



**CareAdvantage (HMO SNP)  
2012 Formulary Supplement I  
(List of Covered Drugs)**

**Prior Authorization (PA)  
Criteria**  
(Criteria for PA Required Drugs)

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	ABATACEPT
Drug Name	ORENCIA Injectable Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION THAT PATIENT HAS HAD AN INADEQUATE RESPONSE OR INTOLERANT TO ANY OF THE TNF ANTAGONIST AGENTS - ENBREL, HUMIRA, REMICADE, CIMZIA.
Age Restrictions	
Prescriber Restrictions	RHEUMATOLOGISTS.
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>ABIRATERONE ACETATE</b>
Drug Name	ZYTIGA Oral Tablet
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DIAGNOSIS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	ADALIMUMAB
Drug Name	
PA Type	
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

**\*This Prior Authorization (PA) Criterion is currently under review by Medicare.\***

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	AGALSIDASE
Drug Name	FABRAZYME Injectable Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	ALEFACEPT
Drug Name	
PA Type	
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

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**KEY**

**PA Type:**

1 = PA Applies

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3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	ALGLUCERASE
Drug Name	CEREDASE Injectable Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

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3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	ALISKIREN
Drug Name	TEKTURNA Oral Tablet
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE THAT PATIENT HAS TRIED AND FAILED ON AN ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR AND ANGIOTENSIN RECEPTOR (ARB) BLOCKER.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

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3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>ALISKIREN HCT</b>
Drug Name	TEKTURNA HCT 300/25 Oral Tablet   TEKTURNA HCT 300/12.5 Oral Tablet   TEKTURNA HCT 150/25 Oral Tablet   TEKTURNA HCT 150/12.5 Oral Tablet
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE THAT PATIENT HAS TRIED AND FAILED ON AN ANGIOTENSIN CONVERTING ENZYME (ACE) INHIBITOR AND ANGIOTENSIN RECEPTOR (ARB) BLOCKER.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

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**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>ALOSETRON</b>
Drug Name	LOTRONEX Oral Tablet
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	MALE PATIENTS WILL BE EXCLUDED.
Required Medical Information	
Age Restrictions	18 YEARS AND OLDER
Prescriber Restrictions	GASTROINTESTINAL SPECIALISTS.
Coverage Duration	APPROVED FOR 2 MONTHS MAXIMUM FOR INITIAL THERAPY, AND UP TO 12 MONTHS FOR CONTINUING TREATMENT.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

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3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	ALPHA-1 PROTEINASE INHIBITOR
Drug Name	
PA Type	
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

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**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>AMBRISENTAN</b>
Drug Name	LETAIRIS Oral Tablet
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE PATIENT HAS TRIED AND FAILED SILDENAFIL (REVATIO).
Age Restrictions	
Prescriber Restrictions	CARDIOLOGISTS, PULMONOLOGISTS.
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

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3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	ANAKINRA
Drug Name	
PA Type	
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

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**KEY**

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**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	ANIDULAFUNGIN
Drug Name	ERAXIS Injectable Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	LABORATORY REQUIREMENT - CULTURE AND SENSITIVITY OF FUNGAL ORGANISM.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 3 MONTH.
Other Criteria	

**KEY**

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**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	ANTIEMETICS, MISC
Drug Name	
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

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**PA Type:**

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**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>ANTINEOPLASTICS</b>
Drug Name	ERBITUX Injectable Solution   AVASTIN Injectable Solution
PA Type	2
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

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**PA Type:**

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**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	APREPITANT
Drug Name	
PA Type	
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	

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2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Other Criteria	
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**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>ASENA PINE</b>
Drug Name	SAPHRIS Sublingual Tablet
PA Type	2
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	FOR ASENA PINE (DISINTEGRATING TABLETS), DOCUMENTATION IS REQUIRED TO INDICATE PATIENT HAS DIFFICULTY IN SWALLOWING, OR HAS TRIED AND FAILED ONE FORMULARY ATYPICAL ANTIPSYCHOTIC AGENT SUCH AS REGULAR RELEASE RISPERIDONE TABLET OR RISPERIDONE SOLUTION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

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3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>ATORVASTATIN</b>
Drug Name	LIPITOR Oral Tablet
PA Type	1
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE THAT A PATIENT HAS TRIED AND FAILED ANY ONE OF THE FOLLOWING AGENTS LOVASTATIN, PRAVASTATIN, OR SIMVASTATIN. IF APPROVABLE, PILL SPLITTING OF LIPITOR WILL BE ENFORCED OR APPLIED ON THE REQUEST. ALSO, DOCUMENTATION TO INCLUDE IF PATIENT IS AFFECTED BY PHYSICAL DISABILITIES OR BLINDNESS, OR IF PATIENT RESIDES IN A LONG TERM CARE FACILITY, THEN THE APPROVAL WOULD BE FOR ONE TABLET PER DAY. TABLET SPLITTING IS EXCLUDED FOR THESE PATIENTS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED OPEN ENDED.
Other Criteria	

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**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>ATYPICAL ANTIPSYCHOTICS</b> <b>*This Prior Authorization (PA) Criterion is currently under review by Medicare.*</b>
Drug Name	
PA Type	
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	

**KEY**

**PA Type:**

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3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prescriber Restrictions	
Coverage Duration	
Other Criteria	

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**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>BASILIXIMAB</b>
Drug Name	SIMULECT Injectable Solution
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED OPEN ENDED.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

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**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>BECAPLERMIN</b>
Drug Name	
PA Type	
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

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**KEY**

**PA Type:**

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**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>BOSENTAN</b>
Drug Name	TRACLEER Oral Tablet
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE PATIENT HAS TRIED AND FAILED SILDENAFIL (RENETIO).
Age Restrictions	
Prescriber Restrictions	CARDIOLOGISTS, PULMONOLOGISTS.
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

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**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>BUPRENORPHINE</b>
Drug Name	
PA Type	<b>1</b>
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE PATIENT IS UNDERGOING PSYCHOSOCIAL COUNSELING IN ADDITION TO A DIAGNOSIS OF OPIOID ADDICTION.
Age Restrictions	
Prescriber Restrictions	PHYSICIAN MUST HAVE DATA 2000 WAIVER WITH A UNIQUE ID NUMBER, AND A DEA IDENTIFICATION NUMBER
Coverage Duration	APPROVED FOR UP TO 3 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

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**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>BUPRENORPHINE/ NALOXONE</b>
Drug Name	SUBOXONE Sublingual Tablet
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE PATIENT IS UNDERGOING PSYCHOSOCIAL COUNSELING IN ADDITION TO A DIAGNOSIS OF OPIOID ADDICTION.
Age Restrictions	
Prescriber Restrictions	PHYSICIAN MUST HAVE DATA 2000 WAIVER WITH A UNIQUE ID NUMBER, AND A DEA IDENTIFICATION NUMBER
Coverage Duration	APPROVED FOR UP TO 3 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

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**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>CABAZITAXEL</b>
Drug Name	JEVTANA Injectable Solution
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DIAGNOSIS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>CALCITONIN</b>
Drug Name	MIACALCIN Injectable Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED OPEN ENDED FOR OSTEOPOROSIS/OSTEOPENIA, AND PAGET'S DISEASE, AND 1 MONTH FOR HYPERCALCEMIA.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>CASPOFUNGIN</b>
Drug Name	CANCIDAS Injectable Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	LABORATORY REQUIREMENT - CULTURE AND SENSITIVITY OF FUNGAL ORGANISM.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	CHANTIX
Drug Name	CHANTIX Oral Tablet
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE PATIENT IS CURRENTLY ENROLLED IN A SMOKING CESSATION PROGRAM OR HAVE A PLAN OF ONGOING COUNSELING. A COPY OF AN ENROLLMENT CERTIFICATE MUST BE PRODUCED. OTHER DOCUMENTATION REQUIRED INCLUDES TRIAL AND FAILURE OF NICOTINE PATCHES OR ORAL BUPROPION (ZYBAN).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 WEEKS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	CHORIONIC GONADOTROPIN
Drug Name	
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR TOTAL OF 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>CICLOPIROX</b>
Drug Name	
PA Type	<b>1</b>
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	LABORATORY TEST - RESULT OF THE POTASSIUM HYDROXIDE (KOH) TEST. POSITIVE KOH TEST WOULD CONFIRM DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>CLOZAPINE TBDP</b>
Drug Name	FAZACLO Disintegrating Tablet
PA Type	2
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE PATIENT HAS INADEQUATE RESPONSE OR INTOLERANCE TO REGULAR RELEASE CLOZAPINE. EXPLANATION OF SPECIFIC RESULTS AND OUTCOMES WITH CLOZAPINE THERAPY REQUIRED.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

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3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>DARBEPOETIN</b>
Drug Name	ARANESP Prefilled Syringe   ARANESP Injectable Solution
PA Type	1
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	FOR CANCER RELATED CONDITIONS, HEMOGLOBIN LEVEL GREATER THAN 10 G/DL (PRETREATMENT LEVEL). FOR CHRONIC RENAL FAILURE CONDITIONS, HEMOGLOBIN LEVEL GREATER THAN 12 G/DL.
Required Medical Information	LABORATORY TEST - COMPLETE BLOOD COUNT INDICATING HEMOGLOBIN LEVEL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED 4 WEEKS FOR CANCER RELATED DIAGNOSIS. APPROVED 6 MONS FOR CRF.
Other Criteria	

**KEY**

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1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>DAUNORUBICIN LIPOSOME</b>
Drug Name	DAUNOXOME Injectable Solution
PA Type	2
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DIAGNOSIS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

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**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>DECITABINE</b>
Drug Name	DACOGEN Injectable Solution
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

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**PA Type:**

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**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	DENOSUMAB - XGEVA
Drug Name	XGEVA Injectable Solution
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

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**PA Type:**

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**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>DESVENLAFAXINE</b>
Drug Name	PRISTIQ Extended Release Tablet
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE THAT PATIENT HAS TRIED AND FAILED (OR INTOLERANT TO) VENLAFAXINE (IMMEDIATE-RELEASE, OR EXTENDED RELEASE) THERAPY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION, AND OPEN ENDED ON RENEWAL.
Other Criteria	

**KEY**

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3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	DORNASE
Drug Name	PULMOZYME Inhalant Solution
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED OPEN ENDED.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>DRONABINOL</b>
Drug Name	
PA Type	<b>1</b>
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	FOR CANCER CHEMOTHERAPY-INDUCED NAUSEA AND VOMITTING - DOCUMENTATION REQUIRED TO SHOW PATIENT HAS HAD AN INADEQUATE RESPONSE TO ONE OR MORE ANTINAUSEANTS SUCH AS ONDANSETRON, GRANISETRON, OR PROCHLORPERAZINE . FOR APETITE STIMULATION IN AIDS PATIENTS ù DOCUMENTATION THAT TREATMENT IS FOR ANOREXIA ASSOCIATED WITH WEIGHT LOSS IN PATIENTS WITH AIDS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>DRONEDARONE</b>
Drug Name	MULTAQ Oral Tablet
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION TO INDICATE PATIENT HAS TRIED AND FAILED AMIODARONE.
Age Restrictions	
Prescriber Restrictions	CARDIOLOGIST
Coverage Duration	APPROVED UP TO 12 MONTHS
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>EPLERENONE</b>
Drug Name	
PA Type	<b>1</b>
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE PATIENT HAS TRIED AND FAILED SPIRONOLACTONE OR INTOLERANT TO TREATMENT WITH SPIRONOLACTONE DUE TO HYPERSENSITIVITY REACTION TO SPIRONOLACTONE, GYNECOMASTIA OR BREAST PAIN.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>ERIBULIN MESYLATE</b>
Drug Name	HALAVEN Injectable Solution
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DIAGNOSIS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	ERLOTINIB
Drug Name	TARCEVA Oral Tablet
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>ERYTHROPOIETIN</b>
Drug Name	PROCRIT Injectable Solution   EPOGEN Injectable Solution
PA Type	1
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	FOR CANCER RELATED CONDITIONS, HEMOGLOBIN LEVEL GREATER THAN 10 G/DL (PRETREATMENT LEVEL). FOR CHRONIC RENAL FAILURE CONDITIONS, HEMOGLOBIN LEVEL GREATER THAN 12 G/DL.
Required Medical Information	LABORATORY TEST - COMPLETE BLOOD COUNT INDICATING HEMOGLOBIN LEVEL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED 4 WEEKS FOR CANCER RELATED DIAGNOSIS. APPROVED 6 MONS FOR CRF.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	ETANERCEPT
Drug Name	
PA Type	
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

**\*This Prior Authorization (PA) Criterion is currently under review by Medicare.\***

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>EVEROLIMUS - ZORTRESS</b>
Drug Name	ZORTRESS Oral Tablet
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DIAGNOSIS
Age Restrictions	
Prescriber Restrictions	TRANSPLANT SPECIALIST
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>EXENATIDE</b>
Drug Name	BYETTA Prefilled Syringe
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE THAT PATIENT HAS HAD PREVIOUS TREATMENT AND FAILURE ON TWO OR MORE OF THE FIRST LINE DIABETIC AGENTS SUCH AS METFORMIN, SULFONYLUREAS, AVANDIA, AND INSULIN PREPARATIONS. RECENT LABORATORY LEVELS SUCH AS HEMOGLOBIN A1C, FASTING BLOOD GLUCOSE SHOULD BE DOCUMENTED.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>EZETIMIBE</b>
Drug Name	ZETIA Oral Tablet
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE THAT PATIENT HAS TRIED AND FAILED ON MAXIMUM DOSE STATIN THERAPY SUCH AS ANY ONE OF THE FOLLOWING DRUGS - LOVASTATIN, SIMVASTATIN, OR PRAVASTATIN, OR IF PATIENT IS INTOLERANT TO STATINS, OR HAS EXPERIENCED ADR SUCH AS MUSCLE PAIN OR RHABDOMYOLYSIS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED OPEN ENDED.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	EZETIMIBE/SIMVASTATIN
Drug Name	VYTORIN Oral Tablet
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE THAT PATIENT HAS TRIED AND FAILED ON A HIGH POTENCY STATIN SUCH AS LIPITOR 80 MG, OR CRESTOR 40 MG.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED OPEN ENDED.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>FILGRASTIM</b>
Drug Name	NEUPOGEN Prefilled Syringe   NEUPOGEN Injectable Solution
PA Type	1
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	LABORATORY TEST - COMPLETE BLOOD COUNT PANEL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>GEFITINIB</b>
Drug Name	IRESSA Oral Tablet
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 3 MONTHS FOR INITIAL REQUEST. APPROVED FOR UP TO 1 YEAR ON RENEWAL.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	GEODON
Drug Name	GEODON Injectable Solution
PA Type	2
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>GLATIRAMER</b>
Drug Name	COPAXONE Prefilled Syringe
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	NEUROLOGIST
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>ILOPERIDONE</b>
Drug Name	FANAPT TITRATION PACK Pack   FANAPT Oral Tablet
PA Type	2
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION IS REQUIRED TO INDICATE PATIENT HAS TRIED AND FAILED ONE FORMULARY ATYPICAL ANTIPSYCHOTIC AGENT SUCH AS RISPERIDONE, OLANZAPINE, ARIPIRAZOLE, OR ZIPRASIDONE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>IMATINIB</b>
Drug Name	GLEEVEC Oral Tablet
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>IMIGLUCERASE</b>
Drug Name	CEREZYME Injectable Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO STATE THE SIGNS AND SYMPTOMS PATIENT IS EXPERIENCING, AND COMPLETE BLOOD COUNT PANEL IS REQUIRED.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	IMMUNOGLOBULINS IV
Drug Name	GAMUNEX Injectable Solution   GAMMAGARD Injectable Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DIAGNOSIS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>INFLIXIMAB</b>
Drug Name	REMICADE Injectable Solution
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	FOR RHEUMATOID ARTHRITIS, DOCUMENTATION REQUIRED TO INDICATE PATIENT HAS INADEQUATE RESPONSE OR INABILITY TO TOLERATE METHOTREXATE, AND PATIENT HAS TRIED AND FAILED ONE OF THE FOLLOWING AGENTS SUCH AS ENBREL, HUMIRA, OR ARAVA AS PRIOR TREATMENT. FOR CROHN'S DISEASE, DOCUMENTATION REQUIRED TO INDICATE PATIENT HAS INADEQUATE RESPONSE TO ORAL CORTICOSTEROIDS. FOR ULCERATIVE COLITIS DISEASE, DOCUMENTATION REQUIRED TO INDICATE PATIENT HAS INADEQUATE RESPONSE TO TWO OR MORE OF THE FOLLOWING AGENTS - ORAL CORTICOSTEROIDS, SULFASALAZINE, AZULFIDINE, ASACOL, PENTASA, ROWASA, DIPENTUM, COLAZAL. FOR ANKYLOSING SPONDYLITIS AND OTHER SPONDYLOARTHROPATHIES, DOCUMENTATION REQUIRED TO INDICATE PATIENT HAS TRIED AND FAILED A NON-STEROIDAL ANTIINFLAMMATORY DRUG (NSAID), AND ONE OF THE FOLLOWING AGENTS - ENBREL, OR HUMIRA.
Age Restrictions	
Prescriber Restrictions	RHEUMATOLOGISTS, GASTROINTESTINAL

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

	SPECIALISTS, DERMATOLOGISTS
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	INTERFERON ALFA-2B
Drug Name	
PA Type	
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

**\*This Prior Authorization (PA) Criterion is currently under review by Medicare.\***

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	INTERFERON ALFACON-1
Drug Name	
PA Type	
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

**\*This Prior Authorization (PA) Criterion is currently under review by Medicare.\***

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>INTERFERON GAMMA-1B</b>
Drug Name	ACTIMMUNE Injectable Solution
PA Type	2
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	ITRACONAZOLE
Drug Name	SPORANOX Oral Solution
PA Type	1
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	FOR ONYCHOMYCOSIS/TINEA UNGUIUM, A KOH LABORATORY TEST IS REQUIRED TO CONFIRM DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS TO A YEAR.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>IXABEPILONE</b>
Drug Name	IXEMPRA Injectable Solution
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	documentation required to indicate that patient has metastatic or locally advanced cancer whose tumors are resistant or refractory to anthracyclines, taxanes, and capecitabine, and in combination with capecitabine in patients with metastatic or locally advanced breast cancer resistant to treatment with an anthracycline and a taxane or whose cancer is taxane resistant and for whom further anthracycline therapy is contraindicated
Age Restrictions	
Prescriber Restrictions	ONCOLOGIST
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	LANREOTIDE
Drug Name	SOMATULINE Prefilled Syringe
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION TO INDICATE PATIENT HAS TRIED AND FAILED OCTREOTIDE THERAPY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 1 YEAR.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	LAPATINIB
Drug Name	
PA Type	
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

**\*This Prior Authorization (PA) Criterion is currently under review by Medicare.\***

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	LARONIDASE
Drug Name	ALDURAZYME Injectable Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	LIDOCAINE PATCH
Drug Name	LIDODERM Transdermal Patch
PA Type	1
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE PATIENT HAS TRIED AND FAILED ON TWO OF THE FOLLING AGENTS - LIDOCAINE OINTMENT, TRICYCLIC ANTIDEPRESSANTS (AMITRIPILINE, NORTRIPTILINE), GABAPENTIN, OR CYMBALTA.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>LIRAGLUTIDE</b>
Drug Name	VICTOZA Prefilled Syringe
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE THAT PATIENT HAS HAD PREVIOUS TREATMENT AND FAILURE ON TWO OR MORE OF THE FIRST LINE DIABETIC AGENTS SUCH AS METFORMIN, SULFONYLUREAS, AVANDIA, AND INSULIN PREPARATIONS. RECENT LABORATORY LEVELS SUCH AS HEMOGLOBIN A1C, FASTING BLOOD GLUCOSE SHOULD BE DOCUMENTED.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	LUBIPROSTONE
Drug Name	
PA Type	
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

**\*This Prior Authorization (PA) Criterion is currently under review by Medicare.\***

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>MECASERMIN</b>
Drug Name	INCRELEX Injectable Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DIAGNOSIS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 1 YEAR.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>METHOCARBAMOL</b>
Drug Name	ROBAXIN Injectable Solution
PA Type	1
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>METHOXSALEN</b>
Drug Name	UVADEX Injectable Solution
PA Type	2
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>methylnaltrexone</b>
Drug Name	RELISTOR Injectable Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE PATIENT HAS INADEQUATE RESPONSE OR INTOLERANCE TO FIRST LINE LAXATIVE AGENTS SUCH AS DOCUSATE, SENNA, OR LACTULOSE SYRUP.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>NILOTINIB</b>
Drug Name	TASIGNA Oral Capsule
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE THAT PATIENT HAS TRIED AND FAILED (OR INTOLERANT TO) IMATINIB (GLEEVEC) THERAPY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>OCTREOTIDE</b>
Drug Name	SANDOSTATIN Injectable Suspension
PA Type	1
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR 6 MONTHS UP TO 1 YEAR.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>OFATUMUMAB</b>
Drug Name	ARZERRA Injectable Solution
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE THAT PATIENT HAS TRIED AND FAILED FLUDARABINE, OR ALEMTUZUMAB.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
 Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>OMALIZUMAB</b> <b>*This Prior Authorization (PA) Criterion is currently under review by Medicare.*</b>
Drug Name	
PA Type	
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prescriber Restrictions	
Coverage Duration	
Other Criteria	

**\*This Prior Authorization (PA) Criterion is currently under review by Medicare.\***

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	OPRELVEKIN
Drug Name	
PA Type	
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

**\*This Prior Authorization (PA) Criterion is currently under review by Medicare.\***

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	ORPHENADRINE
Drug Name	
PA Type	1
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO STATE PATIENT IS USING THIS AGENT AS AN ADJUNCT THERAPY SUCH AS REST, PHYSICAL THERAPY, OR OTHER MEASURES FOR RELIEF OF MUSCLE SPASM ASSOCIATED WITH PAINFUL MUSCULOSKELETON CONDITIONS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	OXYMETHOLONE
Drug Name	ANADROL-50 Oral Tablet
PA Type	1
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	PALIFERMIN
Drug Name	KEPIVANCE Injectable Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>PALIPERIDONE</b>
Drug Name	INVEGA Extended Release Tablet
PA Type	2
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE PATIENT HAS INADEQUATE RESPONSE OR INTOLERANCE TO REGULAR RELEASE RISPERIDONE (RISPERDAL). EXPLANATION OF SPECIFIC RESULTS AND OUTCOMES WITH RISPERDAL THERAPY REQUIRED.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>PALIPERIDONE INJECTION</b>
Drug Name	INVEGA Prefilled Syringe
PA Type	2
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE PATIENT HAS TRIED AND FAILED HALOPERIDOL DECONOATE OR FLUPHENAZINE DECONOATE INJECTIONS, AND HISTORY OF REPEATED HOSPITALIZATION DUE TO NONCOMPLIANCE OR DIFFICULTY IN SWALLOWING ORAL ANTIPSYCHOTICS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>PANITUMUMAB</b>
Drug Name	VECTIBIX Injectable Solution
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ONCOLOGIST
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	PAZOPANIB
Drug Name	VOTRIENT Oral Tablet
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	PEGADEMASE
Drug Name	ADAGEN Injectable Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	PEGFILGRASTIM
Drug Name	NEULASTA Prefilled Syringe
PA Type	1
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	LABORATORY TEST - COMPLETE BLOOD COUNT PANEL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	PEGINTERFERON ALFA-2A
Drug Name	PEGASYS Prefilled Syringe
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	LABORATORY LEVELS REQUIRED - HCV RNA LEVELS, AST/ALT LEVELS, VIRAL GENOTYPE. BIOPSY RESULTS OF LIVER IS PREFERABLY DOCUMENTED IF AVAILABLE.
Age Restrictions	
Prescriber Restrictions	GASTROENTEROLOGISTS, HEPATOLOGISTS, TRANSPLANT SPECIALISTS, INFECTIOUS DISEASE SPECIALISTS
Coverage Duration	APPROVED FOR 6 MONTHS UP TO 1 YEAR.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	PEGINTERFERON ALFA-2B
Drug Name	PEGINTRON Prefilled Syringe   PEGINTRON Injectable Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	LABORATORY LEVELS REQUIRED - HCV RNA LEVELS, AST/ALT LEVELS, VIRAL GENOTYPE. BIOPSY RESULTS OF LIVER IS PREFERRABLY DOCUMENTED IF AVAILABLE.
Age Restrictions	
Prescriber Restrictions	GASTROENTEROLOGISTS, HEPATOLOGISTS, TRANSPLANT SPECIALISTS, INFECTIOUS DISEASE SPECIALISTS
Coverage Duration	APPROVED FOR 6 MONTHS UP TO 1 YEAR.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	PEGVISOMANT
Drug Name	SOMAVERT Injectable Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>PRAMLINTIDE ACETATE</b>
Drug Name	SYMLIN Injectable Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE THAT PATIENT HAS HAD PREVIOUS TREATMENT AND FAILURE ON TWO OR MORE OF THE FIRST LINE DIABETIC AGENTS SUCH AS METFORMIN, SULFONYLUREAS, AVANDIA, AND INSULIN PREPARATIONS. RECENT LABORATORY LEVELS SUCH AS HEMOGLOBIN A1C, FASTING BLOOD GLUCOSE SHOULD BE DOCUMENTED.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	RASBURICASE
Drug Name	ELITEK Injectable Solution
PA Type	1
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 7 DAYS PER TREATMENT.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	RILONACEPT
Drug Name	ARCALYST Injectable Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DIAGNOSIS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 1 YEAR.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	ROSUVASTATIN
Drug Name	CRESTOR Oral Tablet
PA Type	1
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE THAT A PATIENT HAS TRIED AND FAILED ANY ONE OF THE FOLLOWING AGENTS LOVASTATIN, PRAVASTATIN, OR SIMVASTATIN. IF APPROVABLE, PILL SPLITTING OF ROSUVASTATIN WILL BE ENFORCED OR APPLIED ON THE REQUEST. ALSO, DOCUMENTATION TO INCLUDE IF PATIENT IS AFFECTED BY PHYSICAL DISABILITIES OR BLINDNESS, OR IF PATIENT RESIDES IN A LONG TERM CARE FACILITY, THEN THE APPROVAL WOULD BE FOR ONE TABLET PER DAY. TABLET SPLITTING IS EXCLUDED FOR THESE PATIENTS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	SAPROPTERIN
Drug Name	KUVAN Oral Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DIAGNOSIS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 1 YEAR.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>SARGRAMOSTIM</b>
Drug Name	LEUKINE Injectable Solution
PA Type	1
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	LABORATORY TEST - COMPLETE BLOOD COUNT PANEL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 3 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>SAXAGLIPTIN</b>
Drug Name	ONGLYZA Oral Tablet
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE THAT PATIENT HAS HAD PREVIOUS TREATMENT AND FAILURE ON TWO OR MORE OF THE FIRST LINE DIABETIC AGENTS SUCH AS METFORMIN, SULFONYLUREAS, AVANDIA OR ACTOS, AND INSULIN PREPARATIONS. RECENT LABORATORY LEVELS SUCH AS HEMOGLOBIN A1C, FASTING BLOOD GLUCOSE SHOULD BE DOCUMENTED.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>SITAGLIPTIN PHOSPHATE</b>
Drug Name	JANUVIA Oral Tablet
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE THAT PATIENT HAS HAD PREVIOUS TREATMENT AND FAILURE ON TWO OR MORE OF THE FIRST LINE DIABETIC AGENTS SUCH AS METFORMIN, SULFONYLUREAS, AVANDIA OR ACTOS, AND INSULIN PREPARATIONS. RECENT LABORATORY LEVELS SUCH AS HEMOGLOBIN A1C, FASTING BLOOD GLUCOSE SHOULD BE DOCUMENTED.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>SITAGLIPTIN PHOSPHATE - METFORMIN</b>
Drug Name	JANUMET 50/500 Oral Tablet   JANUMET 50/1000 Oral Tablet
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE THAT PATIENT HAS HAD PREVIOUS TREATMENT AND FAILURE ON TWO OR MORE OF THE FIRST LINE DIABETIC AGENTS SUCH AS METFORMIN, SULFONYLUREAS, AVANDIA OR ACTOS, AND INSULIN PREPARATIONS. RECENT LABORATORY LEVELS SUCH AS HEMOGLOBIN A1C, FASTING BLOOD GLUCOSE SHOULD BE DOCUMENTED.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>SMOKING CESSATION</b>
Drug Name	NICOTROL Nasal Inhaler   NICOTROL Inhalant Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE PATIENT IS CURRENTLY ENROLLED IN A SMOKING CESSATION PROGRAM OR HAVE A PLAN OF ONGOING COUNSELING. A COPY OF AN ENROLLMENT CERTIFICATE MUST BE PRODUCED. OTHER DOCUMENTATION REQUIRED INCLUDES TRIAL AND FAILURE OF BUPROPION SR, AND INFORMATION ON HOW MANY 12-WEEK TREATMENTS HAD PATIENT COMPLETED IN THE PAST YEAR.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 WEEKS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>SODIUM OXYBATE</b>
Drug Name	XYREM Oral Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 3 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>SOMATROPIN</b>
Drug Name	ZORBTIVE Injectable Solution   TEV TROPIN Injectable Solution   SEROSTIM Injectable Solution   SAIZEN Prefilled Syringe   SAIZEN Injectable Solution   OMNITROPE Injectable Solution   NUTROPIN Prefilled Syringe   NUTROPIN Injectable Solution   NORDITROPIN Prefilled Syringe   HUMATROPE Injectable Solution   GENOTROPIN Prefilled Syringe
PA Type	1
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 1 YEAR.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>SUNITINIB MALATE</b>
Drug Name	SUTENT Oral Capsule
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE THAT PATIENT WITH DIAGNOSIS OF GIST HAS TRIED AND FAILED (OR INTOLERANT TO) IMATINIB (GLEEVEC) THERAPY. DOCUMENTATION REQUIRED FOR PATIENT USING DRUG TO TREAT ADVANCED RENAL CELL CARCINOMA.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>TADALAFIL</b>
Drug Name	ADCIRCA Oral Tablet
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	NOT FOR USE IN ERECTILE DYSFUNCTION.
Required Medical Information	DIAGNOSIS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	TERIPARATIDE
Drug Name	
PA Type	
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

**\*This Prior Authorization (PA) Criterion is currently under review by Medicare.\***

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>TESTOSTERONE</b>
Drug Name	TESTIM Topical Gel   STRIANT Buccal Film   ANDROGEL Topical Gel   ANDRODERM Transdermal Patch
PA Type	1
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>TETRABENAZINE</b>
Drug Name	XENAZINE Oral Tablet
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DIAGNOSIS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>TOBRAMYCIN AMPUL-NEB</b>
Drug Name	TOBI Inhalant Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR OPEN ENDED.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	TRANEXAMIC ACID
Drug Name	CYKLOKAPRON Injectable Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 8 DAYS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>TRASTUZUMAB</b>
Drug Name	HERCEPTIN Injectable Solution
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ONCOLOGIST
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	treprostinil
Drug Name	
PA Type	
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

**\*This Prior Authorization (PA) Criterion is currently under review by Medicare.\***

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>TRETINOIN, TOPICAL</b>
Drug Name	RETIN-A Topical Gel   AVITA Topical Gel   AVITA Topical Cream
PA Type	1
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	COSMETIC CONDITIONS SUCH AS HYPERPIGMENTATION (AGE SPOTS), WRINKLES, TACTILE ROUGHNESS OF SKIN, SUN DAMAGE.
Required Medical Information	FOR ACNE VULGARIS, DOCUMENTATION REQUIRED TO INDICATE THE PATIENT HAS TRIED AND FAILED 2 PREFERRED FORMULARY ALTERNATIVES (AN ORAL ANTIBIOTIC SUCH AS TETRACYCLINE, DOXYCLINE OR MINOCYCLINE, AND A TOPICAL AGENT SUCH AS BENZOYL PEROXIDE, ERYTHROMYCIN, OR CLINDAMYCIN).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	TRIPTORELIN
Drug Name	TRELSTAR Injectable Suspension
PA Type	2
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 12 MONTHS DURATION.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>VIGABATRIN POWDER</b>
Drug Name	SABRIL Oral Solution
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	1 MONTH TO 2 YEARS OLD
Prescriber Restrictions	NEUROLOGIST ENROLLED IN SHARE PROGRAM
Coverage Duration	APPROVED FOR UP TO 1 YEAR.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>VIGABATRIN TABLET</b>
Drug Name	SABRIL Oral Tablet
PA Type	2
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTATION REQUIRED TO INDICATE THAT PATIENT IS CURRENTLY ON A SEIZURE MEDICATION, AND HAS TRIED AND FAILED TWO COMMON FIRST LINE COMPLEX PARTIAL SEIZURE AGENTS, SUCH AS CARBAMAZEPINE, FELBAMATE, GABAPENTIN, LEVETIRACETAM, TOPIRAMATE, VALPROPATE, WITHOUT ADEQUATE CONTROL.
Age Restrictions	16 YEARS AND OLDER
Prescriber Restrictions	NEUROLOGIST ENROLLED IN SHARE PROGRAM
Coverage Duration	APPROVED FOR UP TO 1 YEAR.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies

**2012 CareAdvantage Formulary – Supplement 1  
Prior Authorization Criteria – CMS approved 08/10/11**

Prior Authorization Group Description	<b>VORICONAZOLE</b>
Drug Name	VFEND Injectable Solution
PA Type	1
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	LABORATORY REQUIREMENT - CULTURE AND SENSITIVITY OF FUNGAL ORGANISM.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	APPROVED FOR UP TO 6 MONTHS.
Other Criteria	

**KEY**

**PA Type:**

1 = PA Applies

2 = PA Applies to NEW STARTS only

3 = Part B vs Part D Determination PA only Applies