

**Drugs That Require Prior Authorization (PA)  
Before Being Approved for Coverage**

You will need authorization by your **First United American -- Select(PDP)** before filling prescriptions for the drugs shown in the chart below. The First United American -- Select(PDP) will only provide coverage after it determines that the drug is being prescribed according to the criteria specified in the chart. You, your appointed representative, or your prescriber can request prior authorization by calling First United American toll free at 1-866-524-4171, hours of operation are from 8 am to 8 pm in your time zone. Customer Service is available in English and other languages. TTY/TDD users should call 1-866-524-4172.

<b><u>PRIOR AUTHORIZATION MEDICATIONS</u></b>	
<b><u>ACTIMMUNE</u></b>	
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b><u>AFINITOR</u></b>	
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Additional off-label uses covered are the treatment of advanced, unresectable neuroendocrine tumors.
<b>Exclusion Criteria</b>	Combination use with sorafenib or sunitinib.
<b>Required Medical Info</b>	Coverage for RCC is provided after failure of treatment with sunitinib or sorafenib. Coverage for SEGA is provided for patients who are not candidates for curative surgical resection.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**ALFA INTERFERONS**

<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Additional off-label uses covered are Essential thrombocythemia, Philadelphia chromosome (Ph) positive chronic phase myelogenous leukemia (CML) in a patient who is minimally pretreated (e.g., within 1 year of diagnosis), multiple myeloma and Renal cell carcinoma.
<b>Exclusion Criteria</b>	For chronic hepatitis C: contraindications such as decompensated liver disease or when used in combination with another interferon product
<b>Required Medical Info</b>	For Hepatitis C: positive hepatitis C viral load. For Kaposi sarcoma: T cell count is greater than or equal to 400/mm <sup>3</sup> or in the absence of an opportunistic infection.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For treatment of condylomata acuminata: at least ONE conventional therapy such as, (but not limited to) topical imiquimod (Aldara), podofilox (Condylox) or liquid nitrogen cryotherapy, has failed to treat the patient.

**ALFA INTERFERONS PEGYLATED**

<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	For chronic hepatitis C: contraindications such as decompensated liver disease or is using in combination with another Interferon product
<b>Required Medical Info</b>	Coverage for chronic hepatitis C is provided in the presence of a positive viral load
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**ANDROGENS**

<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Coverage is provided for females for the palliative treatment of breast cancer. Coverage is provided for males for delayed puberty or the treatment of hypogonadism in situations where the patient has a baseline (pre-treatment) serum testosterone level of less than or equal to 300 ng/dL (less than 10.4 nmol/L) OR has symptoms suggestive of androgen deficiency with a baseline free testosterone levels below the lower limit of normal.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	All indications 5 years, except delayed puberty: 6 months
<b>Other Criteria</b>	

**BUTORPHANOL NASAL SPRAY**

<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for the treatment of migraine headache pain.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Coverage for acute pain is provided in situations where the use of oral opioid therapy is not warranted or therapy with a rapid-acting agent is desirable. Coverage for migraine headache pain is provided in situations where the use of serotonin agonists or ergotamine derivatives are not warranted as determined by the prescriber.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months for migraine pain / 3 month for acute pain
<b>Other Criteria</b>	Coverage for acute pain is provided in situations where the use of oral opioid therapy is not warranted or therapy with a rapid-acting agent is desirable. Coverage for migraine headache pain is provided in situations where the use of serotonin agonists or ergotamine derivatives are not warranted as determined by the prescriber.

**CHANTIX**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Coverage is not provided for Chantix (varenicline) use in combination with bupropion or other nicotine replacement products.
<b>Required Medical Info</b>	The patient must be enrolled in a behavioral support/ modification program (e.g., community program, manufacturer sponsored program, counseling by the physician, internet, or telephone quitline).
<b>Age Restrictions</b>	The patient must be 18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

**CIMZIA**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Coverage is not provided for use of Enbrel in combination with other biologics e.g., Humira, Kineret, Remicade, etc
<b>Required Medical Info</b>	Coverage is provided in situations where the patient has been evaluated and screened for the presence of latent TB infection, where warranted, prior to initiating treatment with Cimzia. Coverage for Crohn's disease is provided in situations where the patient experienced intolerance/failure to Humira. Coverage for rheumatoid arthritis is provided in situations where the patient experienced intolerance/failure to Humira AND Enbrel
<b>Age Restrictions</b>	Patient must be 18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Crohn's - 12 months, Rheumatoid arthritis - 5 years
<b>Other Criteria</b>	Renewal coverage is provided in situations where treatment has provided clinical benefit.

<b><u>CNS STIMULANTS - DEXMETHYLPHENIDATE</u></b>	
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Coverage for ADD/ADHD is provided in situations in which the diagnosis of ADD/ADHD has been confirmed using established criteria such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) or other criteria deemed appropriate by the prescriber.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b><u>CNS STIMULANTS - DEXTROAMPHETAMINE AND SALT COMBO</u></b>	
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for depression.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Coverage for ADD/ADHD is provided in situations in which the diagnosis of ADD/ADHD has been confirmed using established criteria such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) or other criteria deemed appropriate by the prescriber. Coverage for narcolepsy is provided in situations in which there are no conditions contributing to or worsening symptoms of narcolepsy (e.g., nocturnal myoclonus, sedating drugs or drugs interfering with sleep, substance abuse, or chronic voluntary or involuntary sleep deprivation) or in situations in which the underlying conditions have been have been addressed or treated.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

<b><u>CNS STIMULANTS - METHYLPHENIDATE</u></b>	
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for depression, narcolepsy, and idiopathic hypersomnolence.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Coverage for ADD/ADHD is provided in situations in which the diagnosis of ADD/ADHD has been confirmed using established criteria such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) or other criteria deemed appropriate by the prescriber. Coverage for narcolepsy is provided in situations in which there are no conditions contributing to or worsening symptoms of narcolepsy (e.g., nocturnal myoclonus, sedating drugs or drugs interfering with sleep, substance abuse, or chronic voluntary or involuntary sleep deprivation) or in situations in which the underlying conditions have been have been addressed or treated. Coverage for idiopathic hypersomnolence is provided in situations in which the diagnosis of idiopathic hypersomnolence has been confirmed by sleep studies (polysomnography) in order to rule out disorders such as narcolepsy, obstructive sleep apnea or posttraumatic hypersomnia.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b><u>COLONY STIMULATING FACTORS</u></b>	
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for neutropenia due to other drugs, AIDS/HIV, and myelodysplasia.
<b>Exclusion Criteria</b>	Combination therapy with Neulasta, Neupogen or Leukine.
<b>Required Medical Info</b>	Patient has experienced neutropenia from previous chemotherapy OR for patient is considered to be at high risk for the development of neutropenia. Coverage is provided for: Myelodysplasia when ANC is less than or equal to 1000/mm <sup>3</sup> , Severe chronic neutropenia (i.e., Neutropenic disorder, cyclic neutropenia) when ANC is less than or equal to 1500/mm <sup>3</sup> , bone marrow transplant when ANC is less than or equal to 1000/mm <sup>3</sup> , Current or post peripheral blood progenitor cell (PBPC) mobilization/transplantation (i.e., harvesting of peripheral blood stem cells) when ANC is less than or equal to 1500/mm <sup>3</sup>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

<b><u>COLONY STIMULATING FACTORS PEGYLATED</u></b>	
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Combination therapy with Neulasta, Neupogen or Leukine. Prescriber indicates that the patient is able to receive daily injections of either Neupogen (Filgrastim) or Leukine (Sargramostim).
<b>Required Medical Info</b>	Patient has experienced neutropenia from previous chemotherapy OR for patient is considered to be at high risk for the development of neutropenia.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b><u>CRINONE</u></b>	
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Additional coverage for off-label use is provided to support established pregnancy
<b>Exclusion Criteria</b>	Coverage is not provided for infertility
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	9 months for support of established pregnancy, 12 months for secondary amenorrhea
<b>Other Criteria</b>	

**DARBEPOETIN ALFA**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for anemia secondary to myelodysplasia.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Treatment of anemia secondary to chronic renal failure or chronic renal insufficiency is covered when Hg is less than or equal to 11 g/dL OR patient is symptomatic or has required transfusion. For cancer-chemotherapy: when patient is currently receiving myelosuppressive chemotherapy OR it has been 6 weeks or less following the completion of the final dose of myelosuppressive chemotherapy AND Hg is less than or equal to 10 g/dL. For myelodysplasia related anemia when Hg is less than or equal to 11 g/dL OR when erythropoietin level is less than 500 units/L
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months - anemia due to cancer-chemotherapy, 12 months - CRF/CRI or myelodysplasia related anemia
<b>Other Criteria</b>	Renewals for CRF/CRI related anemia is provided when Hgb is less than or equal to 12 g/dl or when the dose of Aranesp will be held or titrated down. Renewals for cancer chemotherapy anemia is provided when the pt is currently on chemo or it has been 6 weeks or less since the chemo dose AND Aranesp is still being used to avoid the need for transfusions. Renewals for MDS related anemia is provided in the presence of therapeutic benefit

**DIFICID**

<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	For C. difficile associated diarrhea patient must have experienced failure or intolerance to metronidazole or oral vancomycin
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	

**ENBREL**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Coverage is not provided for use of Enbrel in combination with other biologics e.g., Humira, Kineret, Remicade, etc
<b>Required Medical Info</b>	Coverage is provided in situations where the patient has been evaluated and screened for the presence of latent TB infection, where warranted, prior to initiating treatment with Enbrel.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Renewal coverage is provided in situations where treatment has provided clinical benefit.

**EPOETIN ALFA**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for anemia secondary to HIV infection or HIV drug therapy, myelodysplasia, and chronic hepatitis C treatment from ribavirin and interferon therapy.
<b>Exclusion Criteria</b>	Coverage beyond one month of therapy is NOT provided to reduce allogenic blood transfusions in surgery patients
<b>Required Medical Info</b>	Treatment of anemia secondary to chronic renal failure or chronic renal insufficiency is covered when Hg is less than or equal to 11 g/dL OR patient is symptomatic or has required transfusion. For cancer-chemotherapy: when patient is currently receiving myelosuppressive chemotherapy OR it has been 6 weeks or less following the completion of the final dose of myelosuppressive chemotherapy AND Hg is less than or equal to 10 g/dL. For myelodysplasia related anemia when Hg is less than or equal to 11 g/dL OR when erythropoietin level is less than 500 units/L. For Reducing the need for allogenic blood transfusions in surgery patients when therapy is for elective non-vascular or non-cardiac surgery AND patient refuses or cannot undergo autologous donation prior to surgery AND Hg is less than or equal to 13 g/dL. Anemia secondary to: HIV infection or HIV drug therapy when Hg is less than or equal to 11 g/dL, OR patient is symptomatic or has required transfusion AND erythropoietin level is less than or equal to 500 units/L. Chronic Hepatitis C treatment from ribavirin and interferon therapy when Hg is less than or equal to 11 g/dL.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 month- allogenic blood transfusions, 3 months- chemotherapy, 12 months- other indications
<b>Other Criteria</b>	Renewals for CRF/CRI or Hep C treatment related anemia is provided when Hgb is less than or equal to 12 g/dl or when the dose of epoetin alpha will be held or titrated down. Renewals for cancer chemotherapy anemia is provided when the pt is currently on chemo or it has been 6 weeks or less since the chemo dose AND epoetin alpha is still being used to avoid the need for transfusions. Renewals for MDS related anemia is provided in the presence of therapeutic benefit. Renewals for HIV infections for HIV drug therapy is provided when Hct is less than or equal to 40%.

<b><u>ERIVEDGE</u></b>	
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	For locally advanced BCC, the patient must have disease reoccurrence following surgery or not be a candidate for surgery, and not be a candidate for radiation.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b><u>FENTANYL TRANSMUCOSAL</u></b>	
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Coverage is not provided for patients who are not already receiving and who not are tolerant to opioid therapy. Coverage is not provided for concurrent use with other transmucosal fentanyl products
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

## GROWTH HORMONES

<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for (note - some growth hormone drugs may be labeled for 1 or more of these indications): adult growth hormone deficiency, growth failure in children small for gestational age or with intrauterine growth retardation, idiopathic short stature, GH deficiency associated with Turner Syndrome, growth failure secondary to chronic renal failure/insufficiency in children who have not received a renal transplant, short stature associated with Noonan Syndrome, short bowel syndrome, and for the treatment of Prader-Willi Syndrome.
<b>Exclusion Criteria</b>	Coverage is not provided for constitutional delayed growth
<b>Required Medical Info</b>	<p>Pediatric GHD: epiphyses must be confirmed open in patients 10 years of age and older, AND 1. diagnosis confirmed by any 2 provocative tests or by both low IGF-1 and IGFBP-3 levels in patients who meet the height related conditions of coverage, 2. diagnosis confirmed by 2 provocative tests and both low IGF-1 and IGF-BP3 in patients not meeting height related coverage conditions, or 3. 3 pituitary hormone deficiencies in pt with irreversible hypothalamic-pituitary structural lesions or panhypopituitarism. Growth failure from CRF: PGHD criteria must be met without the provocative tests or IGF-1 and IGF-BP3 related conditions. Idiopathic Short Stature: epiphyses must be confirmed as open in patients greater than or equal 10 years of age, height must be less than or equal - 2.25 sds from the mean. Small for Gestational Age: failure to manifest catch up growth by age 2 defined as birth weight, birth length, or both that are more than 2 sds mean normal values following adjustment for age and gender. Turner's syndrome and Noonan Syndrome: epiphyses must be confirmed as open and when on therapy.</p> <p>Adult GHD: requires either 1. 1 negative GH provocative test when the AGHD is due to childhood onset GHD, pituitary or hypothalamic disease, surgery or radiation therapy, or trauma, OR 2. 3 pituitary hormone deficiencies and serum IGF-I levels below the age- and sex-appropriate reference range or 1 negative stimulation test response is required when the AGHD is due to irreversible hypothalamic-pituitary structural lesions or panhypopituitarism not acquired as a child, OR 3. 3 pituitary hormone deficiencies if adult panhypopit or irreversible hypothalamic-pituitary structural lesions are from childhood.</p>

<b>Age Restrictions</b>	7 years of age or older for Idiopathic short stature
<b>Prescriber Restrictions</b>	Pediatric endocrinologist for ISS
<b>Coverage Duration</b>	1 month for short bowel syndrome, 12 months for other indications
<b>Other Criteria</b>	Height related conditions of coverage - height below the third percentile for their age and gender related height, growth velocity subnormal greater than or equal 2 standard deviations (sds) from the age related mean, delayed skeletal maturation greater than or equal 2 sds below the age/gender related mean. Renewals for PGHD, CFR, SGA, Turner's and Noonan Syndromes require growth response of greater than or equal 4.5 cm/yr (pre-pubertal) or greater than or equal 2.5 cm/yr (post-pubertal). Renewals for short bowel syndrome is provided in the presence of clinical benefit (such as, decreasing the patient's intravenous nutritional requirements). Renewals for Prader-Willi syndrome is provided if pt has increase in lean body mass or decrease in fat mass. Renewals for ISS is provided in the presence of a growth response of greater than or equal 1.5 cm/yr. Renewals for AGHD is provided in the presence of clinical benefit.
<b><u>HUMIRA</u></b>	
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Coverage is not provided for use of Humira in combination with other biologics e.g., Enbrel, Kineret or Remicade, etc
<b>Required Medical Info</b>	Coverage is provided in situations where the patient has been evaluated and screened for the presence of latent TB infection, where warranted, prior to initiating treatment with Humira.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Renewal coverage is provided in situations where treatment has provided clinical benefit.

<b><u>IMMUNE GLOBULINS - INTRAVENOUS</u></b>	
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for post bone marrow transplantation, autoimmune hemolytic anemia, Guillain-Barre syndrome, chronic inflammatory demyelinating polyneuropathy, treatment resistant dermatomyositis, multifocal neuropathy, and myasthenia gravis.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	For Primary immune deficiency and B cell CLL - patient must have history of a recurrent bacterial infection or a single life-threatening bacterial infection AND IgG levels less than or equal to 600 mg/dL. For ITP - platelets must be less than or equal to 30,000/mm <sup>3</sup> . For bone marrow transplantation (BMT) - BMT must be performed within the previous 100 days AND patient is not also receiving CMV immune globulin
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b><u>IMMUNE GLOBULINS - SUBCUTANEOUS</u></b>	
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	For Primary immune deficiency - patient must have history of a recurrent bacterial infection or a single life-threatening bacterial infection AND IgG levels less than or equal to 600 mg/dL
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

<b><u>INCIVEK - HEP C - PROTEASE INHIBITORS</u></b>	
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Coverage is not provided for genotypes other than type 1. Duration of therapy longer than 3 months. Previous failure to Incivek or Victrelis.
<b>Required Medical Info</b>	Chronic Hep C, in patients with genotype 1 who have a quantifiable viral load. Must be used in combination with a pegylated interferon and ribavirin.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	
<b><u>INCRELEX</u></b>	
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Coverage is not provided in the presence of: concurrent treatment with growth hormone or pharmacologic doses of corticosteroids
<b>Required Medical Info</b>	Patient's height standard deviation score must be less than or equal -3.0 AND the basal IGF-1 score must be below the lower limits of normal for the reporting lab AND the patient must have normal or elevated growth hormone (except for patients with growth hormone gene deletion) AND epiphyses must be confirmed as open in patients greater than or equal 10 years of age. A growth response of greater than or equal 4.5 cm/yr (pre-pubertal growth phase) or greater than or equal 2.5 cm/yr (post-pubertal) must occur for continuation of coverage.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Coverage is provided in situations where the diagnosis of IGF-1 deficiency has been made by an endocrinologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**INLYTA**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	For RCC coverage is provided after failure with one prior systemic therapy
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**JAKAFI**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**LETAIRIS**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Coverage is provided in situations where it is being prescribed under the care or referral of a cardiologist or pulmonologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Coverage is provided for use in combination with two or more PAH therapies when treatment with one PAH agent failed to adequately control the patient's symptoms.

<b><u>MULTIPLE SCLEROSIS THERAPY</u></b>	
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for treatment at the time of a first demyelinating event.
<b>Exclusion Criteria</b>	Treatment of primary progressive MS is not covered. Combination therapy with a beta interferon product, Gilenya, or Copaxone is not covered.
<b>Required Medical Info</b>	For relapsing forms of multiple sclerosis: Patient must still either be able to walk at least a few steps or alternatively must have some functional arm/ hand use consistent with performing activities of daily living.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b><u>MULTIPLE SCLEROSIS THERAPY- GILENYA</u></b>	
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Treatment of primary progressive MS is not covered. Combination therapy with a beta interferon product or Copaxone is not covered.
<b>Required Medical Info</b>	Patient must still either be able to walk at least a few steps or alternatively must have some functional arm/ hand use consistent with performing activities of daily living.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**NEUMEGA**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Patient has experienced severe thrombocytopenia (e.g., platelet count less than equal to 20,000/mcL) from previous chemotherapy OR for patient is considered to be at high risk for the development of severe thrombocytopenia.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**NEXAVAR**

<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Additional coverage for off-label use in the treatment of gastrointestinal stromal tumors is provided.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	For GIST - coverage is provided after disease progression with imatinib and sunitinib
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

<b><u>ORENCIA - SUBCUTANEOUS</u></b>	
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Coverage is not provided for use in combination with other biologics e.g., Humira, Kineret, Remicade, etc
<b>Required Medical Info</b>	Coverage is provided in situations where the patient has been evaluated and screened for the presence of latent TB infection, where warranted, prior to initiating treatment. Coverage is provided in situations where the patient experienced intolerance/failure to Humira AND Enbrel.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 years
<b>Other Criteria</b>	Renewal coverage is provided in situations where treatment has provided clinical benefit.
<b><u>OXANDROLONE</u></b>	
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Additional coverage for off-label use is provided for cachexia associated with AIDS
<b>Exclusion Criteria</b>	For weight gain - must be used to promote weight gain after weight loss resulting from chronic diseases or AIDS wasting, per section 1927(k)(6) of the Act
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 years
<b>Other Criteria</b>	
<b><u>OXYMETHOLONE</u></b>	
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Additional coverage for off-label use is provided for cachexia associated with AIDS
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Coverage is provided for anemia due to conditions such as acquired aplastic anemia, anemia of chronic renal failure, pure red cell aplasia, Fanconi's anemia or myelosuppression due to chemotherapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months for anemia or 5 years for cachexia/AIDS wasting
<b>Other Criteria</b>	

<b><u>PAGET'S DISEASE AGENTS</u></b>	
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b><u>PROMACTA</u></b>	
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Coverage is not provided when used in combination with Nplate.
<b>Required Medical Info</b>	Patients have had an inadequate response or have been intolerant to treatment with corticosteroids, immunoglobulins, or splenectomy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Renewal is provided for patients who continue to have a response to therapy (for example, platelet count has increased)

**PROVIGIL**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Coverage is provided for the off-label use of idiopathic hypersomnolence and depression associated with fatigue and/or sleepiness.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	For narcolepsy, patient must not have underlying conditions that may contribute to excessive sleepiness (e.g., nocturnal myoclonus, current drug therapy which affects sleep or contributes to daytime sedation, or chronic voluntary or involuntary sleep deprivation through shift-work). Coverage is provided for SWSD when: (1) the patient is a night worker and (2) has complaints of persistent and frequent excessive sleepiness and/or falling asleep while at work and (3) any medical conditions known to cause or contribute to sleepiness have been considered and treated. Coverage is provided for idiopathic hypersomnolence that is confirmed by polysomnography where excessive sleepiness is not due to other sleep disorders such as narcolepsy, obstructive sleep apnea or posttraumatic hypersomnia.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For OSAHS, coverage is provided for patients who are receiving nasal continuous positive airway pressure therapy (CPAP) or who are not candidates for CPAP. Coverage is provided for depression associated with fatigue and/or sleepiness when the patient is receiving antidepressant therapy

**REGRANEX**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Coverage is provided for the following off-label use: treatment of severe pressure ulcers that are unresponsive to other measures.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Regranex must be used as an adjunct to good ulcer wound care (e.g., debridement, infection control and/or pressure relief).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 months
<b>Other Criteria</b>	For the off-label use- treatment of severe pressure ulcers ONLY: prescriber must indicate that wound has been unresponsive to at least ONE other measure (may include but is not limited to the following: nutritional supplementation, pressure relief, debridement, proteolytic enzymes, epidermal growth factor).

**REMICADE**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Additional coverage for off-label use is provided for moderate to severe Hidradenitis suppurativa.
<b>Exclusion Criteria</b>	Coverage is not provided for use of Remicade in combination with other biologics e.g., Enbrel, Kineret or Humira, etc
<b>Required Medical Info</b>	Coverage is provided in situations where the patient has been evaluated and screened for the presence of latent TB infection prior to initiating treatment with Remicade.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Coverage is provided for mild ulcerative colitis when the patient has had an inadequate response to at least one conventional treatment (for example: sulfasalazine, olsalazine, mesalamine, etc.), and for ankylosing spondylitis when the patient has experienced inadequate symptom relief from at least one other treatment such as NSAIDs, COX2 inhibitors, or methotrexate, unless the patient is unable to receive treatment with these drugs.

**REMODULIN**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Coverage is provided in situations where it is being prescribed under the care or referral of a cardiologist or pulmonologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Coverage is provided for use in combination with two or more PAH therapies when treatment with one PAH agent failed to adequately control the patient's symptoms.

**REVATIO**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Coverage for Revatio is not provided in situations where patients are receiving nitrate therapy.
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Coverage is provided in situations where it is being prescribed under the care or referral of a cardiologist or pulmonologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Coverage is provided for use in combination with two or more PAH therapies when treatment with one PAH agent failed to adequately control the patient's symptoms.

**RIBAVIRIN**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**RITUXAN**

<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Additional coverage for off-label use is provided for relapsed or refractory Waldenstrom's macroglobulinemia.
<b>Exclusion Criteria</b>	Coverage is not provided for use of Rituxan in combination with other biologics e.g., Humira, Kineret or Remicade, etc.
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	For rheumatoid arthritis: 18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 month for rheumatoid arthritis, 12 months for other indications
<b>Other Criteria</b>	For rheumatoid arthritis: inadequate response to at least one TNF inhibitor or been intolerant to treatment with at least two TNF inhibiting drugs. Coverage is provided for Antineutrophil cytoplasmic antibody (ANCA) associated vasculitis (e.g., Wegener's Granulomatosis (WG) or Microscopic Polyangiitis (MPA)) when used in combination with glucocorticoids.

**SIMPONI**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Coverage is not provided for use of Enbrel in combination with other biologics e.g., Humira, Kineret, Remicade, etc
<b>Required Medical Info</b>	Coverage is provided in situations where the patient has been evaluated and screened for the presence of latent TB infection, where warranted, prior to initiating treatment with Simponi. Coverage is provided in situations where the patient experienced intolerance/failure to Humira AND Enbrel. For rheumatoid arthritis, Simponi must be used in combination with methotrexate, per labeling. For ankylosing spondylosis the patient must experience intolerance or failure to other treatments such as NSAIDs, COX2 inhibitors, or methotrexate unless the patient is unable to receive treatment with these drugs
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Renewal coverage is provided in situations where treatment has provided clinical benefit.
<b><u>SMOKING DETERRENTS</u></b>	
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Coverage is not provided for Chantix (varenicline) use in combination with bupropion or other nicotine replacement products. Coverage is provided for one nicotine replacement product with or without concurrent use of bupropion SR (Zyban). Bupropion sustained- release tablet (Zyban) coverage is not provided in the presence of any of the following: Concurrent use with any other form of bupropion, Seizure disorder (epilepsy), Eating disorder (bulimia or anorexia nervosa), Concurrent or recent MAO inhibitor use (within the previous 14 days)
<b>Required Medical Info</b>	The patient must be enrolled in a behavioral support/ modification program (e.g., community program, manufacturer sponsored program, counseling by the physician, internet, or telephone quitline).
<b>Age Restrictions</b>	The patient must be 18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**SOMAVERT**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Coverage is provided when patients have had an inadequate response to surgery, radiation, or other medical therapies or in situations where the patient is not a candidate for other therapies.

**SUTENT**

<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Additional coverage for off-label use is provided for neuroendocrine tumors and metastatic thyroid cancer.
<b>Exclusion Criteria</b>	Combination use with sorafenib (Nexavar).
<b>Required Medical Info</b>	Coverage is provided for Gastrointestinal stromal tumor when the patient had evidence of disease progression or experienced intolerance while receiving imatinib mesylate (Gleevec).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**SYLATRON**

<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Adjunctive treatment of Stage III resected melanoma
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**TARCEVA**

<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Coverage is provided for treatment of pancreatic cancer when used in combination with gemcitabine.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**THALIDOMIDE**

<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Additional coverage for off-label uses include Crohn's disease, aphthous ulcers in the presence of HIV or AIDS, prostate cancer, malignant melanoma, myelofibrosis, and myelodysplastic syndromes.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**TORISEL**

<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Coverage is not provided when used in combination with Sutent or Nexavar.
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**TRACLEER**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Coverage is provided in situations where it is being prescribed under the care or referral of a cardiologist or pulmonologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Coverage is provided for use in combination with two or more PAH therapies when treatment with one PAH agent failed to adequately control the patient's symptoms.

**VACCINES HPV**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Coverage for Gardasil provided for patients 9 through 26 years of age. Coverage for Cervarix is provided for females between 9 and 25 years of age.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**VACCINES SHINGLES**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	Coverage is provided for patients 50 years of age and older.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**VICTRELIS- HEP C - PROTEASE INHIBITORS**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Coverage is not provided for genotypes other than type 1. Duration of therapy longer than 11 months. Previous failure to Incivek or Victrelis.
<b>Required Medical Info</b>	Chronic Hep C, in patients with genotype 1 who have a quantifiable viral load. Must be used in combination with a pegylated interferon and ribavirin.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	11 months
<b>Other Criteria</b>	

**XALKORI**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	ALK positive measured by either Abbott's Vysis ALK Break Apart FISH probe test or another reliable CLIA approved testing method (for example RT-PCR, FISH, or IHC) locally advanced or metastatic NSCLC
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**XGEVA**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Coverage is not provided for prevention of skeletal-related events in patients with multiple myeloma
<b>Required Medical Info</b>	Prevention of skeletal-related events in patients with bone metastases from solid tumors
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**XOLAIR**

<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Baseline IgE must be between 30 and less than or equal to 700 IU/mL. The patient is currently receiving therapy with an inhaled steroid or oral steroid unless the patient should not receive steroids AND either 1. The dose of inhaled or systemic steroid must be reduced to help control adverse side effects and addition of Xolair is the only option that may achieve the needed dosage reduction OR 2. The patient has moderate to severe asthma defined as having had two or more ER visits for an asthma exacerbation AND/OR more than 2 courses of short pulse oral or parenteral corticosteroids for exacerbations within the previous 12 months
<b>Age Restrictions</b>	Coverage is provided for patients 12 years of age and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Coverage may be renewed in situations where treatment is providing clinical benefit as evidenced by a reduction in asthma exacerbations from baseline.

**XYREM**

<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**YERVOY**

<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	

**ZELBORAF**

<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Additional coverage for off-label use includes unresectable or metastatic melanoma in patients with BRAFv600K mutation
<b>Exclusion Criteria</b>	Combination use with ipilimumab
<b>Required Medical Info</b>	For unresectable or metastatic melanoma with BRAFV600E or BRAFV600K mutation as detected by FDA approved or CLIA lab approved reliable assay
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	

**ZYTIGA**

<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Info</b>	Coverage is provided in situations where the patient has been previously treated with a docetaxel-containing treatment regimen.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Coverage is provided in situations where the patient will be using this drug in combination with oral prednisone.

**The following drugs 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.**

<b>Drug Name</b>	<b>Route of Administration / Dosage Form</b>
A-METHAPRED	INJECTION SOLUTION RECONSTITUTED
ACETYLCYSTEINE	INHALATION SOLUTION
ALBUTEROL SULFATE	INHALATION NEBULIZATION SOLUTION
ALDURAZYME	INJECTION SOLUTION
AMPHOTERICIN B	INJECTION SOLUTION RECONSTITUTED
AZATHIOPRINE	ORAL TABLET

<b>Drug Name</b>	<b>Route of Administration / Dosage Form</b>
AZATHIOPRINE SODIUM	INJECTION SOLUTION RECONSTITUTED
BONIVA	ORAL TABLET
BUDESONIDE	INHALATION SUSPENSION
CALCITRIOL	ORAL CAPSULE
CALCITRIOL	INJECTION SOLUTION
CALCITRIOL	ORAL SOLUTION
CELLCEPT	ORAL SUSPENSION RECONSTITUTED
CEREZYME	INJECTION SOLUTION RECONSTITUTED
CROMOLYN SODIUM	INHALATION NEBULIZATION SOLUTION
CUBICIN	INJECTION SOLUTION RECONSTITUTED
CYCLOPHOSPHAMIDE	ORAL TABLET
CYCLOSPORINE	ORAL CAPSULE
CYCLOSPORINE	INJECTION SOLUTION
CYCLOSPORINE MODIFIED	ORAL CAPSULE
CYCLOSPORINE MODIFIED	ORAL SOLUTION
DEPO-MEDROL	INJECTION SUSPENSION
DRONABINOL	ORAL CAPSULE
EMEND	ORAL CAPSULE
ENGERIX-B	INJECTION SUSPENSION
FABRAZYME	INJECTION SOLUTION RECONSTITUTED
FOSCARNET SODIUM	INJECTION SOLUTION
GENGRAF	ORAL SOLUTION
GENGRAF	ORAL CAPSULE
GRANISETRON HCL	ORAL TABLET

<b>Drug Name</b>	<b>Route of Administration / Dosage Form</b>
IPRATROPIUM BROMIDE	INHALATION SOLUTION
IPRATROPIUM BROMIDE/ALBUTEROL SULFATE	INHALATION SOLUTION
LEVOCARNITINE	ORAL SOLUTION
LEVOCARNITINE	ORAL TABLET
LIORESAL INTRATHECAL	INJECTION SOLUTION
METHOTREXATE	ORAL TABLET
METHYLPREDNISOLONE	ORAL TABLET
METHYLPREDNISOLONE ACETATE	INJECTION SUSPENSION
METHYLPREDNISOLONE SODIUMSUCCINATE	INJECTION SOLUTION RECONSTITUTED
MYCOPHENOLATE MOFETIL	ORAL TABLET
MYCOPHENOLATE MOFETIL	ORAL CAPSULE
MYFORTIC	ORAL TABLET DELAYED RELEASE
NEBUPENT	INHALATION SOLUTION RECONSTITUTED
NEORAL	ORAL SOLUTION
NEORAL	ORAL CAPSULE
NITROGLYCERIN	INJECTION SOLUTION
NULOJIX	INJECTION SOLUTION RECONSTITUTED

<b>Drug Name</b>	<b>Route of Administration / Dosage Form</b>
ONDANSETRON HCL	ORAL SOLUTION
ONDANSETRON HCL	ORAL TABLET
ONDANSETRON ODT	ORAL TABLET DISPERSIBLE
PERFOROMIST	INHALATION NEBULIZATION SOLUTION
PREDNISOLONE SODIUM PHOSPHATE	ORAL SOLUTION
PREDNISON	ORAL TABLET
PREDNISON	ORAL SOLUTION
PREDNISON INTENSOL	ORAL CONCENTRATE
PROGRAF	INJECTION SOLUTION
PULMOZYME	INHALATION SOLUTION
RAPAMUNE	ORAL SOLUTION
RAPAMUNE	ORAL TABLET
RECOMBIVAX HB	INJECTION SUSPENSION
RHEUMATREX	ORAL TABLET
SANDIMMUNE	INJECTION SOLUTION
SANDIMMUNE	ORAL SOLUTION
SANDIMMUNE	ORAL CAPSULE
SOLU-MEDROL	INJECTION SOLUTION RECONSTITUTED
TACROLIMUS	ORAL CAPSULE
TOBI	INHALATION NEBULIZATION SOLUTION
VANCOMYCIN HCL	INJECTION SOLUTION RECONSTITUTED
ZEMPLAR	ORAL CAPSULE
ZEMPLAR	INJECTION SOLUTION
ZORTRESS	ORAL TABLET
ZUPLLENZ	ORAL FILM