

Prior Authorization Group Desc	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
Afinitor	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	6 months	Member has failed treatment with Sutent and/or Nexavar.
Amevive	Age greater than 18 years AND Has diagnosis of moderate to severe chronic plaque psoriasis AND Has BSA greater than 10% OR Has BSA less than 10% and the psoriasis: Involves the palms, soles, head and neck, or genitalia and is considered to be moderate to severe in severity AND fails on ONE or more of the following treatments: phototherapy (e.g., psoralens with UVA light) or photochemotherapy acitretin methotrexate cyclosporine.	None	None	None	None	6 months	None

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Antineoplastic	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	1 year	None

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Botulin	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	3 months	In addition Botulin toxin will be covered as a special limited-use drug for the following conditions. Cervical dystonia in adults to decrease the severity of abnormal head position and neck pain. Severe primary axillary hyperhidrosis that is inadequately managed with topical agents. Strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorders in patients 12 years of age and above. Headache when the patient has failed blocking agents (beta-blockers, tricyclics) or triptans or anesthetics. Vocal cord spasms (spasmodic dysphonia). Hemifacial spasm. Spasticity related to cerebral palsy or other chronic neurologic conditions. Other FDA approved

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							indications except for cosmesis. Other neuromuscular conditions as approved by the Medical Director.
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CSF	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	3 months	None
Enbrel	Diagnosis of Active Ankylosing Spondylitis and has failed, had an inadequate response to or is not indicated for treatment with ONE OF THE FOLLOWING: sulfasalazine, methotrexate, or non-steroidal anti-inflammatory drugs. OR a diagnosis of Moderate to severe Chronic Plaque Psoriasis that was not controlled with topical therapy and had a failure to achieve an adequate clinical response or medical contraindication to phototherapy OR ONE other systemic therapies (e.g. methotrexate, acitretin, or cyclosporine). OR a diagnosis of Moderately	Latex allergy as Enbrel prefilled syringe cover contains latex. Tuberculosis or a history of recurrent infection, chronic current infection, or clinically important infection. Patients who have not had a tuberculin skin test to rule out latent tuberculosis. History of systemic malignancy within the last 5 years. Moderate to severe	None	None	restricted to Rheumatologists and Dermatologists	6 months	None

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	to severely active Rheumatoid Arthritis or moderate to severe active polyarticular-course juvenile idiopathic arthritis (JIA) and patient has failed or had an inadequate response to ONE of the disease modifying anti-rheumatic agents (DMARDs). OR a diagnosis of Psoriatic Arthritis and patient has failure or contraindicated for ONE of the DMARDs OR All other FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D.	(NYHA Class III/IV) Congestive Heart Failure (CHF), Multiple Sclerosis or other demyelinating disease. Using Enbrel in combination with other TNF agents or Kineret. Patient is currently receiving phototherapy, systemic psoriasis therapy (except for methotrexate, glucocorticoids, salicylates, non-steroidal anti-inflammatory drugs, or analgesics), immunosuppressive therapy, or Anakinra.					
EPO	All FDA-approved indications not otherwise excluded from Part D. Coverage criteria include. Treatment of anemia associated with the anemia of chronic medical disease including chronic renal failure, connective tissue disease, HIV, etc. (Not intended for patients who require immediate correction of severe anemia). The goal of treatment is to maintain the hemoglobin between 10 – 12 g/dL. Treatment of anemia in cancer patients on 2 weeks or more of chemotherapy. Treatment is indicated if the hemoglobin is less than 10 g/dL and the target is 10 g/dL. ESA treatment for the anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia is only reasonable and necessary under the following	Exclusion criteria include, Any anemia in cancer or cancer treatment patients due to folate deficiency, B-12 deficiency, iron deficiency, hemolysis, bleeding, or bone marrow fibrosis. The anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) or erythroid cancers. The anemia of cancer not related to cancer treatment. Any anemia associated only with radiotherapy. Prophylactic use to prevent chemotherapy-induce	None	None	None	2 months	2-The starting dose for ESA treatment is the FDA label starting dose, no more than 150 U/kg/3 times weekly for epoetin and 2.25 mcg/kg/1 time weekly for darbepoetin alpha. Equivalent doses may be given over other approved time periods. 3-Maintenance of ESA therapy is the starting dose if the hemoglobin level remains below 10 g/dL (or hematocrit is less than 30%) 4 weeks after initiation of

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	<p>specified conditions. 1-The hemoglobin level immediately prior to initiation or maintenance of erythropoiesis stimulating agent (ESA) treatment is less than 10 g/dL (or the hematocrit is less than 30%).</p>	<p>anemia. Prophylactic use to reduce tumor hypoxia. Patients with erythropoietin-type resistance due to neutralizing antibodies. Anemia due to cancer treatment if patients have uncontrolled hypertension.</p>					<p>therapy and the rise in hemoglobin is greater than 1g/dL (hematocrit greater than 3%). 4- For patients whose hemoglobin rises less than 1 g/dl (hematocrit rise less than 3%) compared to pretreatment baseline over 4 weeks of treatment and whose hemoglobin level remains less than 10 g/dL after the 4 weeks of treatment (or the hematocrit is less than 30%), the recommended FDA starting dose may be increased once by 25%. Continued use of the drug is not reasonable and necessary if the hemoglobin rises less than 1 g/dl (hematocrit rise less than 3 %) compared to pretreatment baseline by 8 weeks of treatment. 5-Continued administration of the drug is not reasonable and necessary if there</p>

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							<p>is a rapid rise in hemoglobin greater than 1 g/dl (hematocrit greater than 3%) over 2 weeks of treatment unless the hemoglobin remains below or subsequently falls to less than 10 g/dL (or the hematocrit is less than 30%).</p> <p>Continuation and reinstatement of ESA therapy must include a dose reduction of 25% from the previously administered dose. 6-  ESA treatment duration for each course of chemotherapy includes the 8 weeks following the final dose of myelosuppressive chemotherapy in a chemotherapy regime. For continued reimbursement, the hematocrit should rise four points or more or the need for transfusion should be substantially reduced after three months of therapy.</p>

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Exjade	Exjade is indicated for the indicated for the treatment of chronic iron overload due to blood transfusions (transfusional hemosiderosis) in patients 2 years of age and older.	None	None	2 years of age and older	None	3 months	None
Forteo	Forteo is a covered benefit when the following criteria are met: Patient is postmenopausal with osteoporosis and is at high risk for fracture: or patient with primary or hypogonadal osteoporosis who is at high risk for vertebral or hip fracture AND Patient's bone mineral density (BMD) spine T-scores below 2.5 for post menopausal women or below 2.0 for everyone else. Forteo is also covered if the patient is intolerant of oral agents OR The patient shows declining BMD scores in spite of effective oral therapy. Forteo may be authorized only once for up to 24 months based on patient-specific treatment plan. The service is preauthorized by the Medical Director.	None	None	None	None	6 months	None

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Gleevec	All FDA-approved indications not otherwise excluded from Part D. Gleevec will also be approved if a patient has the appropriate diagnosis of Chronic Myelogenous Leukemia or metastatic malignant stromal GI tumors (GISTs).	None	None	None	None	1 year	None
Growth Hormone	All FDA-approved indications not otherwise excluded from Part D.	Children with normal growth hormone levels, adults 18 yrs or older.	None	None	None	1 year	None
Hepatitis	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	Genotype 1 and 4 48 weeks Genotype 2 and 3 24 weeks	None

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Humira	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	restricted to Rheumatologists, Dermatologist, and Gastroenterologists	6 months	Patients will also be approved if they have symptoms of moderately to severely active rheumatoid arthritis. Have failed, have had an inadequate response to or do not tolerate maximum dose methotrexate and at least 1 other disease modifying antirheumatic drug (DMARD). Patient is eligible for treatment of psoriatic arthritis if: Age is greater than 18 years AND at least ONE of the following: Psoriatic arthritis with spondylitis (spine involvement) and are not responding to therapy with NSAIDs and physiotherapy. Psoriatic arthritis with a history of previous trial/failure or intolerance to disease-modifying anti-rheumatic agents (DMARDs). CROHN'S DISEASE may be approved in

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							adult patients with Crohn's disease who have had an inadequate response to conventional therapy (i.e., aminosalicylates, corticosteroids, immunomodulatory agents) or have also lost response to or are intolerant to infliximab (Remicade).
Hyperparathyroid	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	6 months	None
Injectable Analgesics	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	3 months- duration may be extended pending specific medical circumstances	Patient must have failed 3 oral narcotic and/or non-narcotic analgesics.

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Injectable Antiemetics	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	3 months- duration may be extended pending specific medical circumstances	Patient must have failed oral antiemetic therapy.
Injectable GI	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	2 months	Patient must have failed oral dicyclomine therapy.
Injectable Skeletal Muscle Relaxants	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	2 months	Patient must have failed 3 oral skeletal muscle relaxant therapies.
Injectable Testosterone	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	1 year	Patient must have low testosterone levels.
Injectables	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	3 months	None.

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IVIG	<p>All FDA-approved indications not otherwise excluded from Part D. In addition, Intravenous Immune Globulin Therapy will be approved for the following indications: 1. primary immunodeficiencies, including: Hypogammaglobulinemia Congenital agammaglobulinemia (X-linked agammaglobulinemia) Common variable immunodeficiency X-linked immunodeficiency with hyperimmunoglobulin M Severe combined immunodeficiency Wiskott-Aldrich syndrome 2. idiopathic thrombocytopenic purpura (ITP) 3. Kawasaki Syndrome 4. graft-versus-host disease associated with interstitial pneumonia (infectious or idiopathic) and infections (cytomegalovirus infections, varicella-zoster virus infection, and recurrent bacterial infection) in allogeneic bone marrow transplant (BMT) patients in the first 100 days after transplantation 5. Prevention of infection in: HIV infected pediatric patients, Bone marrow transplant patients (see item 4), Patients with hypogammaglobulinemia and/or recurrent bacterial infection associated with B-cell chronic lymphocytic leukemia (CLL) Intravenous immune globulin therapy (IVIG) will be approved for the following off-label indications: Antenatal alloimmune thrombocytopenia. Autoimmune neutropenia. Chronic inflammatory demyelinating polyneuropathy (CIDP). IVIG is used alone or following therapeutic plasma exchange to</p>	None	None	None	None	1 month-duration may be extended pending specific medical circumstances.	None

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	<p>prolong its effect. IVIG is considered easier to use than repeated therapeutic plasma exchange and to have fewer complications than long-term glucocorticoid therapy.)  Dermatomyositis, refractory, (IVIG is used as a second line treatment of dermatomyositis. Corticosteroids are first-line treatments of dermatomyositis). Eaton-Lambert myasthenic syndrome treatment. Guillain-Barre Syndrome (acute demyelinating polyneuropathy) as an equivalent alternative to plasma exchange.  Hyperimmunoglobulinemia E syndrome (HIE) treatment. Multifocal motor neuropathy in patients with anti GM1 antibodies and conduction block. Myasthenia Gravis, severe refractory. Polymyositis, routine use of IVIG is not recommended. IVIG may be considered in patients with severe polymyositis for whom other treatments have been unsuccessful, have become intolerable, or are contraindicated. Prior to a medically necessary renal transplantation for suppression of panel reactive anti-HLA antibodies in patients with high panel reactive antibody (PRA) levels to human leukocyte antigens(HLA). Prevention of infections in high-risk, preterm, low birth weight neonates. Stiff-person syndrome not controlled by other therapies. Toxic shock syndrome caused by staphylococcal or streptococcal organisms refractory to several hours of aggressive therapy. Solid organ transplant recipients at risk for CMV. Treatment of chronic</p>						
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	parvovirus B19 infection and severe anemia associated with bone marrow suppression. Refractory auto-immune mucocutaneous blistering diseases including pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid, and epidermolysis bullosa aquisita.						
Kineret	Patients must have symptoms of moderately to severely active rheumatoid arthritis. Have failed, have had an inadequate response to or do not tolerate maximum dose methotrexate and at least 1 other disease modifying antirheumatic drug (DMARD).	None	None	None	Restricted to Rheumatologists	6 months	None
Kuvan	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	1 month-duration may be extended pending specific medical circumstances.	None

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Mesna	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	3 months	Patient must be on ifosfamide therapy.
MS	All FDA-approved indications not otherwise excluded from Part D. Must be approved by the Medical Management and/or Medical Director. Clinical course or laboratory data definitive of MS. Member must agree to maintain injections as prescribed by the Participating neurologist's treatment plan. If the member is unable to administer the medication, a person or agency must be identified who will administer the drug. Member must comply with the Participating neurologist's requests for follow-up services at specified dates for re-evaluation. Negative pregnancy test or evidence of sterility for	Excluded in the following 1. services not authorized and/or directed by the Participating Provider 2. Chronic progressive MS. 3. Failure to comply with prescribed self-administration schedule and/or failure to seek necessary follow up care as directed by the Participating Physician. 3. Treatment during pregnancy or while breast-feeding	None	None	None	1 year	None

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	female patients. Members receiving Tysabri must be enrolled in and meet all the conditions of the TOUCH Prescribing Program. Only one of these agents can be used at one time.						
Nexavar	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	1 month-duration may be extended pending specific medical circumstances.	None
Oral Anabolic Steroids	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	1 month-duration may be extended pending specific medical circumstances.	None
Promacta	All FDA-approved indications not otherwise excluded from Part D.	None	Patient is at risk for bleed as a result of thrombocytopenia and clinical condition	None	None	6 months	Previous treatment failure of with one of the following interventions: a) corticosteroids or b) immunoglobulins or c) splenectomy.
Pulmonary Arterial Hypertension	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	1 month-duration may be extended pending specific medical	None

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						circumstances.	
Pulmozyme	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	Restricted to Pulmonologists/Infectious Disease specialists	1 year	None
Relistor	All FDA-approved indications not otherwise excluded from Part D.	None	Patient has advanced illness and receiving palliative care	None	None	4 months	Trial and failure of at least 2 oral laxatives.
Revlimid	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	1 year	None
Rilutek	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	1 month-duration may be extended pending specific medical circumstances.	None
RSV	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	6 months	None

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Sabril	All FDA-approved indications not otherwise excluded from Part D.	Patients with retinopathy or glaucoma	Vision should be tested at baseline, no later than 4 weeks after initiating Sabril therapy, and every 3 months during treatment, and at 3 and 6 months after discontinuation of therapy	Patients 2 yrs of age or less	None	6 months	None
Simponi	All FDA-approved indications not otherwise excluded from Part D.	Patients concurrently using another TNF antagonist, abatacept, or anakinra.	None	None	Restricted to Rheumatologists and Dermatologists	6 months	For diagnosis of Rheumatoid Arthritis, Psoriatic Arthritis, and Ankylosing Spondylitis, patient must have failed at least 1 other conventional systemic therapy (TNF's, NSAIDS, DMARDS).
Sodium Phenylbutyrate	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	1 month-duration may be extended pending specific medical circumstances.	None
Sprycel	Sprycel will be approved if a patient has the appropriate diagnosis of chronic accelerated, or myeloid or lymphoid blast phase chronic	None	None	None	None	1 year	None

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	myeloid leukemia with resistance or intolerance to prior therapy including Gleevec (imatinib).						
Sutent	Sutent will be approved if a patient has the appropriate diagnosis of GISTs and has had disease progression while taking or intolerance to Gleevec (imatinib). Sutent may also be approved if the patient has the appropriate diagnosis of advanced kidney cancer and has experienced failure of prior cytokine-based therapy (e.g., interferon-a, interleukin-2). There are no randomized trials of SUTENT demonstrating clinical benefit such as increased survival or improvement in disease-related symptoms in renal cell carcinoma.	None	None	None	None	1 month-duration may be extended pending specific medical circumstances.	None
Symlin	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	1 year	Patient must be Type 1 or Type 2 Diabetic currently using insulin and have failed to achieve adequate glycemic control. Not recommended if HbA1c is greater than 9. Not recommended for patients with confirmed diagnosis of gastroparesis, severe hypoglycemia requiring treatment in the last 6 months, pediatric patients, or in patients requiring the use of drugs to stimulate GI

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							motility.
Synarel	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	6 months	None
Tarceva	Tarceva will be approved if the patient has the appropriate diagnosis of pancreatic cancer in combination with Gemzar (gemcitabine) or as monotherapy for non-small cell lung cancer.	None	None	None	None	1 year	None
Tasigna	Tasigna will be approved if a patient has the appropriate diagnosis of Chronic Myelogenous Leukemia resistant to or intolerant to prior therapy that included Gleevec.	None	None	None	None	1 year	None
Tobi	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	Restricted to Pulmonologists/Infectious Disease specialists	1 year	None
Trelstar	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	1 year	Patient must have diagnosis of Prostrate Cancer.
Xenazine	All FDA-approved indications not otherwise excluded from Part D.	Patients who are actively suicidal and in patients with untreated or inadequately treated depression	None	None	None	1 year	None
Xolair	Diagnosis of Moderate Persistent or Severe Persistent Asthma.	None	Patient has a positive skin test or in vitro reactivity to a perennial aeroallergen, AND Patient	Patient is 12 years of age or older	Prescribing is limited to allergists and pulmonologists	6 months	Patient's symptoms are inadequately controlled with combination controller therapy (medium to high dose inhaled corticosteroids plus long acting beta-2

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			<p>has an FEV1 less than 80% predicted AND Patient's IgE level is equal to or greater than 30 IU/ml. Severe asthma as defined by the National Heart, Lung, and Blood Institute: Severe Persistent Asthma: Continual symptoms, limited physical activity, and frequent exacerbations, Nocturnal symptoms are frequent, FEV1 or PEF is less than or equal to 60% predicted, PEF variability</p>				<p>agonists and/or Leukotriene receptor antagonists), or cannot tolerate these medications.</p>

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			<p>greater than 30%.  Moderate Persistent Asthma as defined by the National Heart, Lung, and Blood Institute:  Daily symptoms, daily use of inhaled short-acting beta2-agonist, exacerbations affect activity, and exacerbations are greater than 2 times a week and may last for days,  Nocturnal symptoms occur greater than 1 time per week,  FEV1 or PEF is greater than 60% and less than 80% predicted,</p>				
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			PEF variability is greater than 30%.				
Zavesca	All FDA-approved indications not otherwise excluded from Part D.	None	None	None	None	6 months	None
Incretin mimetic Step Therapy	History of trial of at least two of the three different classes of oral agents: sulfonylurea, metformin, TZD, or at least one claim for a combination product containing sulfonylurea and metformin, TZD and metformin, or TZD and sulfonylurea in the last 60 days.						