

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



You will need authorization by AvMed Medicare Choice before filling prescriptions for the drugs shown in the chart below. AvMed Medicare Choice 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 Member Services at 1-800-782-8633, 24 hours a day, 7 days a week. Member Service is available in English and other languages. TTY/TDD users should call 711.

| <u>PRIOR AUTHORIZATION MEDICATIONS</u> | |
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| <u>AMPYRA</u> | |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | History of seizures/evidence of epileptiform activity on EEG, moderate to severe renal impairment (CrCl less than or equal to 50 ml/min), patient not able to walk 25 feet in 8 - 45 seconds |
| Required Medical Info | Diagnosis of multiple sclerosis |
| Age Restrictions | Greater than or equal to 18 years of age |
| Prescriber Restrictions | |
| Coverage Duration | lifetime |
| Other Criteria | |

| Antifungal Therapy | |
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| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | Onychomycosis in patients with evidence of ventricular dysfunction such as CHF or a history of CHF. Coadministration with certain drugs metabolized by the cytochrome P-450 3A4 isoenzyme system (CYP3A4), cisapride, oral midazolam, pimozide, quinidine, dofetilide, triazolam, HMG-CoA reductase inhibitors metabolized by CYP3A4, such as lovastatin and simvastatin, and ergot alkaloids metabolized by CYP3A4, such as dihydroergotamine, ergotamine, ergonovine, and methylergonovine. |
| Required Medical Info | KOH smear, or dermatophyte test medium, or fungal culture. For Sporanox for onychomycosis: diagnosis of onychomycosis of the toenail and/or fingernail determined by the presence of dermatophytes that must be verified by 1 of the following: KOH smear or dermatophyte test medium or fungal culture. Immunosppression as identified by any of the following: diabetes mellitus, concurrent cancer chemotherapy, concurrent chronic oral corticosteroid use, history of solid organ transplant, HIV, or severe peripheral vascular disease. For Sporanox for a topical fungal infection other than onychomycosis: failed an adequate trial of topical antifungal therapy. For Sporanox for a systemic fungal infection: a systemic fungal infection including, but not limited to: blastomycosis, histoplasmosis, aspergillosis, candidiasis, sporotrichosis, paracoccidioidomycosis |
| Age Restrictions | N/A |
| Prescriber Restrictions | N/A |
| Coverage Duration | 12 weeks for onychomycosis |
| Other Criteria | |

| <u>ARANESP</u> | |
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| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | For CKD not on dialysis for initial therapy: inadequate response to epoetin alfa therapy as defined as failure to achieve target H/H in the presence of adequate iron stores within 4 to 6 months or failure to maintain target H/H subsequently at that dose, and diagnosis of CKD defined as GFR less than 60mL/min or creatinine greater than 1.8mg/dL and lab values within the past 30 days indicating H/H less than 10g/dL/30% or H/H greater than 9.9g/dL/29.9% with documentation of S/Sx of anemia, and transferrin saturation greater than 20% and ferritin greater than 100ng/ml. For CKD not on dialysis continuation therapy: current progress notes indicating symptomatic response to therapy and lab values in the past 30 days indicating: H/H less than 12g/dL/36% and iron panel equivalent to initiation criteria. For anemia due to chemotherapy for nonmyeloid malignancies initial therapy: received chemotherapy within the past 8 weeks and inadequate response to epoetin alfa therapy, as defined previously, diagnosis of non-excluded cancer type, chemotherapy regimen noted, and lab values in the past 30 days indicating: H/H less than 10 g/dL/30% or H/H greater than 9.9 g/dL /29.9% with documentation of S/Sx of anemia. For anemia due to chemotherapy for nonmyeloid malignancies continuation therapy: received chemotherapy within the past 8 weeks and lab values within the past 30 days indicating H/H less than 12g/dL/36% and symptomatic response noted. For anemia associated with MDS initial therapy: inadequate response to epoetin alfa therapy, as defined previously, and diagnosis of MDS confirmed by bone marrow aspiration or biopsy and lab values within the past 30 days indicating: H/H less than 10g/dL/30% or H/H greater than 9.9g/dL/29.9% with documentation of S/Sx of anemia. For anemia associated with MDS continuation therapy: lab values in the past 30 days indicating H/H less than 12g/dL/36% and symptomatic response noted. Dose should be based upon maintaining Hgb level between 10-12 g/dL. |
| Age Restrictions | N/A |
| Prescriber Restrictions | N/A |
| Coverage Duration | Approve up to 3 months. |
| Other Criteria | Drug Part B vs D coverage determination may apply |
| <u>CIMZIA</u> | |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | Concurrent use of other biological response modifiers. Member has acute infection or significant chronic infection requiring hospitalization or intravenous antibiotics within the past 30 days |
| Required Medical Info | Diagnosis, medications tried and failed. T/F one of the following TNF blockers: Enbrel, Remicade, Kineret, Humira, or Simponi |
| Age Restrictions | Must be greater than or equal to 18 yo (or FDA approved age). |
| Prescriber Restrictions | Must be Rheumatologist |
| Coverage Duration | Approve up to 1 year. |
| Other Criteria | |

DALIRESP

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| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Diagnosis of severe COPD as evidenced by FEV1 less than 50% of predicted value AND Member had diagnosis of chronic bronchitis, AND A history of exacerbations |
| Age Restrictions | Adult patients 18 years or older |
| Prescriber Restrictions | |
| Coverage Duration | 1 year |
| Other Criteria | |

DIFICID

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| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Required Medical information: -Diagnosis of severe Clostridium difficile-associated diarrhea -Oral vancomycin trial |
| Age Restrictions | Adult patients 18 years or older |
| Prescriber Restrictions | |
| Coverage Duration | 30 days for each treatment |
| Other Criteria | |

Enbrel

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| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | Concurrent use of more than 1 biological response modifier including, but not limited to: alefacept, adalimumab, infliximab, efalizumab. Diagnosis of guttate, erythrodermic, or pustular psoriasis. Individual experiencing acute infection or significant chronic infection. |
| Required Medical Info | For RA/JRA initial therapy: Moderate to severely active RA evidenced by:swollen joints, ESR of 28mm/hr, or CRP of 20 mg/dL, morning stiffness, inadequate response to Methotrexate (MTX) unless contraindicated and inadequate response to 1 of following: DMARDs, Gold, leflunomide, hydroxychloroquine, sulfasalazine, azathioprine, D-Penicillamine, cyclosporine. MTX contraindication includes:chronic liver disease, leukopenia, thrombocytopenia, CrCl less than 40mL/min, immunodeficiency. For RA/JRA continuation: reduction of S/Sx and improved physical functioning. Ankylosing Spondylitis initial therapy:diagnosed active Ankylosing Spondylitis and morning stiffness. Inadequate response to 2 NSAIDs, unless contraindicated. If peripheral arthritis present, must show inadequate response to sulfasalazine unless contraindicated. Ankylosing Spondylitis continuation: reduction of S/Sx. Psoriatic Arthritis initial therapy: swollen/tender joints and skin involvement documented by 1 of following: at least 3% BSA, psoriasis lesion, Psoriasis area and Severity Index (PASI) Score 10, incapacitated due to plaque location, and inadequate response to 1 NSAID, DMARD, and MTX, unless contraindicated. Psoriatic Arthritis continuation: 2 of following: reduction in S/Sx, 50% improvement in PASI score or improved functioning. For Plaque Psoriasis initial therapy: diagnosis of moderate to severe plaque psoriasis with 1 of the following: 10% BSA, PASI Score 10, incapacitated due to plaque location. Inadequate response to/not a candidate for any of following topicals: Anthralin, Coal Tar, Corticosteroids, Emollients, Immunosuppressives, Keratolytics, Retinoic Acid Derivatives, VitaminD Analogues and an inadequate response to or not a candidate for 1 of following systemic: Immunosuppressives, Retinoic Acid Derivatives, MTX and inadequate response to or not a candidate for phototherapy. Plaque Psoriasis continuation: reduction of S/Sx and improved PASI score 50%. |
| Age Restrictions | Must be greater than or equal to 2 years of age. For JRA: must be between 2 and 17 years of age. For Ankylosing Spondylitis and Psoriatic Arthritis: must be greater than or equal to 18 years of age. |
| Prescriber Restrictions | For RA, JRA, Ankylosing Spondylitis: provider must be a rheumatologist. For Psoriatic Arthritis: provider must be a rheumatologist or dermatologist. For Plaque Psoriasis: provider must be a dermatologist. |
| Coverage Duration | May approve for up to 1 year. |
| Other Criteria | |

Epoetin Alfa

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| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | For CKD and not on dialysis: hypersensitivity to mammalian-cell derived products or to human albumin, untreated iron or folate deficiencies, hemolysis, or GI bleeding, uncontrolled hypertension, or in need of immediate correction of severe anemia. For covered indications other than CKD/ESRD: Anemia that is secondary to the malignancy, hypersensitivity to mammalian-cell derived products, or to human albumin, untreated iron or folate deficiencies, hemolysis, or GI bleeding, uncontrolled hypertension, need for immediate correction of severe anemia, inadequate iron stores including transferrin saturation less than 20% and ferritin less than 100ng/mL, endogenous erythropoietin levels greater than 500 mU/mL for zidovudine induced anemia or greater than 200 mU/mL for anemia secondary to cancer. |
| Required Medical Info | Required Medical Information: Diagnosis of CKD: GFR, creatinine, lab values Hgb/Hct (H/H), transferrin saturation and ferritin level within the past 30 days, current body weight, cancer and chemotherapy history. Criteria for anemia secondary to CKD not on dialysis, anemia due to chemotherapy for nonmyeloid malignancies, anemia associated with MDS equivalent to criteria outlined in the Aranesp prior authorization criteria. In addition, for anemia associated with RA initial therapy: diagnosis of RA and within the past 30 days: H/H less than 10g/dL/30%, or H/H greater than 9.9g/dL/29.9% with S/Sx of anemia. For anemia associated with RA continuation therapy: symptomatic response noted and within past 30 days H/H less than 12g/36%. For anemia secondary to zidovudine initial therapy: diagnosis of HIV, currently receiving zidovudine and within the past 30 days: H/H less than 10g/dL/30%, or H/H greater than 9.9g/dL/29.9% with S/Sx of anemia. For anemia secondary to zidovudine continuation therapy: currently receiving zidovudine, symptomatic response noted and within past 30 days H/H less than 12g/dL/36%. For anemia associated with the management of Hep C initial therapy: currently on interferon or peginterferon plus ribavirin and within the past 30 days: H/H less than 10g/dL/30% or H/H greater than 9.9g/dL/29.9% with S/Sx of anemia. For anemia associated with the management of Hep C continuation therapy: continued antiviral regimen, symptomatic response noted and within past 30 days Hgb/Hct less than 12g/36%. For reduction of allogeneic blood transfusion for surgery: scheduled to undergo major elective non-cardiac, non-vascular surgery, expected to require more than 2 units of blood, unable or unwilling to participate in autologous blood donation, and within the past 30 days H/H greater than 10g/dL/30% and less than 13 g/dL/39%.The rate of Hgb increase should not exceed 1 g/dL in a 2-week period. Dose should be based upon maintaining a Hgb level between 10-12 g/dL. |
| Age Restrictions | N/A |
| Prescriber Restrictions | N/A |
| Coverage Duration | Up to 3 months, not to exceed manufacturer recommended duration of therapy based on indication. |
| Other Criteria | Drug Part B vs D coverage determination may apply |

| <u>ERIVEDGE</u> | |
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| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Info | 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. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |
| <u>Forteo</u> | |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | Hypersensitivity to Forteo, diagnosis of Paget's disease, unexplained elevations of alkaline phosphatase, open epiphyses, previously treated with external beam or implant radiation therapy involving the skeleton, bone metastases or a history of skeletal malignancies, metabolic bone diseases other than osteoporosis, pre-existing hypercalcemia, dose greater than 20 mcg per day, total duration of therapy equal to or greater than 2 years. |
| Required Medical Info | Diagnosis of osteoporosis. Total hip and/or spine T-score, current body weight, fracture history, bone mineral density scan, history of bisphosphonate use. Records maintained by the requesting independent practitioner verifying that no severe adverse reactions are experienced for continuation of Forteo. |
| Age Restrictions | N/A |
| Prescriber Restrictions | N/A |
| Coverage Duration | For initial therapy up to 1 year. Continuation up to 1 year not to exceed 2 years of total therapy. |
| Other Criteria | For initial therapy: Females must have a diagnosis of osteoporosis as evidenced by: 1. Postmenopausal with a total hip and/or spine T-score of less than -2.5, and history of non-traumatic fracture or failure of bisphosphonate therapy as evidenced by increased bone mineral density in hip or spine after 2 or more years of therapy. 2. Postmenopausal with a total hip and/or spine T-score score between -2.0 and -2.5 AND at least 1 risk factor, such as non-vertebral non-traumatic fracture, low body weight (less than 127 lbs or 57.7 kg), history of first-degree relative with a non-traumatic hip or vertebral fracture. 3. Males must be diagnosed with primary or hypogonadal osteoporosis as evidenced by total hip and/or spine T-score of less than -2.5 or total hip and/or spine T-score between -2.0 and -2.5 with history of non-traumatic non-vertebral fracture. For continuation therapy: records maintained by the requesting independent practitioner verifying that no severe adverse reactions are experienced. |

| GCSF | |
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| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | For Neupogen: Hypersensitivity to E. coli-derived proteins, filgrastim, or any component of the product. For Neulasta: Hypersensitivity to pegfilgrastim or filgrastim. For Leukine: In patients with excessive leukemic myeloid blasts in the bone marrow or peripheral blood (10% or greater), hypersensitivity to GM-CSF, yeast-derived products or any component of the product, concomitant use with chemotherapy and radiotherapy. |
| Required Medical Info | CBC with differential, platelet count, and ANC obtained within the last 30 days. For primary prophylaxis (first and subsequent cycle) of febrile neutropenia due to cytotoxic chemotherapy for nonmyeloid malignancies: must be on chemotherapy. For treatment of febrile neutropenia: if prescriber is not an oncologist, documentation of high risk features must include: expected (greater than 10 days) and profound (less than $0.1 \times 10^9/L$) neutropenia, age greater than 65 years, uncontrolled primary disease, pneumonia, sepsis syndrome (hypotension and multi-organ dysfunction), invasive fungal infection, hospitalization at development of fever. For initiation for treatment of ganciclovir or zidovudine induced neutropenia: current treatment and experiencing neutropenia characterized by an ANC below 1000 cells/uL within the last 30 days. For continuation for treatment of ganciclovir or zidovudine induced neutropenia: CBC with differential and platelet count is obtained 2-3 times weekly during initial filgrastim dosing to maintain an ANC between 2,000-10,000 cells/uL, CBC with differential and platelet count is monitored every 2 weeks once ANC is stabilized within the target range until therapy is discontinued. For treatment of pegylated interferon and ribavirin induced neutropenia: current treatment and experiencing neutropenia characterized by an ANC below 1000 cells/uL obtained within the last 30 days. Filgrastim is administered at a dose of 5 mcg/kg/day IV/SC or by continuous IV/SC infusion. Duration is usually 14 days but will be determined by the desired ANC following the expected chemotherapy-induced neutrophils nadir. If the ANC is above 1000/mm ³ for 3 consecutive days, filgrastim may be discontinued. Filgrastim must be discontinued when ANC reaches 10,000/mm ³ . Administer medication 24 hours after the completion of myelosuppressive chemotherapy for non-myeloid malignancies and pegfilgrastim should not be given within 14 days of next chemotherapy administration. |
| Age Restrictions | N/A |
| Prescriber Restrictions | Requesting practitioner must be a oncologist, infectious disease specialist, or gastroenterologist. |
| Coverage Duration | Up to 3 months, not to exceed manufacturer recommended duration of therapy based on indication. |
| Other Criteria | |

Gilenya

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| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Diagnosis of relapsing MS (RMS) or relapsing-remitting MS (RRMS). Initial treatment: Member has a documented complete blood count (CBC) within the last six (6) months AND Members currently using antiarrhythmics (including beta-blockers, calcium channel blockers, Class Ia and Class III antiarrhythmics) or with cardiac risk factors (2nd degree or higher AV blocks, sick sinus syndrome, prolonged QT interval, ischemic heart disease, or congestive heart failure, bradycardia less than 55 beats per minute) have a documented EKG (electrocardiogram) within the last six (6) months AND Member has a documented liver transaminase and bilirubin level within the last six (6) months AND Member has a documented ophthalmologic evaluation at time of initiation (within two (2) weeks AND A documented history of chicken pox or administration of the varicella zoster vaccine (VZV). If no history or administration of VZV, then titers should be drawn and if low VZV should be considered AND Member has had an inadequate response (as demonstrated by continued disease activity measured clinically or by MRI) and/or intolerance to Rebif and Copaxone. Continuation of treatment: Documented adherence to fingolimod dosing regimen AND Member is responding to therapy evidenced by no elapse AND Documented absence of disability progression. |
| Age Restrictions | 18 years of age and older |
| Prescriber Restrictions | neurologist |
| Coverage Duration | 3 months for initial treatment. 1 year for continuation. |
| Other Criteria | Approved dosing is 0.5mg daily. |

| <u>Growth Hormone</u> | |
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| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | Contraindicated in children with active malignancies and is generally withheld for at least 1 year after completion of successful therapy for a malignancy. Glucocorticoid-induced growth failure, renal transplantation, and genetic and chromosomal disorders (except PWS and Turner Syndrome) associated with short stature are not covered. If while on growth hormone, growth rate decreases to less than 2.5 cm/year. Bones age suggests no further growth potential (14 years for females and 16 years for males). Reached the 10th percentile for normal adult height. Achieved height consistent with midparental height. Fused epiphyses. |
| Required Medical Info | Growth rate and height chart, endogenous pituitary growth hormone level, 2 growth hormone tests excluding GHRH tests, current bone age, pretreatment growth rate, BMI, blood glucose levels. Diagnosis of: chronic renal insufficiency up to the time of renal transplan, diagnosis of Turner Syndrome or Prader-Willi Syndrome. For growth hormone deficiency initial therapy: height is less than 5th percentile, growth rate is less than 4 cm/year, endogenous pituitary growth hormone level is less than 10mg/ml on 2 standard growth hormone tests excluding GHRH tests, delayed bone age greater or equal to 2 years below actual age. For growth hormone deficiency continuation therapy: pretreatment growth rate has doubled while on growth hormone or growth rate is at least 3 cm/year in children with extremely low pretreatment growth rates. For chronic renal insufficiency up to renal transplant initial therapy: diagnosis of chronic renal insufficiency, height less than 5th percentile, growth rate less than 4 cm/year, delayed bone age greater or equal to 2 years below actual age. For chronic renal insufficiency up to renal transplant continuation therapy: pretreatment growth rate doubled on growth hormone or growth rate at least 3 cm/year in children with extremely low pretreatment growth rates. For Turner Syndrome initial therapy: diagnosis confirmed by karyotype genetic testing, height less than 5th percentile, growth rate less than 4 cm/year, delayed bone age greater or equal to 2 years below actual age. For Turner Syndrome continuation therapy: pretreatment growth rate doubled while on growth hormone or growth rate is at least 3 cm/year in children with extremely low pretreatment growth rates. For Prader-Willi Syndrome initial therapy: diagnosis confirmed by genetic testing, diet to maintain low BMI, 5% reduction body fat, 5% increase fat free mass, blood glucose levels. Omnitrope contains preservative. Members with a contraindication to preservative, Genotropin may be used. |
| Age Restrictions | N/A |
| Prescriber Restrictions | N/A |
| Coverage Duration | May approve for up to 1 year. |
| Other Criteria | |

| <u>High Risk Medication</u> | |
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| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Prescriber or patient provides a reason why any ONE unrestricted formulary alternative can not be tried, OR pt has already tried and failed any ONE alternative medication, OR MD has been made aware that the incoming drugs is a high risk medications and wishes to proceed with originally prescribed medication. |
| Age Restrictions | 65 years or older |
| Prescriber Restrictions | |
| Coverage Duration | 1 year |
| Other Criteria | |
| <u>HORMONAL AGENTS</u> | |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Diagnosis |
| Age Restrictions | |
| Prescriber Restrictions | gynecologist, or endocrinologist, or oncologist |
| Coverage Duration | 1 year |
| Other Criteria | |

| Humira | |
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| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Number of tender or swollen joints,ESR,CRP,CrCl,degree of morning stiffness, Hx of NSAID/DMARD use,BSA affected,Psoriasis Area and Severity Index (PASI),plaque location,reduction of S/Sx and improved physical functioning.For RA/JRA initial therapy: moderate to severely active RA defined by:swollen joints, ESR of 28mm/hr or more or CRP of 20 mg/dL or more,morning stiffness, inadequate response or contraindicated to MTX,and inadequate response to 1 DMARD.For RA/JRA continuing therapy: reduction of S/Sx and improved physical functioning.For Ankylosing Spondylitis (AS) initial therapy: diagnosis of active AS and morning stiffness.At least 2 trials of 2 NSAID therapies, including sulfasalazine if peripheral arthritis evident,unless contraindicated. For AS continuing therapy:reduction of S/Sx.For Psoriatic Arthritis (PsA) initial therapy: swollen, tender joints and skin involvement documented by 1 of the following:minimum of 3% BSA affected, psoriasis lesion,PASI Score of 10 or more, incapacitation due to plaque location,and inadequate response to trial of 1 NSAID,DMARD,and MTX,unless contraindicated.For Psoriasis initial therapy: diagnosis of moderate to severe plaque psoriasis documented with 1 of the following:at least 10% BSA involvement,PASI Score of 10 or more,incapacitation due to plaque location.Inadequate response to trial of or not a candidate for a topical agent and a systemic agent.For Psoriasis continuing therapy:reduction of S/Sx and improvement in PASI score of at least 50%.For Crohn's Disease (CD) initial therapy:diagnosis of moderate to severe CD by radiological or endoscopic evidence and 1 of the following symptoms: fevers, significant weight loss,abdominal pain or tenderness,intermittent nausea or vomiting, significant anemia,or CD Activity Index (CDAI) score of 220-450 and inadequate response to 2 of the following:Mesalamine,Sulfasalazine,Predinsone,Budesonide,Azathioprine,6-MP, MTX,Infliximab.For CD continuation:reduction of S/Sx |
| Age Restrictions | Must be greater than or equal to 4 years of age. |
| Prescriber Restrictions | For RA, JRA, and Ankylosing Spondylitis: provider must be a rheumatologist. For Psoriatic Arthritis: provider must be a rheumatologist or dermatologist. For Crohn's Disease: provider must be a gastroenterologist. |
| Coverage Duration | Initial therapy approve up to 6 months. Continuation therapy approve up to 1 year. |
| Other Criteria | |

| <u>INCIVEK</u> | |
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| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | Coverage is not provided fo genotypes other than type 1. Duration of therapy longer than 3 months. Previous failure to Incivek or Victrelis. |
| Required Medical Info | 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. |
| Age Restrictions | |
| Prescriber Restrictions | gastroenterologist, hepatologist, or infectious disease physician specializing in the treatment of Hepatitis C |
| Coverage Duration | 3 months |
| Other Criteria | |
| <u>INCRELEX</u> | |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | Contraindicated in children with active malignancies and is generally withheld for at least 1 year after completion of successful therapy for a malignancy. Glucocorticoid-induced growth failure, renal transplantation, and genetic and chromosomal disorders (except PWS and Turner Syndrome) associated with short stature are not covered. If while on growth hormone, growth rate decreases to less than 2.5 cm/year. Bones age suggests no further growth potential (14 years for females and 16 years for males). Reached the 10th percentile for normal adult height. Achieved height consistent with midparental height. Fused epiphyses. |
| Required Medical Info | Diagnosis of Primary insulin-like growth factor-1 deficiency (IGFD) or Growth hormone gene deletion with the development of growth hormone neutralizing antibodies. Confirmation that epiphyses open via wrist film. For continuation therapy confirmation of epiphyses open via wrist film is required. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | Approve up to 1 year. |
| Other Criteria | |
| <u>INLYTA</u> | |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Info | For RCC coverage is provided after failure with one prior systemic therapy |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |

| <u>INTRON-A</u> | |
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| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | Hypersensitivity to interferon alfa or any of its components, diagnosis of autoimmune hepatitis, hepatic decompensation (Child-Pugh class B and C) before, or during treatment, unstable laboratory values: neutrophil count less than 1500/mm ³ , platelet count less than 70,000/mm ³ , hemoglobin less than 10g/dL, serum creatinine greater than 1.5 mg/dL. |
| Required Medical Info | Laboratory reports indicating all of the following: presence of antibody to HCV, bilirubin level, platelet count, WBC count, creatinine, albumin level, ALT levels. For Roferon-A initial therapy: diagnosis of hairy cell leukemia or diagnosis of chronic myelogenous leukemia and minimally pretreated within 1 year of diagnosis, or diagnosis of chronic HCV: liver biopsy (genotype 1) verifying the diagnosis of HCV, and laboratory reports indicating all of the following: presence of antibody to HCV, bilirubin level of 2mg/dL or greater, platelet count of 70,000/mm ³ or greater, white blood cell count of 3,000/mm ³ or greater, creatinine within normal limits (WNL), albumin level WNL. For Roferon-A continuation therapy: no severe adverse reactions. For Intron A initial therapy: diagnosis of hairy cell leukemia, or diagnosis of malignant melanoma and free of disease, but at a high risk for systemic recurrence (within 56 days of surgery), or diagnosis of follicular Non-Hodgkins lymphoma, and used in conjunction with anthracycline-containing chemotherapy, or diagnosis of condylomata acuminata, or diagnosis of AIDS-related Kaposi's sarcoma or diagnosis of chronic hepatitis C virus (HCV): liver biopsy (genotype 1) verifying the diagnosis of HCV, and laboratory reports indicating all of the following: presence of antibody to HCV, bilirubin level of 2mg/dL or greater, platelet count of 70,000/mm ³ or greater, white blood cell count of 3,000/mm ³ or greater, serum creatinine WNL, albumin level WNL or diagnosis of chronic hepatitis B (HBV): laboratory reports indicating all of the following: serum hepatitis surface antigen (HbsAg) positive for at least six (6) months, evidence of HBV replication (or HbeAg positive), elevated ALT levels for at least 3 months, bilirubin level WNL, albumin level WNL, white blood cell (WBC) count of 4,000/mm ³ or greater, platelet count of 100,000/mm ³ (adults) or 150,000/mm ³ (pediatrics). For Intron A continuation therapy: no severe adverse reactions. |
| Age Restrictions | For all indications other than chronic HBV: must be greater than or equal to 18 years of age. For HBV: must be greater than or equal 1 year of age. |
| Prescriber Restrictions | Requesting practitioner must be a oncologist or gastroenterologist. |
| Coverage Duration | Initial therapy approve up to 3 months. Continuation therapy may approve for up to 1 year. |
| Other Criteria | |
| <u>JAKAFI</u> | |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |
| <u>Jevtana</u> | |

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| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Patient has been previously treated with a Taxotere (docetaxel) containing treatment regimen AND is being treated with prednisone in combination with Jevtana. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 1 year |
| Other Criteria | Subject to Part B vs D review |

KINERET

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| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | Concurrent use of Enbrel, Humira, Remicade, Raptiva. |
| Required Medical Info | Diagnosis, drugs tried and failed. Diagnosis moderate to severe Rheumatoid Arthritis (RA). Previous trial of one of the following: Humira, Enbrel, Remicade, Simponi, or Methotrexate and trial of one DMARD therapy |
| Age Restrictions | Must be greater than or equal to 18 years of age. |
| Prescriber Restrictions | Prescriber must be a Rheumatologist. |
| Coverage Duration | Initially approved for 3 months, with adequate response approve for 1 year |
| Other Criteria | |

KUVAN

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| Covered Uses | All medically accepted indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Diagnosis, phenylalanine levels |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 3 months initially |
| Other Criteria | |

| <u>MOZOBIL</u> | |
|--------------------------------|---|
| Covered Uses | All medically accepted indications not otherwise excluded from Part D |
| Exclusion Criteria | Part B Coverage |
| Required Medical Info | Diagnosis: Harvesting of peripheral blood stem cells, In patients with non-Hodgkin's lymphoma and multiple myeloma. Patients weight for dosage determination. Concurrent Treatments: used in combination with granulocyte-colony stimulating factor |
| Age Restrictions | Approve for those patients 18 years of age or older |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |
| <u>Neumega</u> | |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | History of hypersensitivity to oprelvekin or any component of the product. Dosing beyond 21 days per treatment course. |
| Required Medical Info | Current lab values indicating platelet count. |
| Age Restrictions | Must be greater than or equal to 8 months of age. |
| Prescriber Restrictions | N/A |
| Coverage Duration | May approve for up to 18 weeks. |
| Other Criteria | Laboratory monitoring, a complete blood count should be obtained prior to chemotherapy and at regular intervals during Neumega therapy. Platelet counts should be monitored during the time of the expected nadir and until adequate recovery has occurred (postnadir counts greater than 50,000 per mcL). |
| <u>Noxafil</u> | |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | Hypersensitivity to posaconazole, co-administration with ergot alkaloids or CYP3A4 substrates. |
| Required Medical Info | Diagnosis being treated. Previous antifungal therapy tried and response to treatment. |
| Age Restrictions | Must be greater than or equal to 13 years of age. |
| Prescriber Restrictions | N/A |
| Coverage Duration | Approvable not to exceed manufacturer recommended dose based on requested indication. |
| Other Criteria | Persons with diagnosis of oropharyngeal candidiasis that have tried and failed at least 2 weeks of therapy with, or is not a candidate for, fluconazole or itraconazole. Also, prophylactic use against Aspergillus and Candida infection in individuals that are immunosuppressed due to hematopoietic stem cell transplant secondary to graft-versus host disease or hematologic malignancy with prolonged neutropenia secondary to chemotherapy. |

ORENCIA SC

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| Covered Uses | All FDA-approved indications not otherwise excluded from Part D |
| Exclusion Criteria | Coverage is not provided for use in combination with other biologics e.g., Humira, Kineret, Remicade, etc |
| Required Medical Info | 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. |
| Age Restrictions | 18 years of age or older |
| Prescriber Restrictions | |
| Coverage Duration | 5 years |
| Other Criteria | Renewal coverage is provided in situations where treatment has provided clinical benefit. |

Pegasys, PEG-Intron

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| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | Advanced cirrhosis at risk for decompensation (Child-Pugh class B/C). Advanced cirrhosis may be identified with any of the following signs or complications of liver failure: coagulopathy or elevated INR in absence of warfarin, ascites, encephalopathy, hypoalbuminemia, hyperbilirubinemia. Also, persistently normal ALT levels in absence of biopsy documenting liver damage secondary to HCV or HBV, a diagnosis of major depression, hyperthyroidism, or evidence of autoimmune disease, history of significant or unstable cardiac disease, history of solid organ or bone marrow transplant, prescription for or is currently taking Epivir, Hepsera, Tyzeka, or Baraclude for the treatment of hepatitis B. Also, Hgb less than 8.5g/L without cardiac disease, Hgb less than 12.0g/L with cardiac disease, WBC less than $1.0 \times 10^9/L$, neutrophils less than $0.5 \times 10^9/L$, platelets less than 50×10^9 . Also, does not have at least a 100-fold (2 log 10) decrease in HCV RNA viral load after 12-weeks of therapy confirmed via quantitative measurement, or has completed recommended course of therapy: 48 weeks for genotype 1, 24 weeks for genotypes other than 1, 48 weeks for Hepatitis B. |
| Required Medical Info | Viral load (VL),ALT/AST levels,INR,Hgb, WBC,neutrophils,platelets measured within 30 days.HCV genotyping,HBV antigen test.T/F of Pegasys before approving Peg-intron will be required. For Hep C initial therapy:detectable HCV RNA VL with persistently elevated ALT,or ALT WNL and liver biopsy (genotype 1) indicating portal,bridging fibrosis,moderate degrees of inflammation and necrosis,or current INR WNL.Approval of ribavirin must be approved thru 16 week period.Repeat HCV RNA VL is required for treatment beyond initial16 weeks .For initial monotherapy for HepC:all previous criteria are met plus a contraindication for ribavirin.Request for continuation of therapy for Hep C requires: adherence to regimen, repeat HCV RNA VL is undetectable or has decreased at least 100-fold (2 log 10) from pre-treatment HCV RNA VL,repeat ALT is normal or significantly decreased from pre-treatment level,and Hgb,WBC,neutrophils, and platelets are within range to continue therapy,and has not completed course of therapy.For interferon naive Hep B initial therapy: HbsAg-+ for 6 months.HBeAg-+ with the following:quantitative HBV DNA greater than 20K IU/mL,ALT greater than 2X ULN.Or has ALT less than 2X ULN with both:a liver biopsy (genotype 1) that indicates moderate to severe necroinflammation or significant fibrosis and a current INR WNL.HBeAg- with all of the following:quantitative HBV DNA greater than 20K IU/mL and ALT greater than 2X ULN,or has quantitative HBV DNA greater than 20K IU/mL and/or ALT less than 2X ULN with the following:a liver biopsy (genotype 1) that indicates moderate to severe necroinflammation or significant fibrosis and a current INR WNL.For Hep B continuation therapy:adherence to regimen,has not completed course of therapy,and Hgb,neutrophils, and platelets are within range to continue therapy.Authorization for ribavirin must be current through the 16week period.Repeat HCV RNA VL will be required for continuation beyond initial 16 |
| Age Restrictions | Must be greater than or equal to 3 years of age. |
| Prescriber Restrictions | N/A |
| Coverage Duration | Initial for 16 weeks. Continuation not to exceed manufacturer recommended duration for indication. |
| Other Criteria | |

| <u>Promacta</u> | |
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| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | Not diagnosis of chronic ITP. Chronic ITP diagnosis less than 3 months. |
| Required Medical Info | Diagnosis of chronic ITP, platelet count less than 30 x 10 ⁹ /L. For initial therapy: Must have diagnosis of chronic ITP of greater than 3 months in duration, must have a platelet count less than 30 x 10 ⁹ /L, must have been splenectomized OR had an inadequate response to corticosteroids AND intravenous immune globulin (IVIG or IGIV), or anti Rh(D) immune globulin, initial dose is 50mg /d (except 25 mg/d for a patient of East Asian ancestry OR a patient with moderate to severe hepatic impairment). For continuation: must have experienced an increase in platelet count over baseline to a level sufficient to avoid clinically important bleeding, cannot be experiencing an ALT elevation greater than or equal to 3 times the upper limit of normal that is progressive, persistent for greater than or equal to 4 weeks, accompanied by increased direct bilirubin, clinical symptoms of liver injury, OR evidence for hepatic decompression, requested dose of Promacta less than or equal to 75mg daily, the patient cant be experiencing any intolerable side effects or any new or worsening morphological abnormalities. |
| Age Restrictions | Must be greater than or equal to 18 years of age. |
| Prescriber Restrictions | Requesting prescriber must be registered with the Promacta Cares Program. |
| Coverage Duration | May approve up to 6 months. |
| Other Criteria | |
| <u>Pulmonary Artery Hypertension</u> | |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part |
| Exclusion Criteria | |
| Required Medical Info | PAH: Patients with a confirmed diagnosis of pulmonary arterial hypertension (modified WHO Group I) which is symptomatic. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 1 year |
| Other Criteria | |

| <u>Quaalquin</u> | |
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| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | Persons diagnosed with: prolonged QT interval, glucose-6-phosphate dehydrogenase deficiency, Myasthenia Gravis, or optic neuritis. Those with a hypersensitivity to quinine, mefloquine, quinidine, or with potential hypersensitivity associated with previous quinine use. |
| Required Medical Info | N/A |
| Age Restrictions | N/A |
| Prescriber Restrictions | N/A |
| Coverage Duration | May be approved up to a maximum dose of 650mg every 8 hours up to 7 days. |
| Other Criteria | Diagnosis of uncomplicated Malaria with trial and failure of chloroquine. |
| <u>Ribavirin</u> | |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | Pregnancy or male with female partner who is pregnant, or evidence of autoimmune disease or hemoglobinopathy (e.g., thalassemia major, sickle-cell anemia), and creatinine clearance less than 50 mL/minute. |
| Required Medical Info | Diagnosis with Hepatitis C and a detectable viral load, ALT levels, current INR, Hgb, WBC, neutrophils, and platelets measured within the past 30 days. HCV genotyping. For initiation, must meet criteria for peginterferon alpha and have concurrent authorization. For continuation of therapy, demonstrated adherence to prescribed regimen, repeat HCV RNA viral count is undetectable or has decreased at least 100-fold (2 log 10) from pre-treatment HCV RNA viral load, and repeat ALT is normal or significantly decreased from pre-treatment level, and Hgb, WBC, neutrophils, and platelets are within range to continue therapy, continuing with peginterferon alpha treatment. If genotype 1 optimal duration of treatment is 48 weeks. If genotype 2 and 3 optimal duration of treatment is 24 weeks. |
| Age Restrictions | Must be greater than or equal to 3 years of age. |
| Prescriber Restrictions | N/A |
| Coverage Duration | Initial for 16 weeks. Continuation for genotype 1 approve for an additional 32 weeks. Continuation |
| Other Criteria | |

| <u>SIMPONI</u> | |
|--------------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | Concurrent use of other biological response modifiers. Member has acute infection or significant chronic infection requiring hospitalization or intravenous antibiotics within the past 30 days |
| Required Medical Info | For RA initial therapy: moderate to severely active RA as evidenced by: swollen joints, ESR of 28mm/hr or greater, or CRP of 20 mg/dL or more, morning stiffness, inadequate response to a trial of Methotrexate (MTX), unless contraindicated, inadequate response to 1 of the following DMARDs: Gold, leflunomide, hydroxychloroquine, sulfasalazine, azathioprine, D-Penicillamine, cyclosporine and inadequate response to Humira and Enbrel. For RA continuation therapy: reduction of S/Sx and improved physical functioning. For Ankylosing Spondylitis initial therapy: diagnosis of active Ankylosing Spondylitis and morning stiffness. Inadequate response to at least two different trials of 2 NSAID therapies, unless contraindicated. If a component of peripheral arthritis is present, must show an inadequate response to a trial of sulfasalazine, unless contraindicated and inadequate response to Humira and Enbrel. For Ankylosing Spondylitis continuation therapy: reduction of S/Sx. For Psoriatic Arthritis initial therapy: must have swollen and tender joints and skin involvement documented by at least 1 of the following: minimum of 3% BSA affected, psoriasis lesion, Psoriasis area and Severity Index (PASI) Score of 10 or greater, incapacitation due to plaque location, and inadequate response to trial of 1 or more NSAID, DMARD, and MTX, unless contraindicated, and inadequate response to Humira and Enbrel. For Psoriatic Arthritis continuation therapy: verification of at least 2 of the following: reduction in S/Sx, 50% improvement in PASI score, or improvement in physical functioning |
| Age Restrictions | Must be greater than or equal to 18 yo (or FDA approved age). |
| Prescriber Restrictions | Must be Rheumatologist |
| Coverage Duration | Approve up to 1 year. |
| Other Criteria | |
| <u>SYLATRON</u> | |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 1 year |
| Other Criteria | |

| <u>VANDETANIB</u> | |
|--------------------------------|---|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Dx: metastatic or unresectable medullary thyroid cancer |
| Age Restrictions | |
| Prescriber Restrictions | Oncologist |
| Coverage Duration | 1 year |
| Other Criteria | |
| <u>VICTRELIS</u> | |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | Coverage is not provided fo genotypes other than type 1. Duration of therapy longer than 11 months. Previous failure to Incivek or Victrelis. |
| Required Medical Info | Member is not a candidate for Incivek treatment. 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. |
| Age Restrictions | |
| Prescriber Restrictions | gastroenterologist, hepatologist, or infectious disease physician specializing in the treatment of Hepatitis C |
| Coverage Duration | 11 months |
| Other Criteria | |
| <u>XALKORI</u> | |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Info | 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 |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |
| <u>YERVOY</u> | |
| Covered Uses | All FDA approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | |
| Age Restrictions | 18 years of age or older |
| Prescriber Restrictions | |
| Coverage Duration | 3 months |
| Other Criteria | |
| <u>ZELBORAF</u> | |

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|--------------------------------|--|
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. Additional coverage for off-label use includes unresctable or metastatic melanoma in patients with BRAFv600K mutation |
| Exclusion Criteria | Combination use with ipilimumab |
| Required Medical Info | For unresctable or metastatic melanoma with BRAFV600E or BRAFV600K mutation as detected by FDA approved or CLIA lab approved reliable assay |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 months |
| Other Criteria | |
| <u>ZYTIGA</u> | |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria | |
| Required Medical Info | Diagnosis of metastatic castrate-resistant prostate cancer. Member tried and failed Taxotere (docetaxel) therapy. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | Initial approval 6 months |
| Other Criteria | |

| 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. | |
|---|--|
| Drug Name | Route of Administration / Dosage Form |
| A-METHAPRED | INJECTION SOLUTION RECONSTITUTED |
| ACCUNEB | INHALATION NEBULIZATION SOLUTION |
| ACETYLCYSTEINE | INHALATION SOLUTION |
| ALBUTEROL SULFATE | INHALATION NEBULIZATION SOLUTION |
| ALDURAZYME | INJECTION SOLUTION |
| AMPHOTERICIN B | INJECTION SOLUTION RECONSTITUTED |
| ANZEMET | ORAL TABLET |
| ATGAM | INJECTION INJECTABLE |
| AZATHIOPRINE | ORAL TABLET |
| AZATHIOPRINE SODIUM | INJECTION SOLUTION RECONSTITUTED |
| BONIVA | INJECTION SOLUTION |
| BROVANA | INHALATION NEBULIZATION SOLUTION |
| BUDESONIDE | INHALATION SUSPENSION |
| CELLCEPT | ORAL SUSPENSION RECONSTITUTED |

| Drug Name | Route of Administration / Dosage Form |
|---|--|
| CELLCEPT | ORAL TABLET |
| CELLCEPT | ORAL CAPSULE |
| CELLCEPT INTRAVENOUS | INJECTION SOLUTION RECONSTITUTED |
| CEREZYME | INJECTION SOLUTION RECONSTITUTED |
| CROMOLYN SODIUM | INHALATION NEBULIZATION SOLUTION |
| CYCLOPHOSPHAMIDE | ORAL TABLET |
| CYCLOSPORINE | ORAL CAPSULE |
| CYCLOSPORINE | INJECTION SOLUTION |
| CYCLOSPORINE MODIFIED | ORAL CAPSULE |
| CYCLOSPORINE MODIFIED | ORAL SOLUTION |
| DEPO-MEDROL | INJECTION SUSPENSION |
| DUONEB | INHALATION SOLUTION |
| 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 |
| GRANISOL | ORAL SOLUTION |
| IMURAN | ORAL TABLET |
| IPRATROPIUM BROMIDE | INHALATION SOLUTION |
| IPRATROPIUM BROMIDE/ALBUTEROL SULFATE | INHALATION SOLUTION |
| LEVALBUTEROL | INHALATION NEBULIZATION SOLUTION |
| 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 CAPSULE |
| NEORAL | ORAL SOLUTION |

| Drug Name | Route of Administration / Dosage Form |
|----------------------|--|
| NULOJIX | INJECTION SOLUTION RECONSTITUTED |
| ONDANSETRON HCL | ORAL SOLUTION |
| ONDANSETRON HCL | ORAL TABLET |
| ONDANSETRON ODT | ORAL TABLET DISPERSIBLE |
| ORTHOCLONE OKT3 | INJECTION INJECTABLE |
| PAMIDRONATE DISODIUM | INJECTION SOLUTION |
| PERFORMIST | INHALATION NEBULIZATION SOLUTION |
| PROGRAF | INJECTION SOLUTION |
| PROGRAF | ORAL CAPSULE |
| PULMICORT | INHALATION SUSPENSION |
| PULMOZYME | INHALATION SOLUTION |
| RAPAMUNE | ORAL SOLUTION |
| RAPAMUNE | ORAL TABLET |
| RECOMBIVAX HB | INJECTION SUSPENSION |
| SANDIMMUNE | ORAL CAPSULE |
| SANDIMMUNE | INJECTION SOLUTION |
| SANDIMMUNE | ORAL SOLUTION |
| SOLU-MEDROL | INJECTION SOLUTION RECONSTITUTED |
| TACROLIMUS | ORAL CAPSULE |
| THYMOGLOBULIN | INJECTION SOLUTION RECONSTITUTED |
| TWINRIX | INJECTION SUSPENSION |
| VANCOMYCIN HCL | INJECTION SOLUTION RECONSTITUTED |
| XOPENEX | INHALATION NEBULIZATION SOLUTION |
| ZOFRAN | ORAL TABLET |
| ZOFRAN | ORAL SOLUTION |
| ZOFRAN ODT | ORAL TABLET DISPERSIBLE |
| ZORTRESS | ORAL TABLET |