

Prior Authorization Criteria

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Prior Authorization Group Description	Antifungal Therapy
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Immunocompetent persons or individuals with hypersensitivity to terbinafine, ciclopirox, or itraconazole.
Required Medical Information	KOH smear, or dermatophyte test medium, or fungal culture.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Not to exceed manufacturer recommended duration of therapy based on requested indication.
Other Criteria	<p>For Lamisil or 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. Immunosuppression 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 Lamisil or 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. For Penlac 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. Immunosuppression 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. In addition, must not be a candidate for oral antifungal therapy (Lamisil or Sporanox).</p>

Prior Authorization Group Description	Aranesp
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	For CKD and not on dialysis: hypersensitivity to the active substance or any of the excipients of darbepoetin alfa, untreated iron or folate deficiencies, hemolysis, or GI bleeding, uncontrolled hypertension, in need of immediate correction of severe anemia. For covered indications other than CKD/ESRD: Anemia secondary to malignancy, diagnosis of Acute Myelocytic Leukemia, Chronic Myelocytic Leukemia, Myeloid leukemia or Monocytic leukemia, hypersensitivity to the active substance or any of the excipients of darbepoetin alfa, 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.
Required Medical Information	Hgb, Hct, GFR, serum creatinine, iron panel including transferrin saturation and ferritin level measured within the last 30 days. Current body weight. Current chemotherapy and history. Documentation of epoetin use.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve up to 3 months.
Other Criteria	For CKD not on dialysis for initial therapy: inadequate response to epoetin alfa therapy as defined as failure to achieve target Hgb/Hct in the presence of adequate iron stores at a dose of 300 units/kg three times a week SC within 4 to 6 months or failure to maintain target Hgb/Hct subsequently at that dose, and diagnosis of CKD defined as GFR less than 60mL/min or creatinine greater than 1.8mg/dL for at least 3 months, and lab values within the past 30 days indicating Hgb less than 10g/dL or Hct less than 30%, or Hgb greater than 9.9g/dL or Hct greater than 29.9% with documentation of S/Sx of anemia, and iron panel including transferrin saturation greater than or equal to 20% and ferritin greater than or equal to 100ng/ml. For CKD not on dialysis continuation therapy: current progress notes indicating symptomatic response to therapy and lab values within the past 30 days indicating: Hgb/Hct 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 with an inadequate response to epoetin

alfa therapy, as defined previously, diagnosis of non-excluded cancer type, chemotherapy regimen noted, and lab values within the past 30 days indicating: Hgb level less than 10 g/dL and/or Hct level less than 30%, or Hgb greater than 9.9 g/dL or Hct greater than 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 Hgb/Hct 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 and/or biopsy, and lab values within the past 30 days indicating: Hgb less than 10g/dL and/or Hct less than 30% or Hgb greater than 9.9g/dL or Hct greater than 29.9% with documentation of S/Sx of anemia. For anemia associated with MDS continuation therapy: lab values within the past 30 days indicating Hgb/Hct less than 12g/dL/36% and symptomatic response noted. 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. Reduce dose by 25% when Hgb approaches 12 g/dL or Hct approaches 36%, or Hgb increases more than 1g/dL or Hct increases more than 4% in any 2 week period. Increase dose by 25-50% when Hgb has not increased by 1 g/dL after 4 weeks of therapy or Hct has not increased by 5-6 % and is still below target, or Hgb does not increase by 2 g/dL after 8 weeks of therapy and is still below target, and iron stores are adequate. Increases in dose and/or frequency should not be made more often than once per 4 weeks.

Prior Authorization Group Description	Emend
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Part B Coverage
Required Medical Information	Diagnosis and concomitant therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	None

Prior Authorization Group Description	Enbrel
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 Information	For RA or JRA: tender or swollen joints, ESR, CRP, morning stiffness, history of NSAID/DMARD use, Body Surface Area (BSA), Psoriasis Area and Severity Index (PASI), plaque location. Reduction of signs and symptoms and improved physical functioning for continuation.
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	For RA or JRA initial therapy: moderate to severely active RA as evidenced by: swollen joints, ESR of 28mm/hr or greater, or CRP of 2.0 mg/dL or more, morning stiffness, inadequate response to a trial of Methotrexate (MTX), unless contraindicated, and inadequate response to 1 of the following DMARDs: Gold, leflunomide, hydroxychloroquine, sulfasalazine, azathioprine, D-Penicillamine, cyclosporine. Contraindication to MTX includes: chronic liver disease, leukopenia, thrombocytopenia, creatinine clearance less than 40mL/min, and immunodeficiency. For RA or JRA 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 NSAID therapy, unless contraindicated. If a component of peripheral arthritis is present, must show an inadequate response to a trial of sulfasalazine, unless contraindicated. For Ankylosing Spondylitis continuation therapy: reduction of S/Sx. For Psoriatic Arthritis initial therapy: must have swollen and tender joints and, and inadequate response to trial of 1 or more NSAID, DMARD, and MTX, unless contraindicated. For Psoriatic Arthritis continuation therapy: verification of at least 2 of the following: reduction in S/Sx, or improvement in physical

	<p>functioning. For Plaque 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 greater, incapacitation due to plaque location. Inadequate response to trial of or not a candidate for any of the following topical agents: Anthralin, Coal Tar Preparations, Corticosteroids, Emollients, Immunosuppressives, Keratolytics, Retinoic Acid Derivatives, Vitamin D Analogues. And an inadequate response to trial of or is not a candidate for at least 1 of the following systemic agents: Immunosuppressives, Retinoic Acid Derivatives, MTX. And an inadequate response to trial of or is not a candidate for phototherapy. For Plaque Psoriasis continuation therapy: reduction of S/Sx and improvement in PASI score of at least 50%.</p>
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Prior Authorization Group Description	Epoetin Alfa
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 Information	Diagnosis of CKD: GFR, creatinine, lab values within the past 30 days indicating Hgb/Hct, iron panel including transferrin saturation and ferritin level, current body weight, cancer and chemotherapy history.
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	Criteria for anemia secondary to CKD and not on dialysis, anemia due to chemotherapy for nonmyeloid malignancies, anemia associated with MDS equivalent to criteria outlined in the Aranesp prior authorization criteria for those diagnosis. In addition, for anemia associated with RA initial therapy: diagnosis of RA and within the past 30 days: Hgb less than 10g/dL or Hct less than 30%, or Hgb greater than 9.9g/dL or Hct greater than 29.9% with S/Sx of anemia. For anemia associated with RA continuation therapy: symptomatic response noted and within past 30 days Hgb/Hct less than 12g/36%. For anemia secondary to zidovudine initial therapy: diagnosis of HIV, currently receiving 4200mg/wk or less of zidovudine and within the past 30 days: Hgb less than 10g/dL or Hct less than 30%, or Hgb greater than 9.9g/dL or Hct greater than 29.9% with S/Sx of anemia. For anemia secondary to zidovudine continuation therapy: currently receiving 4200mg/wk or less of zidovudine, symptomatic response noted and within past 30 days

Hgb/Hct less than 12g/36%. For anemia associated with the management of Hep C initial therapy: currently on interferon or peginterferon plus ribavirin antiviral therapy and within the past 30 days: Hgb less than 10g/dL or Hct less than 30%, or Hgb greater than 9.9g/dL or Hct greater than 29.9% with S/Sx of anemia. For anemia associated with the management of Hep C continuation therapy: continued on 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 Hgb greater than 10g/dL and less than 13 g/dL or Hct greater than 30% and less than 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. Reduce dose by 25% when Hgb approaches 12 g/dL or Hct approaches 36%, or Hgb increases more than 1g/dL or Hct increases more than 4% in any 2 week period. Increase dose by 25-50% when Hgb has not increased by 1 g/dL after 4 weeks of therapy or Hct has not increased by 5-6 % and is still below target, or Hgb does not increase by 2 g/dL after 8 weeks of therapy and is still below target, and iron stores are adequate. Increases in dose and/or frequency should not be made more often than once per 4 weeks.

Prior Authorization Group Description	Forteo
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 Information	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.

Prior Authorization Group Description	Granulocyte Colony Stimulating Factor (GCSF)
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Hypersensitivity to E. coli-derived proteins, filgrastim, or any component of the product.
Required Medical Information	CBC with differential, platelet count, and Absolute Neutrophil Count (ANC) obtained within the last 30 days.
Age Restrictions	N/A
Prescriber Restrictions	Requesting practitioner must be an 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	<p>For primary prophylaxis (first and subsequent cycle use) 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, there must be documentation of high risk features that include: expected (greater than 10 days) and profound (less than $0.1 \times 10^5/L$) neutropenia, age greater than 65 years, uncontrolled primary disease, pneumonia, sepsis syndrome (hypotension and multi-organ dysfunction), invasive fungal infection, hospitalization at the time of the development of fever. For initiation for treatment of ganciclovir or zidovudine induced neutropenia: currently being treated with ganciclovir or zidovudine and experiencing neutropenia characterized by an ANC less than 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: currently being treated with pegylated interferon and ribavirin and experiencing neutropenia characterized by an ANC less than 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 of therapy is usually 14 days but will be determined by the desired ANC following the expected chemotherapy-induced neutrophils nadir. If the ANC is greater than 1000/mm³ for 3 consecutive days, filgrastim may be discontinued. Filgrastim must be discontinued when ANC reaches 10,000/mm³. Medication should be administered 24</p>

	<p>hours after the completion of myelosuppressive chemotherapy for non-myeloid malignancies and pegfilgrastim should not be given within 14 days of next chemotherapy administration. A CBC and platelet count should be obtained prior to chemotherapy and at regular intervals (twice per week) during filgrastim therapy. Discontinuation of therapy: obtain an ANC level of greater than 10,000/mm³, individuals receiving filgrastim/pegfilgrastim who report left upper abdominal and/or shoulder tip pain should be evaluated for an enlarged spleen or splenic rupture.</p>
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Prior Authorization Group Description	Growth Hormone
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. Greater than 18 years of age. 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). Achieved height consistent with midparental height. Fused epiphyses.
Required Medical Information	Growth rate and height from growth chart, endogenous pituitary growth hormone level, 2 standard growth hormone provocation tests excluding tests using growth hormone releasing hormone for stimulation, current bone age, pretreatment growth rate, BMI, glucose/insulin sensitivity analysis measuring blood glucose levels. Diagnosis of: chronic renal insufficiency up to the time of renal transplantation, diagnosis of Turner Syndrome or Prader-Willi Syndrome.
Age Restrictions	Must be less than or equal to 18 years of age.
Prescriber Restrictions	N/A
Coverage Duration	May approve Omnitrope for up to 1 year.
Other Criteria	For growth hormone deficiency initial therapy: height is less than the 5th percentile on growth chart, growth rate is less than 4 cm/year, endogenous pituitary growth hormone level is less than 10mg/ml on 2 standard growth hormone provocation tests excluding tests using growth hormone releasing hormone for stimulation, delayed bone age greater than or equal to 2 years below actual age. For growth hormone deficiency continuation therapy: pretreatment growth rate has doubled while on growth hormone therapy or growth rate is at least 3 cm/year in those children with extremely low pretreatment growth rates. For chronic renal insufficiency up to the time of renal transplantation initial therapy: diagnosis of chronic renal insufficiency, height less than the 5th percentile on the growth chart, growth rate less than 4 cm/year, delayed bone age greater than or equal to 2 years below actual age. For chronic renal insufficiency up to the time of renal transplantation continuation therapy: pretreatment growth

rate has doubled while on growth hormone therapy or growth rate is at least 3 cm/year in those children with extremely low pretreatment growth rates. For Turner Syndrome initial therapy: diagnosis of Turner Syndrome confirmed by karyotype genetic testing, height less than the 5th percentile on growth chart, growth rate less than 4 cm/year, delayed bone age greater than or equal to 2 years below actual age. For Turner Syndrome continuation therapy: pretreatment growth rate has doubled while on growth hormone therapy or growth rate is at least 3 cm/year in those children with extremely low pretreatment growth rates. For Prader-Willi Syndrome initial therapy: diagnosis of Prader-Willi Syndrome confirmed by appropriate genetic testing, a dietary approach is followed in order to maintain a low BMI, 5% reduction in body fat mass, 5% increase in fat free mass, glucose/insulin sensitivity analysis measuring blood glucose levels. Omnitrope Pediatric Dosage: 0.16 to 0.24 mg/kg/week, divided into 6-7 daily injections. Omnitrope Cartridge 5mg/1.5 mL and Omnitrope for injection 5.8mg/vial contain preservative. For individuals with a contraindication to preservative, Genotropin two-chamber cartridge may be used.

Prior Authorization Group Description	Humira
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Serious active infection within the past 30 days, concurrent use of multiple biological response modifiers including, but not limited to: alefacept, etanercept, infliximab, anakinra.
Required Medical Information	Number of tender or swollen joints, ESR, CRP, degree of morning stiffness, history of NSAID/DMARD use, Body Surface Area (BSA) affected, Psoriasis Area and Severity Index (PASI), plaque location. Reduction of signs and symptoms and improved physical functioning for continuation.
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	Therapy can be approved up to 1 year.
Other Criteria	Criteria for RA, JRA, Ankylosing Spondylitis, Psoriatic Arthritis, and Plaque Psoriasis equal to criteria outlined in the Enbrel prior authorization criteria for those diagnosis. In addition, for Crohn's Disease initial therapy: diagnosis of moderate to severe active Crohn's Disease as evidenced by: radiological or endoscopic evidence, and at least 1 of the following more prominent symptoms: fevers, significant weight loss, abdominal pain or tenderness, intermittent nausea or vomiting (without obstructive findings), significant anemia, or Crohn's Disease Activity Index (CDAI) score of 220-450 points, and an inadequate response to an adequate trial of 2 or more of the following or is not a candidate for any of the following: Mesalamine, Sulfasalazine, Predinsone, Budesonide, Azathioprine, Mercaptopurine, Methotrexate. For Crohn's Disease continuation therapy: reduction of signs and symptoms clinical remission not achieved, or a need to continue adalimumab as maintenance therapy.

Prior Authorization Group Description	Ketek
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of: Myasthenia Gravis, hepatitis and/or jaundice associated with the use of Ketek or any macrolide antibiotic, hypersensitivity to Ketek or any macrolide antibiotic. Also concomitant administration of Ketek with cisapride or pimozone. Finally, a diagnosis of congenital prolongation of QTc interval, or currently receiving Class IA (i.e., quinidine or procainamide) or Class III antiarrhythmic agents (i.e., dofetilide, amiodarone, or sotalol).
Required Medical Information	Diagnosis and bacteria culture and sensitivity analysis.
Age Restrictions	Must be greater than or equal to 18 years of age.
Prescriber Restrictions	N/A
Coverage Duration	May be approved up to 10 days therapy.
Other Criteria	Diagnosis of community-acquired pneumonia of mild to moderate severity due to Streptococcus pneumonia (including multi-drug resistant Streptococcus pneumonia), Haemophilus influenzae, Moraxella catarrhalis, Chlamydia pneumoniae or Mycoplasma pneumoniae: Multi-drug resistant Streptococcus pneumonia includes isolates known as penicillin-resistant Streptococcus pneumonia and are isolates resistant to two or more of the following antibiotics: penicillin, second generation cephalosporins (i.e., cefuroxime, cefoxitin, cefotetan, cefaclor, cefprozil, cefpodoxime, loracarbef), macrolides, tetracyclines, trimethoprim/sulfamethoxazole and culture and sensitivity results indicating bacteria susceptible to Ketek or, local epidemiology and susceptibility patterns for initiation of empiric therapy.

Prior Authorization Group Description	Kineret
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of Enbrel, Humira, Remicade, Raptiva.
Required Medical Information	Diagnosis, drugs tried and failed
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	Diagnosis moderate to severe Rheumatoid Arthritis (RA). Must be prescribed by Rheumatologist. Patient must be 18 years of age or older. Previous trial of Humira, Enbrel, Remicade, Raptiva, or methotrexate for 3 to 6 months and DMARD therapy for 3 to 6 months.

Prior Authorization Group Description	Lotronex
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of: chronic or severe constipation, sequelae from constipation, intestinal colitis, impaired intestinal circulation, thrombophlebitis, hypercoagulable state, Crohn's disease, ulcerative colitis, diverticulitis, hypersensitivity to any component of the product. Also, an impaired mental capacity that limits ability to understand or comply with the Patient-Physician Agreement or absence of the Patient-Physician Agreement form prior to receiving the prescription. Therapy will be discontinued if constipation or ischemic colitis is experienced during treatment.
Required Medical Information	N/A
Age Restrictions	Must be greater than or equal to 18 years of age.
Prescriber Restrictions	Prescriber must be enrolled in the manufacturer-sponsored prescribing program for Lotronex.
Coverage Duration	Therapy may be approved for up to 1 year
Other Criteria	For initial therapy: diagnosis of diarrhea predominant IBS, prescriber must be enrolled in the manufacturer-sponsored prescribing program for Lotronex, must be female, symptoms documented for at least 3 consecutive months, must have tried and failed 2 treatment regimens including any of the following: single therapy antidiarrheal at maximum tolerated dose up to the recommended daily maximum, dual therapy with antidiarrheal and anti-spasmodic. Also, must have severe symptoms as specified by 1 or more of the following: frequent and severe abdominal pain/discomfort, frequent bowel urgency or fecal incontinence, disability or restriction of daily activities due to IBS. For continuation therapy: must not have developed any new contraindications during previous year.

Prior Authorization Group Description	Marinol
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. For use as an appetite stimulant in patients with anorexia due to AIDS or cancer.
Exclusion Criteria	Any indication/disease other than cancer or HiV/AIDs
Required Medical Information	Diagnosis being treated. Current chemotherapy regimen. History of antiemetic use. History of megesterol use.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	May approve for up to 1 year.
Other Criteria	For treatment of chemotherapy-induced nausea/vomiting initial therapy: currently on chemotherapy and failed adequate trial of first line antiemetic agents. For treatment as an appetite stimulant initial therapy: diagnosis of cancer or AIDS AND tried and failed megesterol. Prescribed quantity should not exceed 120 tablets per 30 days.

Prior Authorization Group Description	Neumega
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 Information	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/mm ³).

Prior Authorization Group Description	Noxafil
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 Information	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.

Prior Authorization Group Description	Pegasys, PEG-Intron
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 untreated 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, 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, 4, 6; 24 weeks for genotypes other than 1, 4, 6; 48 weeks for Hepatitis B.
Required Medical Information	Diagnosis with Hepatitis B or Hepatitis C. Viral load, ALT/AST levels, INR, Hgb, WBC, neutrophils, platelets measured within the last 30 days. HCV genotyping, HBV antigen test.
Age Restrictions	Must be greater than or equal to 18 years of age.
Prescriber Restrictions	N/A
Coverage Duration	Initial for 16 weeks. Continuation not to exceed manufacturer recommended duration for indication.
Other Criteria	For Hepatitis C initial therapy: diagnosis with Hep C, detectable HCV RNA viral load, and persistently elevated ALT, or ALT within normal limits (WNL) and liver biopsy (genotype 1) indicating portal or bridging fibrosis or moderate degrees of inflammation and necrosis or current INR WNL. Authorization for ribavirin must also be current through end of the 16-week period. Repeat HCV RNA viral count (drawn 12-weeks after initiating treatment) will be required with request to continue therapy beyond the 16-week initial authorization. For initial monotherapy for Hepatitis C: monotherapy will be approved only if all previous criteria are met in addition to 1 or more of the following contraindications for use of ribavirin: allergy to ribavirin, pregnancy, or male with female partner who is pregnant, autoimmune hepatitis, history of anemia due to ribavirin, history of neutropenia due to ribavirin, renal

impairment (CrCl < 50ml/min) or on dialysis. Request for continuation of therapy beyond initial authorization period for Hepatitis C: documentation of all of the following criteria must be provided: has 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, repeat ALT is normal or significantly decreased from pre-treatment level, and Hgb, and has not completed course of therapy. For genotype 1, 4, 6 the optimal duration of treatment is 48 weeks. For genotypes 2 and 3, the optimal duration of treatment is 24 weeks. Repeat HCV RNA viral count (drawn 12-weeks after initiating treatment) will be required with request to continue therapy beyond the 16-week initial authorization. For interferon naive Hepatitis B initial therapy: a diagnoses with Hepatitis B and documentation verifying all of the following must be provided: HbsAg-positive for 6 months. HBeAg-positive with documentation verifying all of the following: quantitative HBV DNA greater than 20,000 IU/mL, and has ALT greater than 2 times upper limit of normal. Or has ALT less than 2 times upper limit of normal with both of the following: a liver biopsy that indicates moderate to severe necroinflammation or significant fibrosis and a current INR WNL. HBeAg-negative with documentation verifying all of the following: has quantitative HBV DNA greater than 20,000 IU/mL, and has ALT greater than 2 times upper limit of normal, or has quantitative HBV DNA greater than 2,000 IU/mL and/or ALT less than 2 times upper limit of normal with both of the following: a liver biopsy that indicates moderate to severe necroinflammation or significant fibrosis and a current INR WNL. For Hepatitis B continuation therapy: demonstrated adherence to prescribed regimen, has not completed course of therapy, and Hgb. Authorization for ribavirin must also be current through end of the 16-week period.

Prior Authorization Group Description	Promacta
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 Information	Diagnosis of chronic ITP, platelet count less than $30 \times 10^9/L$.
Age Restrictions	Must be greater than or equal to 18 years of age.
Prescriber Restrictions	Requesting practitioner must be an oncologist/hematologist registered with the Promacta Cares Program.
Coverage Duration	May approve up to 6 months.
Other Criteria	<p>For initial therapy: Must have diagnosis of chronic ITP of greater than 3 months in duration, must have a platelet count less than $30 \times 10^9/L$, 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).</p> <p>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 can't be experiencing any intolerable side effects or any new or worsening morphological abnormalities.</p>

Prior Authorization Group Description	Qualaquin
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 Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	May be approved up to a maximum dose of 648mg every 8 hours up to 7 days.
Other Criteria	Diagnosis of uncomplicated Malaria.

Prior Authorization Group Description	Rebetron, Intron-A
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.
Required Medical Information	Laboratory reports indicating all of the following: presence of antibody to HCV, bilirubin level, platelet count, WBC count, serum creatinine, albumin level, ALT levels.
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 an oncologist or gastroenterologist.
Coverage Duration	Initial therapy approve up to 3 months. Continuation therapy may approve for up to 1 year.
Other Criteria	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 sarcoma, or Diagnosis of chronic hepatitis C virus (HCV): results of liver biopsy (genotype 1) verifying the diagnosis of HCV, and laboratory reports indicating all of the following: presence of antibody to HCV, 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 within normal limits. For Intron A continuation therapy: verification of no severe adverse reactions.

Prior Authorization Group Description	Relistor
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Non-Opioid induced constipation. Patient has a life expectancy greater than 6 months.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Up to 4 months.
Other Criteria	Diagnosis of opioid induced constipation with life expectancy less than 6 months. Patient must not have had laxation for at least 48 hours. Patient failed at least 1 laxative at the maximum recommended dose.

Prior Authorization Group Description	Revatio
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Currently using organic nitrates in any form, either regularly or intermittently. Diagnosis of Erectile Dysfunction. Diagnosis of Pulmonary Veno-Occlusive Disease. Concomitant use with any other PDE5 inhibitors. Concomitant administration with Ritonavir.
Required Medical Information	N/A
Age Restrictions	Must be greater than or equal to 18 years of age.
Prescriber Restrictions	N/A
Coverage Duration	For initial therapy for 3 months. For continuation therapy: may approve up to 1 year.
Other Criteria	Diagnosis and patient must try and fail CCB unless they are not a candidate for CCB therapy due to American College of Chest Physicians (ACCP) PAH Practice Guidelines.

Prior Authorization Group Description	Ribavirin
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 Information	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.
Age Restrictions	Must be greater than or equal to 3 years of age.
Prescriber Restrictions	N/A
Coverage Duration	Concurrently with peginterferon alpha for duration recommended by manufacturer for indication.
Other Criteria	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, continuing with peginterferon alpha treatment. If genotype 1, 4, 6 optimal duration of treatment is 48 weeks. If genotype 2 and 3 optimal duration of treatment is 24 weeks.

Prior Authorization Group Description	Sancuso
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	No diagnosis of chemotherapy- or radiotherapy-induced nausea and vomiting, hyperemesis gravidarum, or refractory nausea and vomiting.
Required Medical Information	Diagnosis for chemo or radiation - need documentation of regimen. For hyperemesis gravidarum and refractory nausea and vomiting - documentation of previous therapies tried and/or failed.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Max 6 months, depends on diagnosis
Other Criteria	Approved for prevention of chemotherapy-induced N/V, in patients receiving moderately to highly emetogenic chemotherapy, radiotherapy, or for treatment of hyperemesis gravidarium in pregnancy. For all indications patient has to fail oral ondansetron and oral granisetron or have an inability to swallow.

Prior Authorization Group Description	Simponi
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	none
Required Medical Information	Diagnosis, medications tried and failed
Age Restrictions	Must be greater than or equal to 18 yo (or FDA approved age).
Prescriber Restrictions	N/A
Coverage Duration	Approve up to 1 year.
Other Criteria	Diagnosis. Medications tried and failed.

Prior Authorization Group Description	Uloric
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	No diagnosis of hyperuricemia.
Required Medical Information	Diagnosis of hyperuricemia. Must be used for chronic management of hyperuricemia with history of allopurinol failure or side effect to therapy.
Age Restrictions	Must be greater than or equal to 18 years of age.
Prescriber Restrictions	N/A
Coverage Duration	Up to 12 months.
Other Criteria	Diagnosis of hyperuricemia.

Prior Authorization Group Description	Zyvox
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Culture and sensitivity reports. Documentation of Infectious Disease consult. Previous antibiotics therapies used.
Age Restrictions	N/A
Prescriber Restrictions	Consultation with an Infectious Disease Specialist will be required for persons beginning therapy in the ambulatory setting.
Coverage Duration	May be approved for up to 28 days.
Other Criteria	If prescribing provider is an Infectious Disease (ID) Specialist or an ID Specialist was consulted on the case, request is approvable. For Members being discharged from an inpatient setting with no ID specialist consult, one of the following 2 criteria must be met: Culture and sensitivity reports are provided that shows Methacillin-resistant Staphylococcus aureus (MRSA) or Vancomycin-resistant Enterococcus faecium (VRE) infections, OR therapy with vancomycin or linezolid (Zyvox) was initiated in the inpatient setting. For Members beginning therapy in the ambulatory setting, consultation with an ID Specialist is required in the absence of a culture and sensitivity reports are provided that shows Methacillin-resistant Staphylococcus aureus (MRSA) or Vancomycin-resistant Enterococcus faecium (VRE) infections.

Prior Authorization Group Description	Part B vs Part D	
These 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.		
ABRAXANE INJ 100MG ACYCLOVIR NA INJ 500MG ADAGEN INJ 250/ML ALDURAZYME INJ 2.9MG/5M ALLOPURINOL INJ 500MG A-METHAPRED INJ 40MG AMINOSYN II INJ 10% AMINOSYN II INJ 15% AMINOSYN II INJ 3.5/D25 AMINOSYN II INJ 4.25/D10 AMINOSYN II INJ 4.25/D20 AMINOSYN II INJ 4.25/D25 AMINOSYN II INJ 5/D25 AMINOSYN II INJ 7% AMINOSYN II INJ 8.5% AMINOSYN IIM INJ 3.5%/D5W AMINOSYN INJ 10% AMINOSYN INJ 3.5% AMINOSYN INJ 8.5/LYTE AMINOSYN M INJ 3.5% AMINOSYN-HBC INJ 7% AMINOSYN-HF INJ 8% AMPICILLIN INJ 10GM AMPICILLIN INJ 125MG AMPICILLIN INJ 1GM AMP-SULBACTA INJ 15GM AMP-SULBACTA INJ 3GM ANZEMET TAB 100MG ANZEMET TAB 50MG ARALAST INJ 400MG AVELOX INJ BACIIM INJ 50000UNT BACTOCILL INJ DEX 1GM BACTOCILL INJ DEX 2GM BLEOMYCIN INJ 30UNIT CALCITRIOL INJ 1MCG/ML CALCITRIOL INJ 2MCG/ML CAMPATH INJ 30MG/ML CANCIDAS INJ 50MG CANCIDAS INJ 70MG CAPASTAT SUL INJ 1GM	CEFAZOLIN INJ 1GM CEFAZOLIN INJ 1GM/50ML CEFAZOLIN INJ 20GM CEFAZOLIN INJ 500MG CEFEPIME INJ 1GM CEFEPIME INJ 2GM CEFIZOX/D5W INJ 1GM CEFIZOX/D5W INJ 2GM CEFOTAXIME INJ 10GM CEFOTAXIME INJ 1GM CEFOTAXIME INJ 2GM CEFOTAXIME INJ 500MG CEFOXITIN INJ 10GM CEFOXITIN INJ 1GM CEFOXITIN INJ 1GM CEFOXITIN INJ 2GM CEFOXITIN INJ 2GM CEFTAZIDIME INJ 1GM CEFTAZIDIME INJ 2GM CEFTAZIDIME INJ 6GM CEFTRIAX/DEX INJ 1GM CEFTRIAX/DEX INJ 2GM CEFUROX/DEXT INJ 1.5GM CEFUROXIME INJ 1.5GM CEFUROXIME INJ 750MG CEREDASE INJ 80UNT/ML CEREZYME INJ 200UNIT CIPROFLOXACN INJ 400MG CLAFORAN/D5W INJ 1GM CLAFORAN/D5W INJ 2GM CLEOCIN INJ 300MG CLEOCIN INJ 600MG CLEOCIN INJ 900MG CLINDAMYCIN INJ 150MG/ML CLINIMIX E INJ 2.75/D10 CLINIMIX E INJ 2.75/D5W CLINIMIX E INJ 4.25/D5W CLINIMIX E INJ 5%/D15W CLINIMIX E INJ 5%/D20W CLINIMIX E INJ 5%/D25W CLINIMIX E INJ 5%/D35W	CLINIMIX INJ 4.25/D5W CLINIMIX INJ 5%/D15W CLINIMIX INJ 5%/D20W COLISTIMETH INJ 150MG COMVAX INJ CUBICIN SOL 500MG CYKLOKAPRON INJ 100MG/ML CYTOVENE INJ 500MG D10W/NACL INJ 0.2% D10W/NACL INJ 0.45% D2.5W/NACL INJ 0.45% D5W/NACL INJ 0.2% D5W/NACL INJ 0.225% D5W/NACL INJ 0.33% D5W/NACL INJ 0.45% D5W/NACL INJ 0.9% DEPO-MEDROL INJ 20MG/ML DESMOPRESSIN INJ 4MCG/ML DEXTROSE INJ 10% DEXTROSE INJ 5% DICYCLOMINE INJ 10MG/ML DIHYDROERGOT INJ 1MG/ML DILTIAZEM INJ 25MG/5ML DIPHENHYDRAM INJ 50MG/ML DOXYCYCL HYC INJ 100MG DURAMORPH INJ 0.5MG/ML DURAMORPH INJ 1MG/ML ELITEK INJ 1.5MG ENGERIX-B INJ 10/0.5ML ENGERIX-B INJ 20MCG/ML ERAXIS INJ 100MG ERYTHROCIN INJ 500MG ETOPOSIDE INJ 20MG/ML FABRAZYME INJ 35MG FAMOTIDINE INJ 10MG/ML FAMOTIDINE INJ 20MG/50ML FLUCONAZOLE/ INJ DEX 400 FOMEPIZOLE INJ 1GM/ML FORTAZ INJ 1GM FORTAZ INJ 2GM FOSCARNET INJ 24MG/ML

FOSPHENYTOIN INJ 100/2ML
 FREAMINE HBC INJ 6.9%
 FREAMINE III INJ 3%
 FUROSEMIDE INJ 10MG/ML
 GAMMAGARD INJ 2.5GM/25
 GENTAM/NAACL INJ 0.9MG/ML
 GENTAM/NAACL INJ 100MG
 GENTAM/NAACL INJ 60MG
 GENTAM/NAACL INJ 60MG
 GENTAM/NAACL INJ 80MG
 GRANISETRON TAB 1MG
 HECTOROL INJ 4MCG/2ML
 HEP SOD/D5W INJ 20000UNT
 HEP SOD/D5W INJ 25000UNT
 HEP SOD/D5W INJ 25000UNT
 HEP SOD/NAACL INJ 1000UNIT
 HYDRALAZINE INJ 20MG/ML
 HYDROMORPHON INJ 10MG/ML
 HYDROXYZ HCL INJ 25MG/ML
 HYDROXYZ HCL INJ 50MG/ML
 INTRALIPID INJ 20%
 ISOLYTE-H INJ /D5W
 ISOLYTE-M INJ /D5W
 ISOLYTE-P INJ /D5W
 ISOLYTE-S INJ
 ISOLYTE-S INJ /D5W
 ISONIAZID INJ 100MG/ML
 KANAMYCIN INJ 333MG/ML
 KCL IN NAACL SOL
 KCL/D10/NAACL INJ 0.15/0.2
 KCL/D5W INJ 0.15%
 KCL/D5W INJ 0.3%
 KCL/D5W/LR INJ 0.3%
 KCL/D5W/NAACL INJ .075/.2%
 KCL/D5W/NAACL INJ .15/.33%
 KCL/D5W/NAACL INJ .15/.45%
 KCL/D5W/NAACL INJ .22/.45
 KCL/D5W/NAACL INJ .224/.33
 KCL/D5W/NAACL INJ .224/0.2
 KCL/D5W/NAACL INJ 0.15/0.9
 KCL/D5W/NAACL INJ 0.3/0.2%
 KCL/D5W/NAACL INJ 0.3/0.9%
 KCL/NAACL INJ 0.15-0.9
 KCL/NAACL INJ 0.3-0.9
 KETOROLAC INJ 15MG/ML
 KETOROLAC INJ 30MG/ML

LABETALOL INJ 5MG/ML
 LACTATED RIN INJ
 LEUPROLIDE INJ 1MG/0.2
 LEVAQUIN INJ 25MG/ML
 LEVAQUIN/D5W INJ 250/50ML
 LINCOCIN INJ 300MG/ML
 LUPR DEP-PED INJ 15MG
 LUPRON DEPOT INJ 22.5MG
 LUPRON DEPOT INJ 30MG
 LUPRON DEPOT INJ 7.5MG
 MEPERIDINE INJ 10MG/ML
 METHADONE INJ 10MG/ML
 METHOTREXATE INJ 25MG/ML
 METHYLPR ACE INJ 40MG/ML
 METHYLPR ACE INJ 80MG/ML
 METHYLPR SS INJ 1000MG
 METHYLPR SS INJ 125MG
 METHYLPR SS INJ 40MG
 METOPROLOL INJ 1MG/ML
 MITOXANTRON INJ 2MG/ML
 MORPHINE SUL INJ 0.5MG/ML
 MORPHINE SUL INJ 5MG/ML
 NAFICILLIN INJ 1GM
 NAGLAZYME INJ 1MG/ML
 NALOXONE INJ 0.4MG/ML
 NALOXONE INJ 1MG/ML
 NEPHRAMINE INJ 5.4%
 NEUTREXIN INJ 25MG
 NEXIUM I.V. INJ 20MG
 NEXIUM I.V. INJ 40MG
 NORMOSOL -M INJ /D5W
 NORMOSOL -R INJ /D5W
 NORMOSOL-R INJ PH 7.4
 NOVAMINE INJ 15%
 OCTREOTIDE INJ 1000MCG
 OCTREOTIDE INJ 200MCG
 OCTREOTIDE INJ 50MCG/ML
 ONDANSETRON SOL 4MG/5ML
 ONDANSETRON TAB 24MG
 ONDANSETRON TAB 4MG
 ONDANSETRON TAB 4MG ODT
 ONDANSETRON TAB 8MG
 ONDANSETRON TAB 8MG ODT
 ONTAK INJ 150/ML
 ORENCIA INJ 250MG
 OXACILLIN INJ 10GM
 OXACILLIN INJ 1GM

PEDIARIX INJ 0.5ML
 PEN G PROC INJ 600000
 PEN G SOD INJ 5000000
 PENICILL GK/ INJ DEX 2MU
 PENICILL GK/ INJ DEX 3MU
 PENICILLN GK INJ 20MU
 PENICILLN GK INJ 5MU
 PENTAM 300 INJ 300MG
 PHYSIOLYTE SOL
 PIPERACILLIN INJ 3GM
 PIPERACILLIN INJ 40GM
 PLASMA-LYTE INJ /D5W
 PLASMA-LYTE INJ -148
 PLASMA-LYTE INJ 56
 PLASMA-LYTE INJ 56/D5W
 PLASMA-LYTE INJ -A
 PLASMA-LYTE INJ -R
 POLYGAM S/D SOL 10GM
 POT CHLORIDE INJ 10MEQ
 POT CHLORIDE INJ 10MEQ
 POT CHLORIDE INJ 20MEQ
 POT CHLORIDE INJ 2MEQ/ML
 POT CHLORIDE INJ 30MEQ
 PREMARIN INJ 25MG
 PREMASOL SOL 6%
 PROCALAMINE INJ 3%
 PROLEUKIN INJ 22MU
 PROMETHAZINE INJ 25MG/ML
 PROMETHAZINE INJ 50MG/ML
 RANITIDINE INJ 150/6ML
 RECOMBIVA-HB INJ 10MCG/ML
 RECOMBIVA-HB INJ 40MCG/ML
 REMICADE INJ 100MG
 RIFAMPIN INJ 600 MG
 RITUXAN INJ 500MG
 ROTATEQ SUS
 SMZ-TMP INJ 400-80/5
 SOD CHLORIDE INJ 0.45%
 SOD CHLORIDE INJ 2.5/ML
 SOD CHLORIDE INJ 3%
 SOD CHLORIDE INJ 5%
 SOLU-CORTEF INJ 250MG
 SOLU-MEDROL INJ 2GM
 STREPTOMYCIN INJ 1GM
 TAZICEF INJ 1GM
 TAZICEF INJ 2GM
 TAZICEF INJ 6GM

TIMENTIN INJ 3.1GM
TIS-U-SOL SOL
TOBRA/NACL INJ 60/0.9
TOBRA/NACL INJ 80/0.9
TOBRAMYCIN INJ 10MG/ML
TOBRAMYCIN INJ 80MG/2ML
TPN ELECTROL INJ
TRAVASOL INJ 5.5%
TRAVASOL/D10 INJ 2.75%
TRAVASOL/D10 INJ 8.5%
TRAVASOL/D20 INJ 8.5%
TRAVASOL/D5 INJ 2.75%
TRAVASOL/D50 INJ 8.5%
TRELSTAR LA INJ 11.25MG
TRIMETHOBENZ INJ 100MG/ML
TRISENOX SOL 10MG/10M
TROPHAMINE INJ 10%
TROPHAMINE INJ 6%
TWINRIX INJ
TYGACIL INJ 50MG
VANCOMYC/DEX INJ 1GM
VANCOMYCIN INJ 1000MG
VANCOMYCIN INJ 10GM
VELCADE INJ 3.5MG
VFEND IV INJ 200MG
VIBATIV INJ
VIDAZA INJ 100MG
VIMPAT INJ 200MG/20
VISTIDE INJ 75MG/ML
VIVAGLOBIN SOL 160MG/ML
ZOSYN SOL 2-0.25GM
ZOSYN SOL 3-0.375G
ZYVOX SOL 2MG/ML