: 4 DOSES (UP TO 8 VIALS) FOR ONE FILL

QUININE SULFATE

Drug Name: QUALAQUIN

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

Coverage Duration: 12 MONTHS

RABIES VACCINE BVD DETERMINATION

Drug Name: IMOVAX RABIES VACCINE, RABAVERT

Covered Uses: 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.

RANOLAZINE

Drug Name: RANEXA

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

Coverage Duration: 12 MONTHS

Other Criteria: PATIENT HAS NOT TRIED/FAILED OR HAVE CONTRAINDICATION TO 1 ANTI-ANGINA AGENT (BETA-BLOCKER, AMLODIPINE, NIFEDIPINE, ISOSORBIDE, OR LONG ACTING NITROGLYCERIN).

SAPROPTERIN

Drug Name: KUVAN

Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria: INITIAL: HAS NOT TRIED DIETARY MODIFICATIONS RENEWAL: PATIENT HAS NOT ACHIEVED AT LEAST 20% REDUCTION IN BLOOD PHENYLALANINE WITH INITIAL TREATMENT

Prescriber Restrictions: ENDOCRINOLOGIST ONLY

Coverage Duration: INITIAL USE: 4 WEEKS. CONTINUED USE: 6 MONTHS

SOMATROPIN

Drug Name: GENOTROPIN, HUMATROPE, NORDITROPIN NORDIFLEX, NUTROPIN, NUTROPIN AQ, OMNITROPE, SAIZEN, SEROSTIM, TEV-TROPIN, ZORBTIVE

Covered Uses: ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria: ATHLETIC ENHANCEMENT OR ANTI-AGING PURPOSE. GROWTH FAILURE DUE TO CHRONIC RENAL INSUFFICIENCY(CRI) IF PATIENT HAS HAD A RENAL TRANSPLANT

Required Medical Information: FOR GROWTH FAILURE DUE TO (CRI): PATIENT HAS NOT UN-

DERGONE A RENAL TRANSPLANT, PATIENT'S HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER, LACK OF RESPONSE FROM PREVIOUS YEAR, PATIENT HAS REACHED 50TH PERCENTILE FOR TARGET HEIGHT FOLLOWING GROWTH HORMONE THERAPY. FOR HIV/WASTING: THE PATIENT ON ANTIRETROVIRAL THERAPY, MEETS SPECIFIED CRITERIA OF WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, 7.5% OVER 6 MONTHS, 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN) OR 23% (WOMEN) OF TOTAL BODY WT. AND A BODY MASS INDEX (BMI) LESS THAN 27KG/M², OR BMI LESS THAN 20KG/M². IF CURRENTLY ON GROWTH HORMONE, PATIENT HAS SHOWN CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT OR IF NOT ON GROWTH HORMONE, PATIENT HAS HAD INADEQUATE RESPONSE TO PREVIOUS THERAPY. FOR SHORT-BOWEL SYNDROME: CURRENTLY ON SPECIALIZED NUTRITIONAL SUPPORT

Coverage Duration: HIV/AIDS: 3 MONTHS. SHORT BOWEL: 4 WEEK ONCE. ALL OTHER DIAGNOSES: 12 MONTHS.

TESTOSTERONE AGENTS

Drug Name: ANDRODERM, ANDROGEL, TESTIM, TESTOSTERONE, TESTOSTERONE CYPIONATE

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria: FEMALE, UNLESS DIAGNOSED WITH METASTATIC BREAST CANCER.

Required Medical Information: MALE HYPOGONADISM CONFIRMED BY EITHER: 1) LABORATORY CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL OF LESS THAN 250NG/DL (8.7NMOL/L) OBTAINED WITHIN 90 DAYS, OR 2) LABORATORY CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL BETWEEN 250NG/DL AND 350NG/DL (12NMOL/L) TOGETHER WITH A FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 50NG/L (174 PMOL/L) OR 3) MALE DELAYED PUBERTY NOT SECONDARY TO PATHOLOGY.

Coverage Duration: 12 MONTHS

TETANUS TOXOID VACCINE BVD DETERMINATION

Drug Name: TETANUS TOXOID ADSORBED

Covered Uses: 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.

TOTAL PARENTERAL NUTRITION AGENT BVD DETERMINATION

Drug Name: AMINOSYN, AMINOSYN II, AMINOSYN II 3.5% M-DEXTROSE 5%, AMINOSYN II 3.5%-DEXTROSE 25%, AMINOSYN II 3.5%-DEXTROSE 5%, AMINOSYN II 4.25% M-DEXT 10%, AMINOSYN II 4.25%-DEXTROSE 25%, AMINOSYN II 5% IN 25% DEXTROSE, AMINOSYN II IN DEXTROSE, AMINOSYN II W/ELEC IN DEX W/CA, AMINOSYN M, AMINOSYN W/ELECTROLYTES, AMINOSYN-HBC, AMINOSYN-HF, AMINOSYN-PF, CLINIMIX, CLINIMIX E, CLINISOL, DEXTROSE

10%-1/4NS, DEXTROSE IN WATER, DEXTROSE WITH SODIUM CHLORIDE, FREAMINE HBC, FREAMINE III, FREAMINE III WITH ELECTROLYTES, HEPATAMINE, HEPATASOL, INTRALIPID, LIPO-SYN II, LIPOSYN III, NEPHRAMINE, NOVAMINE, PREMASOL, PROCALAMINE, PROSOL, QUICK MIX WITH LYTES, RENAMIN, TRAVASOL, TRAVASOL W/ELECTROLYTES, TRAVASOL WITH DEXTROSE, TRAVASOL WITH ELECTROLYTES, TROPHAMINE

Covered Uses: 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.

USTEKINUMAB

Drug Name: STELARA

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria: INITIAL: PLAQUE PSORIASIS: LESS THAN 10% BODY SURFACE AREA OR PASI SCORE LESS THAN 12. NO TRIAL/FAILURE OF PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORIN. RENEWAL: PHYSICIAN'S GLOBAL ASSESMENT GREATER THAN 1 OR LESS THAN 50% DECREASE IN PASI SCORE.

Required Medical Information: WEIGHT GREATER THAN 100KG (220LBS).

Prescriber Restrictions: DERMATOLOGIST OR RHEUMATOLOGIST

Coverage Duration: INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS

VALGANCICLOVIR

Drug Name: VALCYTE

Covered Uses: ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria: OVER 16 YEARS OF AGE AND ABLE TO TOLERATE ORAL MEDICATIONS

Required Medical Information: PREVENTION OF CYTOMEGALOVIRUS: FOLLOWING KIDNEY OR HEART TRANSPLANT OR TREATMENT OF CYTOME GALOVIRUS RETINITIS: AIDS

Coverage Duration: 6 MONTHS