

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

You will need authorization by your **UA Medicare Group Part D Prescription Drug Plan** before filling prescriptions for the drugs shown in the chart below. The **UA Medicare Group Part D Prescription Drug Plan** 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 Customer Service toll free at 1-866-524-4199, 8:00 a.m. to 8:00 p.m., in your local time zone, Monday through Friday. Customer Service is available in English and other languages.

TTY/TDD users should call 1-866-524-4170

PRIOR AUTHORIZATION MEDICATIONS								
Prior Authorization Group Description	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria	Excluded Drug Criteria
ACTIMMUNE	All FDA approved indications not otherwise excluded from Part D.					12 months		
AFINITOR	All FDA approved indications not otherwise excluded from Part D.	Combination use with sorafenib or sunitinib.	Coverage is provided after failure of treatment with sunitinib or sorafenib.			12 months		
ALFA INTERFERONS	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), and Renal cell carcinoma.	For chronic hepatitis: contraindications such as decompensated liver disease when used in combination with another interferon product. For chronic hepatitis C: contraindications such as decompensated liver disease or is using in combination with another Interferon product	For Hepatitis C: positive hepatitis C viral load. For Kaposi sarcoma: T cell count is less than 400/mm ³ or in the presence of an opportunistic infection.			12 months	For treatment of condyloma acuminata: conventional therapy has failed to treat the patient.	
ALFA INTERFERONS PEGYLATED	All FDA approved indications not otherwise excluded from Part D.		Coverage for chronic hepatitis C is provided in the presence of a positive viral load			12 months		
ANDROGENS	All FDA approved indications not otherwise excluded from Part D.		Coverage for the prescribed testosterone product is provided for females for the palliative treatment of breast cancer. Coverage for androgens (testosterone drug) 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).			All indications 5 years, except delayed puberty: 6 months		
APOKYN	All FDA approved indications not otherwise excluded from Part D.					12 months		
BUTORPHANOL NASAL SPRAY	All FDA approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for the treatment of migraine headache pain.					12 months for migraine pain / 3 months for acute pain	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	All FDA-approved indications not otherwise excluded from Part D.	Coverage is not provided for Chantix (varenicline) use in combination with bupropion or other nicotine replacement products.	The patient must be enrolled in a behavior support/ modification program (e.g., community program, manufacturer sponsored program, counseling by the physician, internet, or telephone quitline).	The patient must be 18 years of age or older		6 months		
CNS STIMULANTS - DEXMETHYLPHENIDATE	All FDA approved indications not otherwise excluded from Part D.	Coverage is not provided for long term (greater than 2 months) combination therapy with Strattera for ADD/ADHD. Coverage is not provided in situations in which the patient has any of the following contraindications to its use: uncontrolled cardiovascular disease (for example, uncontrolled hypertension or the presence of arrhythmias or structural cardiac abnormalities), hyperthyroidism, narrow-angle glaucoma, agitated states including psychosis and/or schizophrenia, history of drug abuse or the use of a MAO inhibitor concurrently or within the previous 14 days.	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.			12 months		
CNS STIMULANTS - DEXTROAMPHETAMINE AND SALT COMBO	All FDA approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for depression.	Coverage is not provided for long term (greater than 2 months) combination therapy with Strattera for ADD/ADHD. Coverage is not provided in situations in which the patient has any of the following contraindications to its use: uncontrolled cardiovascular disease (for example, uncontrolled hypertension or the presence of arrhythmias or structural cardiac abnormalities), hyperthyroidism, narrow-angle glaucoma, agitated states including psychosis and/or schizophrenia, history of drug abuse or the use of a MAO inhibitor concurrently or within the previous 14 days.	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 addressed or treated.			12 months		
CNS STIMULANTS - METHYLPHENIDATE	All FDA approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for depression, narcolepsy, and idiopathic hypersomnolence.	Coverage is not provided for long term (greater than 2 months) combination therapy with Strattera for ADD/ADHD. Coverage is not provided in situations in which the patient has any of the following contraindications to its use: uncontrolled cardiovascular disease (for example, uncontrolled hypertension or the presence of arrhythmias or structural cardiac abnormalities), hyperthyroidism, narrow-angle glaucoma, agitated states including psychosis and/or schizophrenia, history of drug abuse or the use of a MAO inhibitor concurrently or within the previous 14 days.	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 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.			12 months		

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COLONY STIMULATING FACTORS	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.	Combination therapy with Neulasta, Neupogen or Leukine.	Patient has experienced neutropenia from previous chemotherapy OR for patient is considered to be at high risk for the development of neutropenia. Absolute Neutrophil Count (ANC). That is, coverage is provided for: AIDS/HIV when ANC is less than or equal to 500/mm ³ . Myelodysplasia when ANC is less than or equal to 1000/mm ³ . Severe chronic neutropenia (i.e., Neutropenic disorder, cyclic neutropenia) when ANC is less than or equal to 1500/mm ³ . bone marrow transplant when ANC is less than or equal to 1000/mm ³ . 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 ³			12 months		
COLONY STIMULATING FACTORS PEGYLATED	All FDA-approved indications not otherwise excluded from Part D.	Combination therapy with Neulasta, Neupogen or Leukine. Patients who weigh less than or equal to 45kg, prescriber indicates that the patient is able to receive daily injections of either Neupogen (Filgrastim) or Leukine (Sargramostim).	Patient has experienced neutropenia from previous chemotherapy OR for patient is considered to be at high risk for the development of neutropenia.			12 months		
DARBEPOETIN ALFA	All FDA-approved indications not otherwise excluded from Part D.		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 and 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.			2 months for anemia due to cancer-chemotherapy, 12 months for CRF or CRI	Coverage for Aranesp is provided when the prescriber indicates that the patient is not able to comply with the more frequent dosing regimen used for Procrit.	
ENBREL	All FDA-approved indications not otherwise excluded from Part D	Coverage is not provided for use of Enbrel in combination with other biologics e.g., Humira, Kineret or Remicade.	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.			12 months	For the treatment of moderate to severe rheumatoid arthritis or psoriatic arthritis: coverage is provided when Enbrel is used in combination with methotrexate or when the patient has had an inadequate response to treatment with methotrexate unless the patient is unable to receive methotrexate. Enbrel is covered for the treatment of ankylosing spondylitis in situations where the patient has experienced inadequate symptom relief from treatment with at least two NSAIDs or COX2 inhibitors unless the patient is unable to receive NSAIDs or COX2 inhibitors.	
EPOETIN ALFA	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.		The 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 and 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. Erythropoietin is covered for Reducing the need for allogeneic 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, for the treatment of 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, and Myelodysplasia and Chronic Hepatitis C treatment from ribavirin and interferon therapy when Hg is less than or equal to 11 g/dL.			1 month- allogeneic blood transfusions 2 months- anemia due to chemotherapy, 12 months- others		
FENTANYL TRANSMUCOSAL	All FDA-approved indications not otherwise excluded from Part D	Coverage is not provided for patients who are not already receiving and who are not tolerant to opioid therapy				12 months		
GROWTH HORMONES	All FDA approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for 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.	Coverage is not provided for constitutional delayed growth	For pediatric growth hormone deficiency: patient's height must be below the third percentile for their age and gender related height, growth velocity subnormal greater than or equal 2 standard deviations from the age related mean, delayed skeletal maturation greater than or equal 2 standard deviations below the age/gender related mean, epiphyses confirmed as open in patients greater than or equal 10 years of age, growth hormone deficiency confirmed by any 2 provocative tests OR by insulin growth factor-1 (IGF-1) a.k.a. somatomedin C, or IGF binding protein-3 (IGFBP-3) levels, 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. For idiopathic short stature: height must be less than or equal to 2.25 standard deviations from the mean and epiphyses must be confirmed as open in patients greater than or equal 10 years of age. Coverage is provided for pediatric growth failure due to chronic renal failure (in situations where the patient has not undergone a renal transplant)	7 years of age or older for idiopathic short stature	Pediatric endocrinologist for ISS	1 month for short bowel syndrome, 12 months for other indications		

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HUMIRA	All FDA approved indications not otherwise excluded from Part D.	Coverage is not provided for use of Humira in combination with other biologics e.g., Enbrel, Kineret or Remicade.	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.			12 months	For the treatment of moderate to severe rheumatoid arthritis or psoriatic arthritis: coverage is provided when Humira is used in combination with methotrexate or when the patient has had an inadequate response to treatment with methotrexate unless the patient is unable to receive methotrexate. Humira is covered for the treatment of ankylosing spondylitis in situations where the patient has experienced inadequate symptom relief from treatment with at least two NSAIDs or COX2 inhibitors unless the patient is unable to receive NSAIDs or COX2 inhibitors.	
IMMUNE GLOBULINS	All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for post bone marrow transplantation, post transfusion purpura, autoimmune hemolytic anemia, Guillain-Barre syndrome, chronic inflammatory demyelinating polyneuropathy, and pediatric HIV infection.	For BMT, benefit not covered in patients concurrently receiving CMV immune globulin.	Coverage is provided for primary humoral immunodeficiency OR B-cell chronic lymphocytic leukemia (CLL) when patient has serum IgG concentration less than 600 mg/dL AND patient must have history of a recurrent bacterial infection or a single life-threatening bacterial infection. Coverage is provided for idiopathic thrombocytopenic purpura (ITP) when platelet count is less than 30,000/mm3. Coverage is provided for bone marrow transplantation when bone marrow transplant performed within the previous 100 days.			12 months		
INCRELEX	All FDA-approved indications not otherwise excluded from Part D.	Coverage is not provided in the presence of: Concurrent treatment with growth hormone or Pharmacologic doses of corticosteroids	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.		Coverage is provided in situations where the diagnosis of IGF-1 deficiency has been made by an endocrinologist.	12 months		
LEFLUNOMIDE	All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for the prevention of acute and chronic rejection in recipients of solid organ transplants.					12 months	For the treatment of moderate to severe rheumatoid arthritis in situations where the patient is currently receiving methotrexate, has experienced a therapeutic failure with methotrexate, or in situations where the patient is unable to receive methotrexate.	
LIDODERM	All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for neuropathic pain (from etiologies other than a herpes zoster outbreak).					12 months	For neuropathic pain: the patient must have previous use and inadequate response or intolerance to ANY neuropathic pain medication, including (but is not limited to) Cymbalta, Lyrica that are labeled for neuropathic pain, as well as amitriptyline or gabapentin.	
MULTIPLE SCLEROSIS THERAPY	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.	Treatment of primary progressive MS is not covered. Combination therapy with a beta interferon product and Copaxone is not covered.	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.			12 months		
NEUMEGA	All FDA-approved indications not otherwise excluded from Part D.		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.			12 months		
NEXAVAR	All FDA approved indications not otherwise excluded from Part D.					12 months		
OXANDROLONE	All FDA approved indications not otherwise excluded from Part D.					5 years		
OXYMETHOLONE	All FDA approved indications not otherwise excluded from Part D.		Coverage is provided for anemia due to conditions such as acquired aplastic anemia, anemia of chronic renal failure, pure red cell aplasia, Fanconi anemia or myelosuppression due to chemotherapy.			12 months for anemia or 5 years for cachexia/AIDS wasting		
PAGET'S DISEASE AGENTS	All FDA-approved indications not otherwise excluded from Part D.					12 months		
PROMACTA	All FDA approved indications not otherwise excluded from Part D.	Coverage is not provided when used in combination with Nplate.	Renewal is provided for patients who continue to have a response to therapy (for example, platelet count has increased).			12 months	Patients have had an inadequate response or have been intolerant to treatment with corticosteroids, immunoglobulins, or splenectomy.	
PROVIGIL	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.		For narcolepsy, the prescriber must confirm that the patient does 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) Prescriber must confirm that 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.			12 months	For OSAHS, coverage is provided for patients who are receiving nasal continuous positive airway pressure therapy (CPAP) or who are not candidate for CPAP. Coverage is provided for depression associated with fatigue and/or sleepiness when the patient is receiving antidepressant therapy.	
REGANEX	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.		Regranex must be used as an adjunct to good ulcer wound care (e.g., debridement, infection control and/or pressure relief).			5 months	For the treatment of severe pressure ulcers ONLY wound must be unresponsive to other measures	

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REMICADE	All FDA-approved indications not otherwise excluded from Part D.	Coverage is not provided for use of Remicade in combination with other biologics e.g., Enbrel, Kineret or Humira	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.			12 months	Coverage is provided for mild ulcerative colitis when the patient has had an inadequate response to conventional treatments (for example: sulfasalazine, olsalazine, mesalamine, etc.), and for ankylosing spondylitis when the patient has experienced inadequate symptom relief from other treatments such as NSAIDs or COX2 inhibitors, or methotrexate, unless the patient is unable to receive treatment with these drugs.	
RIBAVIRIN	All FDA-approved indications not otherwise excluded from Part D.					12 months		
RITUXAN	All FDA-approved indications not otherwise excluded from Part D. Additional coverage for off-label use is provided for relapsed or refractory chronic lymphoid lymphoma and relapsed or refractory Waldenstrom's macroglobulinemia.			For rheumatoid arthritis: 18 years of age or older		1 month for rheumatoid arthritis, 12 months for other indications	For rheumatoid arthritis: inadequate response to at least one TNF inhibitor or been intolerant to treatment with all TNF inhibiting drugs.	
SENSIPAR	All FDA-approved indications not otherwise excluded from Part D.		For the treatment of secondary hyperparathyroidism in patients with Chronic Kidney Disease on dialysis patients must have a parathyroid hormone level (PTH) of greater than equal to 300 pg/mL			12 months		
SMOKING DETERRENTS	All FDA-approved indications not otherwise excluded from Part D.	Coverage is not provided for Chantix (varenicline) use in combination with bupropion or other nicotine replacement products. Coverage is provided for or 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)	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).	The patient must be 18 years of age or older		12 months		
SOMAVERT	All FDA-approved indications not otherwise excluded from Part D.					12 months	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	All FDA approved indications not otherwise excluded from Part D.	Combination use with sorafenib (Nexavar®).				12 months		
TARCEVA	All FDA approved indications not otherwise excluded from Part D.		For NSCLC: patient has never smoked or has received at least 1 prior chemotherapy agent unless prescriber indicates patient is not a candidate for injectable chemotherapy. For pancreatic cancer, must be used in combination with gemcitabine			12 months	For NSCLC: patient has never smoked or has received at least 1 prior chemotherapy agent unless prescriber indicates patient is not a candidate for injectable chemotherapy.	
TARGRETIN	All FDA approved indications not otherwise excluded from Part D.					12 months	For treatment of stage 1A or stage 1B cutaneous T cell lymphoma when the patient had intolerance, is refractory or has persistent disease following other therapies (e.g. PUVA, UVB, EBT, interferon, topical mechlorethamine, topical camustine, or systemic chemotherapy)	
THALIDOMIDE	All FDA approved indications not otherwise excluded from Part D. Additional coverage for off-label uses include Crohn's disease, aphthous ulcer in the presence of HIV or AIDS, prostate cancer, malignant melanoma, myelofibrosis, and myelodysplastic syndromes.					12 months	For ENL with moderate to severe neuritis: is provided in situations in which corticosteroids are used concurrently with thalidomide.	
TRACLEER	All FDA-approved indications not otherwise excluded from Part D.				Coverage is provided in situations where Tracleer is being prescribed under the care or referral of a cardiologist or pulmonologist.	12 months	Coverage is provided for use of Tracleer in combination with other PAH therapies when treatment with one PAH agent failed to adequately control the patient's symptoms.	
VACCINES	All FDA-approved indications not otherwise excluded from Part D.		Coverage is provided through Part D when the vaccine is NOT being administered to treat an injury or as a result of the patient's direct exposure to a disease or condition. Coverage for Hepatitis B vaccine is provided for low risk patients through Part D.			12 months		
VACCINES HPV	All FDA-approved indications not otherwise excluded from Part D.			Coverage is provided for girls and women 9 through 26 years of age		12 months		
VACCINES SHINGLES	All FDA-approved indications not otherwise excluded from Part D.			Coverage is provided for patients 60 years of age and older.		12 months		
XYREM	All FDA approved indications not otherwise excluded from Part D.					12 months		
IMMUNOSUPPRESSANTS	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.					12 months		
NEBULIZED DRUGS	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.					12 months		
NON-INJECTABLE ANTIEMETICS	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.					12 months		
NON-SELF ADMINISTERED INJECTABLES	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.					12 months		