

**Drugs that Require Prior-Authorization  
Effective 01/01/2012**

Prior Authorization Group Desc	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration
Actemra	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>• Patient must have tried and failed therapy with a TNF antagonist</li> <li>• Please state which TNF antagonist</li> <li>• Documentation of approved diagnosis by prescribing provider.</li> </ul>		<ul style="list-style-type: none"> <li>• Rheumatologist</li> </ul>	1 year
Adcirca	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>• Documentation of approved diagnosis by prescribing physician</li> </ul>		<ul style="list-style-type: none"> <li>• Pulmonologist</li> <li>-or-</li> <li>• Cardiologist</li> </ul>	1 year
Afinitor	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>• Documentation of approved diagnosis by prescribing physician</li> <li>• For advanced renal cell carcinoma, documentation of failure of either sunitinib or sorafenib.</li> </ul>		<ul style="list-style-type: none"> <li>• Oncologist</li> </ul>	1 year
Amevive	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>• Documentation of approved diagnosis by prescribing provider</li> <li>• Documentation of phototherapy failure or clinical rationale for excluding phototherapy</li> <li>• Documentation of failure or intolerance with at least two oral therapies (including methotrexate, cyclosporine, or Soriatane), or clinical rationale for not attempting treatment with two oral agents.</li> </ul>		<ul style="list-style-type: none"> <li>• Rheumatologist</li> <li>-or-</li> <li>• Dermatologist</li> </ul>	1 year

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Apokyn	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>			1 year
Arzerra	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Patient refractory to both fludarabine and alemtuzumab</li> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> </ul>	1 year
Avastin	<ul style="list-style-type: none"> <li>All FDA-approved indications not otherwise excluded from Part D</li> <li>Neovascular (wet) Age-related Macular Degeneration</li> </ul>		<ul style="list-style-type: none"> <li>Avastin being used in combination with a 5-FU chemotherapy regimen (colorectal CA)</li> <li>Avastin is being used in conjunction with carboplatin and paclitaxel (NSCLC)</li> <li>Avastin has been prepared by a compounding pharmacy and is being administered by an ophthalmologist (wet AMD)</li> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> <li>-or-</li> <li>Ophthalmologist</li> </ul>	1 year
Botox	All FDA-approved indications not otherwise excluded from Part D	<ul style="list-style-type: none"> <li>Cosmetic Indications</li> </ul>	<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>			1 year
Chantix	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of participation in a smoking cessation program</li> </ul>	18 and over		1 year
Cimzia	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Diagnosis must be moderate to severe active Crohn's Disease or moderate to severe Rheumatoid Arthritis</li> </ul>			1 year
Desoxyn	All FDA-approved indications not otherwise excluded from Part D	<ul style="list-style-type: none"> <li>Indications related to the treatment of obesity</li> </ul>	<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>			1 year

Providers may call the Pharmacy Help Desk at 800-641-8921 for a copy of prior authorization criteria or print a copy from our website at [wwwrmhporg/providers/preauthorization.aspx](http://wwwrmhporg/providers/preauthorization.aspx)

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Egrifta	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of HIV related abdominal lipodystrophy</li> </ul>			1 year
Emend	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>For chemotherapy related N/V: Must be used in conjunction with a moderate to highly emetic chemotherapy regimen, please state which regimen</li> <li>For chemotherapy related N/V, must be used in combination with another anti-emetic, please state which anti-emetic</li> <li>If being used for PONV, documentation required</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist -or-</li> <li>Physician supporting post operative N/V</li> </ul>	1 year
Enbrel	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>Rheumatologist -or-</li> <li>Dermatologist</li> </ul>	1 year
Erbix	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Intolerant to irinotecan or cancer that is refractory to therapy with irinotecan (colorectal CA)</li> <li>Given in combination with radiation therapy (head neck CA)</li> <li>Refractory to platinum based therapy if monotherapy (head neck CA)</li> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> </ul>	1 year
Exjade	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Patient over 2 years old</li> <li>Provide serum ferritin level (must be greater than 1000mcg/L)</li> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>			1 year
Faslodex	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Patient has tried and failed tamoxifen</li> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> </ul>	1 year

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Forteo	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescriber</li> <li>Documentation of treatment failure with oral osteoporosis therapy, to include: a) evidence of at least two years of oral therapy (raloxifene or bisphosphonate) with continued osteoporosis confirmed by DXA scan or other suitable diagnostic evaluation or b) evidence of intolerance to oral therapy (raloxifene or bisphosphonate).</li> </ul>			1 year
Gilenya	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of diagnosis of relapsing-remitting multiple sclerosis</li> </ul>		<ul style="list-style-type: none"> <li>Neurologist</li> </ul>	1 year
Glassia	All FDA-approved indications not otherwise excluded from Part D	<ul style="list-style-type: none"> <li>Patients with PiMZ or PIMS phenotypes.</li> <li>Patients with a low risk of developing panacinar emphysema.</li> </ul>	<ul style="list-style-type: none"> <li>Care Management Nurse has been notified and will follow patient's course of therapy</li> <li>Documentation of approved diagnosis by prescribing provider.</li> </ul>		<ul style="list-style-type: none"> <li>Pulmonologist</li> </ul>	1 year
Gleevec	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> </ul>	1 year
Growth Hormone	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of growth hormone deficiency</li> <li>Documentation of diagnosis by prescribing provider</li> </ul>			1 year
Hizentra	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Consider appropriateness of therapy with Immune Globulin infusion</li> <li>Documentation of approved diagnosis by prescribing provider.</li> </ul>			1 year

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Humira	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>Physician experienced with Humira therapy</li> </ul>	1 year
Immune Globulin	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>			1 year
Iressa	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Cancer progression despite prior regimens with docetaxel and platinum based chemotherapy</li> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> </ul>	1 year
Istodax	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>At least 1 prior systemic therapy has been tried</li> <li>Documentation of diagnosis of T-cell lymphoma</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> </ul>	1 year
Ixempra	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Being used in conjunction with capecitabine or cancer is refractory to capecitabine therapy</li> <li>Cancer is refractory or resistant to anthracycline and taxane therapy</li> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> </ul>	1 year
Kineret	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Patient must have tried and failed therapy with a DMARD</li> <li>Please check which DMARD</li> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>Rheumatologist</li> <li>-or-</li> <li>Physician experienced with Kineret therapy</li> </ul>	1 year
Kuvan	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>			1 year

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Letairis	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>Pulmonologist -or-</li> <li>Cardiologist</li> </ul>	1 year
Nexavar	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing physician</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> </ul>	1 year
Orencia	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Patient must have tried and failed therapy with a DMARD and/or TNF antagonist</li> <li>Please state which DMARD or TNF antagonist</li> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>			1 year
Prolastin	All FDA-approved indications not otherwise excluded from Part D	<ul style="list-style-type: none"> <li>Patients with PiMZ or PIMS phenotypes</li> <li>Patients with a low risk of developing panacinar emphysema</li> </ul>	<ul style="list-style-type: none"> <li>Care Management Nurse has been notified and will follow patient's course of therapy</li> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>Pulmonologist</li> </ul>	1 year
Prolia	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Diagnosis of postmenopausal osteoporosis documented by bone densitometry</li> <li>Patient failed and/or is intolerant to bisphosphonate therapy</li> </ul>			1 year
Provigil	All FDA-approved indications not otherwise excluded from Part D and fatigue associated with drug therapy of Parkinson's Disease		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing physician</li> </ul>			1 year

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Remicade	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>PA required ONLY IF PRESCRIBED FOR Rheumatoid arthritis (moderate to severe) in patients with an inadequate response to conventional therapy.</li> <li>Documentation of trial and failure of at least one conventional therapy (Disease Modifying Anti-Rheumatic Drug).</li> </ul>		<ul style="list-style-type: none"> <li>For Rheumatoid Arthritis ONLY, documentation of approved diagnosis by a rheumatologist</li> </ul>	1 year
Revatio	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing physician</li> </ul>		<ul style="list-style-type: none"> <li>Pulmonologist -or- Cardiologist</li> </ul>	1 year
Revlimid	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescriber.</li> <li>For multiple myeloma ONLY: documentation that patient has received at least 1 prior therapy and is taking Revlimid in combination with dexamethasone.</li> <li>For myelodysplastic syndrome ONLY: documentation that patient is transfusion-dependent due to deletion 5q abnormality (low or intermediate-1 risk) Patient must have tried one previous therapy</li> <li>Prescribing provider registered with RevAssist.</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist -or- Hematologist</li> <li>Physician must be registered with RevAssist</li> </ul>	1 year
Sancuso	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of planned administration of moderate to severely emetogenic IV chemotherapy</li> <li>Attestation that a reasonable possibility exists that oral formulations will not sufficiently control patient's symptoms of nausea and vomiting</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> </ul>	1 year

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Simponi	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>Rheumatologist -or-</li> <li>Dermatologist</li> </ul>	1 year
Sprycel	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing provider.</li> <li>For all indications EXCEPT newly diagnosed chronic phase chronic myeloid leukemia, documentation of previous therapy with Gleevec</li> <li>Adult patient</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> </ul>	1 year
Stelara	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing provider</li> <li>If 90mg dose is being prescribed, documentation of at least one other failed therapy is required</li> </ul>		<ul style="list-style-type: none"> <li>Dermatologist</li> </ul>	1 year
Sutent	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documented intolerance to Gleevec therapy (GIST)</li> <li>Disease progression despite previous therapy (GIST)</li> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> </ul>	1 year
Tarceva	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Chemotherapy regimen includes gemcitabine (pancreatic CA)</li> <li>Chemotherapy regimen includes other therapy, please list</li> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> </ul>	1 year
Tasigna	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing provider.</li> <li>For all FDA approved indications EXCEPT newly diagnosed chronic phase chronic myeloid leukemia, documentation that patient has attempted therapy with Gleevec.</li> <li>Adult patient.</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> </ul>	1 year

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Torisel	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing physician</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> </ul>	1 year
Tracleer	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing physician</li> </ul>		<ul style="list-style-type: none"> <li>Pulmonologist</li> <li>-or-</li> <li>Cardiologist</li> </ul>	1 year
Transmucosal Fentanyl Citrate	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation indicating use in patient with cancer pain who is already receiving and who is tolerant to around-the-clock opioid therapy.</li> <li>For Fentora ONLY, documentation of trial and failure of fentanyl citrate lollipop.</li> <li>Documentation that patient has signed a pain/opioid contract with their physician</li> </ul>			1 year
Treanda	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> </ul>	1 year
Tykerb	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> <li>Patient and physician must be registered with the Tykerb Cares program</li> </ul>	1 year
Tysabri	All FDA-approved indications not otherwise excluded from Part D	<ul style="list-style-type: none"> <li>In combination with other MS treatments or immuno-suppressive treatment</li> </ul>	<ul style="list-style-type: none"> <li>Disease progression despite therapy with Avonex, Betaseron, Copaxone, or Rebif (MS)</li> <li>Please state duration of therapy with previous regimen (MS)</li> <li>Must be prescribed as monotherapy (MS)</li> <li>Inadequate response to conventional therapy (CD)</li> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>Neurologist</li> <li>-or-</li> <li>Gastro-enterologist</li> <li>Patient and Physician must be enrolled in TOUCH program</li> </ul>	1 year

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Vandetanib	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of diagnosis of symptomatic or progressive medullary thyroid cancer that is unresectable locally advanced or metastatic disease</li> <li>Consideration will be given to patients with indolent, asymptomatic or slowly progressing disease due to treatment related risks with vandetanib</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> </ul>	1 year
Vectibix	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Refractory to therapy with a fluoropyrimidine, oxaliplatin, and irinotecan based chemotherapy regimen, please state which regimen</li> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> </ul>	1 year
Vivaglobin	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Consider appropriateness of therapy with Immune Globulin infusion</li> <li>Documentation of approved diagnosis by prescribing provider</li> </ul>			1 year
Votrient	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>Documentation of diagnosis of clear-cell renal cell carcinoma</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> </ul>	1 year
Xgeva	All FDA-approved indications not otherwise excluded from Part D		<p>Documentation supporting:</p> <ul style="list-style-type: none"> <li>Risk of skeletal-related events in patient with bone metastases from solid tumor</li> <li>Patient does not have diagnosis of Multiple Myeloma</li> <li>Preexisting hypocalcemia corrected</li> </ul>		<ul style="list-style-type: none"> <li>Oncologist</li> </ul>	1 year

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Xolair	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>• IgE-mediated allergic asthma not controlled by inhaled corticosteroids.</li> <li>• PFT confirmed reversible airway disease</li> <li>• Documentation of patient weight and IgE level</li> <li>• Positive test confirms allergic sensitivity</li> <li>• Inadequate control despite high dose inhaled steroids</li> <li>• Re-approvals must document medication success</li> <li>• Documentation of approved diagnosis by prescribing provider</li> </ul>	12 years old and older	<ul style="list-style-type: none"> <li>• Allergist</li> <li>-or-</li> <li>• Pulmonologist</li> </ul>	1 year
Xyrem	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>• Documentation of diagnosis of cataplexy or other FDA approved diagnosis</li> </ul>		<ul style="list-style-type: none"> <li>• Neurologist</li> </ul>	1 year
Zavesca	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>• Patient refractory or intolerant to enzyme replacement therapy</li> <li>• Documentation of approved diagnosis by prescribing provider</li> </ul>			1 year
Zolinza	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>• At least 2 prior systemic therapies have been tried, please list therapies</li> <li>• Documentation of approved diagnosis by prescribing provider</li> </ul>		<ul style="list-style-type: none"> <li>• Oncologist</li> </ul>	1 year
Zytiga	All FDA-approved indications not otherwise excluded from Part D		<ul style="list-style-type: none"> <li>• Documentation supporting diagnosis of metastatic castration-resistant prostate cancer</li> <li>• Documentation of prior chemotherapy containing docetaxel</li> <li>• Documentation supporting concurrent use with Prednisone twice daily</li> </ul>		<ul style="list-style-type: none"> <li>• Oncologist</li> </ul>	1 year