

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

You will need authorization by your **First UA Medicare Part D Silver Prescription Drug Plan** before filling prescriptions for the drugs shown in the chart below. The **First UA Medicare Part D Silver 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 pharmacist, or your physician can request prior authorization by calling

Customer Service toll-free at 1-866-299-3407,

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 1-866-524-4172.

Prior Authorization Group Description	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration
ACTIMMUNE	Granulomatous disease and osteopetrosis.					12 months
ALFA INTERFERONS	All FDA-approved indications not otherwise excluded from Part D. Additional off label uses covered for Intron-A are multiple myeloma, Philadelphia chromosome positive chronic phase myelogenous leukemia (CML) in a patient who is minimally pretreated, renal cell carcinoma, and essential thrombocythemia.					12 months
ANDROGENS AND ANABOLIC STEROIDS	All FDA-approved indications not otherwise excluded from Part D.					5 years
APOKYN	Apokyn is covered for use in the treatment of acute intermittent episodes of hypomobility, "off" episodes ("end-of-dose wearing off" and unpredictable "on/off" episodes) associated with advanced Parkinson's disease.					12 months
BUTORPHANOL NASAL SPRAY (STADOL NS)	Coverage provided for the management of pain due to migraine or cluster headache in situations where abortive therapy with 5-HT <sub>1</sub> receptor agonists (triptans) and ergotamine derivatives has been attempted, unless otherwise contraindicated. For the management of acute pain due to other conditions, coverage will be provided in the presence of the inability to take oral opioid therapy or for situations where					12 months

	a rapid onset of action is required (e.g., use as an adjunctive agent for the management of breakthrough pain).					
CHANTIX	All FDA-approved indications not otherwise excluded from Part D.	Coverage is not provided if Chantix is used in combination with bupropion or other nicotine replacement products.		The patient must be 18 years of age or older.		6 months
CNS STIMULANTS	All FDA-approved indications not otherwise excluded from Part D. Additional coverage for off-label use of depression for Adderall, Adderall XR, Dexedrine, Dexedrine Spansules, Dextrostat, Desoxyn, Ritalin, Ritalin SR, Ritalin LA, Metadate CD, Metadate ER, Concerta, Methylin or Methylin ER. Coverage for off-label use of Idiopathic hypersomnolence for Desoxyn, Ritalin, Ritalin SR, Ritalin LA, Metadate CD, Metadate ER, Concerta, Methylin or Methylin ER.	Long-term combination therapy (i.e., greater than 2 months) with Strattera and a CNS stimulant is not covered. The patient must not have any contraindications to the prescribed agent such as: Uncontrolled cardiovascular disease (e.g., uncontrolled hypertension or the presence of arrhythmias), hyperthyroidism, history of drug abuse, agitated states including psychosis and/or schizophrenia, narrow angle glaucoma, use of MAO inhibitor concurrently or within previous 14 days.		Adderall, Adderall XR, Dexedrine, Dexedrine Spansules or Dextrostat - 3 years of age or older. Desoxyn, Ritalin, Ritalin SR, Ritalin LA, Metadate CD, Metadate ER, Concerta, Methylin or Methylin ER - 5 years of age or older. Focalin, Focalin XR or Vyvanse - 6 years of age or older.		12 months
COLONY STIMULATING FACTORS	All FDA-approved indications not otherwise excluded from Part D. Additional covered off-labeled uses are Neutropenia due to other drugs, AIDS/HIV, and myelodysplasia.	Combination therapy with Neulasta and Neupogen or Leukine is not covered.				12 months
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.				12 months

ERYTHROID STIMULANTS	All FDA-approved indications not otherwise excluded from Part D. Additional off-label covered uses for erythropoietin are treatment of anemia secondary to HIV infection or HIV drug therapy, myelodysplasia, and chronic hepatitis C treatment from ribavirin and interferon therapy.					12 months
FENTANYL TRANSMUCOSAL	All FDA-approved indications not otherwise excluded from Part D.					12 months
GROWTH HORMONES	Coverage is provided for pediatric growth hormone deficiency in the presence of the following: 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. Coverage is provided for idiopathic short stature (non-growth hormone deficient short stature) in the presence of the following: The patient must be under the care of a pediatric endocrinologist and the patient must be greater than equal to 7 years of age and patient's height must be less than or equal - 2.25 standard deviations from the mean and where the prescriber has determined that the patient does not have constitutional delay of growth and epiphyses must be confirmed as	Coverage is not provided for constitutional delayed growth.				All indications except short bowel syndrome: 12 months. Short bowel syndrome: 1 month.

	<p>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) (provocative tests not required), growth failure in children born small for gestational age (SGA) who fail to manifest catch up growth by age 2 defined as birth weight, birth length, or both that are more than 2 standard deviations below mean normal values following adjustment for age and gender (provocative tests not required), pediatric growth failure due to Turner's syndrome (provocative tests not required), treatment of Prader-Willi syndrome (provocative tests not required), treatment of short stature associated with Noonan Syndrome (provocative tests not required). Coverage is provided for adult growth hormone deficiency (in the presence of a growth hormone stimulation test) due to: childhood onset growth hormone deficiency, pituitary or hypothalamic disease, surgery or radiation therapy, trauma. Coverage is provided for the treatment of short bowel syndrome in patients receiving specialized nutritional support.</p>					
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.				12 months
IMMUNE GLOBULINS	All FDA-approved indications not otherwise excluded from Part D. Coverage is provided for the following off-label uses bone marrow transplantation, posttransfusion purpura, autoimmune hemolytic anemia, Guillain-Barre syndrome, chronic inflammatory demyelinating polyneuropathy, and pediatric HIV infection.					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.				12 months
LEFLUNOMIDE (ARAVA)	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. For prevention of acute and chronic rejection in patients who have received solid organ transplants (such as from BK virus or polyomavirus).					12 months
LIDODERM	All FDA-approved indications not otherwise excluded from Part D. Additional coverage is provided for the off-label use of neuropathic pain.					12 months
MULTIPLE SCLEROSIS THERAPY	Coverage is provided for relapsing-remitting, secondary progressive or progressive-relapsing multiple sclerosis (MS). Coverage is provided for treatment at the time of a first demyelinating event. Treatment of primary progressive MS is not covered. 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.	Combination therapy with a beta interferon product and Copaxone is not covered.				12 months
NEUMEGA	Coverage is provided for the prevention of severe thrombocytopenia in patients with non-myeloid malignancy who have experienced severe thrombocytopenia (e.g., platelet count less than equal to 20,000/uL) from previous chemotherapy and for patients otherwise considered to be	Coverage is not provided for the prevention of thrombocytopenia due to other medical conditions.				12 months

	at high risk for the development of severe thrombocytopenia.					
NEXAVAR	For the treatment of advanced renal cell carcinoma. For the treatment of hepatocellular carcinoma.					12 months
PAGET'S DISEASE AGENTS	Coverage is provided for the treatment of Paget's disease.					12 months
PROMACTA	All FDA approved indications not otherwise excluded from Part D.	Patients who are candidates for treatment with corticosteroids, immunoglobulins, or splenectomy. Coverage is not provided when used in combination with Nplate.	Patients have had an inadequate response or have been intolerant to treatment with corticosteroids, immunoglobulin, or splenectomy			12 months
PROVIGIL	All FDA-approved indications not otherwise excluded from Part D. Coverage of Provigil is also provided for the off-label use of idiopathic hypersomnolence.					12 months
REGRANEX	For the treatment of lower extremity diabetic neuropathic ulcers OR for the treatment of severe pressure ulcers that is unresponsive to other measures AND for use as an adjunct to good ulcer wound care (e.g., debridement, infection control and/or pressure relief).					12 months
REMICADE	All FDA-approved indications not otherwise excluded from Part D.	Coverage is not provided for use in combination with Enbrel, Kineret, or Humira.				12 months
RIBAVIRIN	Ribavirin is covered for the treatment of chronic hepatitis C.					12 months
RITUXAN	For use as monotherapy or in combination for the treatment of non-Hodgkin's lymphomas (NHLs). For use in the treatment of refractory or relapsed chronic lymphoid leukemia (CLL). For use in the	Coverage is not provided for use of Rituxan in combination with a TNF inhibiting drug (i.e., Remicade,				12 months: NHLs, CLL or Waldenstrom's macroglobulinemia. 1

	treatment of refractory or relapsed Waldenstrom's macroglobulinemia. For the treatment of moderate to severely active rheumatoid arthritis (RA) in patients 18 years of age or older who have had an inadequate response to at least one TNF inhibitor or have been intolerant to treatment with ALL TNF inhibiting drugs (i.e., Remicade, Enbrel, and Humira).	Enbrel, Humira, Kineret or Orencia).				month: RA
SENSIPAR	All FDA-approved indications not otherwise excluded from Part D.					12 months
SMOKING DETERRENTS	All FDA-approved indications not otherwise excluded from Part D.	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).				12 months
SOMVERT	Coverage for Somavert is provided for the treatment of acromegaly in situations where 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.					12 months
SUTENT	Coverage for Sutent is provided in accord with the following: For the treatment of advanced renal cell carcinoma. For the treatment of gastrointestinal stromal tumor where there is evidence of disease progression or intolerance with imatinib mesylate.	Coverage is not provided for combination use of Sutent with sorafenib (Nexavar).				Coverage is provided for 12 months at a dose of up to 50 mg per day.
TARCEVA	For the treatment of locally advanced, unresectable or metastatic	Coverage is not provided for first line				12 months

	pancreatic cancer in combination with gemcitabine. For the treatment of locally advanced or metastatic non-small cell lung cancer. The patient must have previously failed or ceased responding to at least one prior chemotherapy regimen.	use of Tarceva in combination with chemotherapy agents.				
TARGRETIN	Coverage provided for treatment of stage IA or IB cutaneous T-cell lymphoma in situations where patients have intolerance or refractory/persistent disease following other therapies (e.g., PUVA, UVB, EBT, interferon, topical mechlorethamine, topical carmustine, systemic chemotherapy).					12 months
THALIDOMIDE (THALOMID)	Coverage is provided: For treatment or prevention of the cutaneous lesions associated with erythema nodosum leprosum (ENL). For situations where moderate to severe neuritis exists with ENL, thalidomide will be covered in the presence of concurrent corticosteroid therapy in patients able to receive corticosteroids. For aphthous ulcers in HIV/AIDS patients. For Crohn's disease or for multiple myeloma.					12 months
TRACLEER	Coverage is provided for the treatment of symptomatic severe pulmonary arterial hypertension due to primary pulmonary hypertension or secondary to systemic connective tissue disorders or autoimmune diseases (e.g., scleroderma, systemic lupus erythematosus). Coverage is provided in situations where patients have WHO functional class III or IV disease despite optimal therapy with vasodilators and diuretics. Coverage is not provided for use of Tracleer in combination with other PPH therapies such as Flolan (epoprostenol). Coverage is provided in situations where Tracleer is being prescribed under the care or referral of a cardiologist or pulmonologist.					12 months

VACCINES	Coverage for the following vaccines (which can be used for post-exposure prophylaxis of certain conditions) 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.			Coverage for zoster vaccine live (Zostavax) is provided for use in patients 60 years of age or older through Part D. Coverage for human papilloma virus vaccine (Gardasil) is provided for use in female patients between the ages of 9 and 26 years of age through Part D.		Coverage provided for one course of treatment as per product labeling.
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
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
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

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
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Date of last update: 5/29/2009