

SGRX MANAGED FORMULARY Prior Authorization/Step Therapy Criteria

PRIOR AUTHORIZATIONS		
Medication	Criteria	Standard Response
Accutane (g)	Isotretinoin	Requires diagnosis of Cystic acne; maximum duration of 20 weeks. Patient requires a Dermatologist consult. Patient will need to be off Accutane for 8 weeks before additional renewals. Renewal after 8 weeks, if 70% reduction in nodules was achieved.
Actos/Actoplusmet	pioglitazone pioglitazone/metformin	Dx- Type 2 diabetes. Requires trial/failure to reach HbA1c goal or intolerance to all of the following: Metformin; sulfonylureas (glipizide, glyburide)
Aggrenox	Aspirin- Dipyridamole	Antiplatelet agent used in patients with history of ischemia of brain/stroke. Documented failure on two separate agents.
Androderm	testosterone	Dx- Erectile dysfunction; Delayed puberty in males; palliative treatment of inoperable breast cancer in females.
Aptivus	Tipranavir	Dx- human immunodeficiency virus (HIV) infection. Must be used in combination with other antiretroviral agents in patients with evidence of HIV replication despite ongoing antiretroviral therapy who are either treatment-experienced or have HIV-1 strains resistant to multiple protease inhibitors
Aranesp <S>	Darbepoetin Alpha	Dx- anemia (due to: chronic renal failure(dialysis or non-dialysis patients), cancer chemotherapy (nonmyeloid cancer)
Atripla	Efavirenz-Emtricitabine- Tenofovir	Dx- HIV. Requires use of individual agents as part of HAART regimen first.
Avonex <s>	interferon beta 1a	Dx- Multiple Sclerosis
Baraclude <s>	entacavir	Dx- treatment of chronic hepatitis B infection in patients with evidence of active viral replication and either evidence of persistent elevations in serum aminotransferases (AST or ALTH) or histologically active disease
Betaseron <s>	interferon beta 1b	Dx- Multiple Sclerosis
Casodex	Bicalutamide	Dx- stage D2 metastatic cancer of the prostate (advanced prostate cancer). Must be prescribed by an Oncologist or Urologist. PSA lab must be provided.
Ceenu <s>	lomustine	Dx- Treatment of Hodgkin's disease and malignant glioma
Cellcept	Mycophenolate	Dx- For rejection prophylaxis of kidney transplant, heart transplant or liver transplant
Combivir	lamivudine, zidovudine	Dx- For the treatment of human immunodeficiency virus (HIV) infection in combination with other antiretroviral agents.
Copaxone <s>	glatiramer	Dx- Multiple Sclerosis
Copegus(g) <s>	ribavirin	Dx- Treatment of chronic hepatitis C infection in patients with compensated liver disease
Cytovene (g)	Ganciclovir	Dx- treatment of CMV retinitis in immunocompromised patients, including AIDS patients. Prophylaxis of CMV infection in transplant patients. Approvable for 6 months therapy.
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Medication		Criteria	Standard Response
Cytoxan(g) <s>	cyclophosphamide	Dx- Treatment of acute lymphocytic leukemia (ALL), breast cancer, Hodgkin's disease, non-Hodgkin's lymphoma (NHL) including Burkitt's lymphoma and cutaneous T-cell lymphoma (CTCL) (mycosis fungoides), chronic lymphocytic leukemia (CLL), multiple myeloma, ovarian cancer, retinoblastoma, acute myelogenous leukemia (AML) or chronic myelogenous leukemia (CML), nephrotic syndrome, OR the prescriber must be an oncologist or have consulted with an oncologist for an appropriate treatment.	Please submit PA with diagnosis and prescribing physician specialty.
Depo-Testosterone(g) <s>	testosterone	Dx- For the treatment of delayed puberty in males, OR For palliative treatment of inoperable breast cancer in women.	Please submit PA with diagnosis and documentation of trial/failure of prior treatments.
Dilaudid liquid (g)	Hydromorphone	Please use formulary narcotic analgesics.	Please submit PA with documentation of diagnosis and previous/current treatment.
Droxia <s>	hydroxyurea	For the treatment of chronic myelogenous leukemia (CML), malignant melanoma, ovarian cancer, head and neck cancer, or sickle cell disease.	Please submit PA with diagnosis.
Duragesic patch	Fentanyl	Requires diagnosis of cancer related pain. Failure or unable to take oral tablets. Must have history of first line agents (Vicodin/ES, Percocet, Tylox, Dilaudid, etc) then MS Contin. Approvable for short term use for recent surgery.	Please evaluate patient for the formulary alternatives per SGRX guidelines.
Elidel	Pimecrolimus	Dx- Atopic dermatitis. Requires use of hydrocortisone, betamethasone or triamcinolone (2 week trial in the last 60 days). Patient must be at least 2 years old for approval.	Please evaluate patient for formulary alternatives.
Elmiron	Pentasan	Requires diagnosis of interstitial cystitis (IC) and a positive PST (potassium sensitivity test) Approvals would be for 1 month and assess efficacy for further refills.	Submit request with documentation of diagnosis.
Enbrel <S>	Etanercept	Dx- Rheumatoid arthritis. Failure on one or more DMARD's (cyclosporine, azathioprine, penicillamine, hydroxychloroquine, oral corticosteroids, gold salts, methotrexate, Enbrel, Kineret, Arava)	Please submit PA with documentation of diagnosis and current/past treatments.
Epivir, HBV	lamivudine	Dx- For the treatment of human immunodeficiency virus (HIV) infection in combination with other antiretroviral agents; For the treatment of chronic hepatitis B infection.	Please submit PA with diagnosis and documentation of current treatment/s.
Epogen <S>	Epoetin alpha	Dx- anemia associated with ONE of the following conditions: Chronic renal failure (CRF), <u>or</u> Solid tumors or multiple myeloma or lymphoma or lymphocytic leukemia who are currently undergoing myelosuppressive chemotherapy. <u>Or</u> HIV/AIDS Zidovudine therapy. Must have maintained adequate iron stores (transferrin saturation > 20%) or ferritin >100ng/ml. Must have Hgb < 10 g/dL or Hct < 30%	Please submit PA with documentation of diagnosis and lab results including hemoglobin and hematocrit; transferrin sats and/or ferritin levels.
Epzicom	abacavir, lamivudine	Dx- For the treatment of human immunodeficiency virus (HIV) infection in combination with other antiretroviral agents.	Please submit PA with diagnosis and documentation of current treatment/s.
Erygel (g)	Erythromycin gel	Dx- Acne vulgaris. Requires 2 weeks each of 2 formulary agents within the last 180 days. Formulary agents include: topical benzoyl peroxide, tetracycline, doxycycline, clindamycin solution, erythromycin solution.	Please consider formulary alternatives per SGRX guidelines.
Eulexin (g) <s>	Flutamide	Dx- stage D2 metastatic cancer of the prostate (advanced prostate cancer). Must be prescribed by an Oncologist or Urologist. PSA lab	Submit PA with documentation of diagnosis and PSA lab values
Exelderm	Sulconazole	Use formulary topical antifungal agents: clotrimazole, ketoconazole, miconazole.	Please consider formulary alternatives per SGRX guidelines.
Exelon	Rivastigmine	Dx- Alzheimer's disease confirmed by a Neurologist.	Submit PA with chart notes indicating patient's diagnosis confirmed by a Neurologist.
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Femara	Letrozole	Dx- Early Breast cancer, locally advanced or metastatic breast cancer. Failure of Tamoxifen.	Please evaluate patient for formulary alternative tamoxifen.
Fuzeon	enfuvirtide	Dx- For the treatment of advanced human immunodeficiency virus (HIV) infection in combination with other antiretroviral agents in treatment-experienced patients with evidence of HIV replication despite ongoing antiretroviral therapy	Please submit PA with diagnosis and documentation of trial/failure of prior treatments, and documentation of current treatment/s.
Gleevec	imatinib	Requires that the prescribing doctor is an oncologist, hematologist or has obtained a consult from the listed specialties. AND if the pt NOT pregnant AND has no plans to conceive.	Please submit PA with diagnosis and prescribing physician specialty.
Hepsera <s>	adefovir	Dx- Treatment of chronic hepatitis B in patients Greater than or equal to 12 years of age AND The prescribing provider is a gastroenterologist or trained in infectious disease or has obtained a consult from the listed specialties.	Please submit PA with diagnosis and prescribing physician specialty.
Humira <S>	Adalimumab	Dx- Rheumatoid arthritis. Failure on one or more DMARD's (cyclosporine, azathioprine, penicillamine, hydroxychloroquine, oral corticosteroids, gold salts, methotrexate, Enbrel, Kineret, Arava)	Please submit PA with documentation of diagnosis and current/past treatments.
Hydrea(g) <s>	hydroxyurea	For the treatment of chronic myelogenous leukemia (CML), malignant melanoma, ovarian cancer, head and neck cancer, or sickle cell disease.	Please submit PA with diagnosis.
Inapsine	Droperidol	Dx- intractable psychoses. Must be prescribed by Neurologist.	Please evaluate patient for formulary alternatives.
InFed, Dexferrum	iron dextran	Dx- For the treatment of iron-deficiency anemia in patients in whom oral iron administration is unsatisfactory or impossible	Please submit PA with diagnosis and documentation of trial/failure of prior treatments.
Infergen <s>	interferon alfacon-1	Dx- For the treatment of chronic hepatitis C infection in patients with compensated liver disease who have anti-HCV serum antibodies and/or the presence of HCV RNA and: •who have not previously received interferon therapy OR •who previously received and tolerated interferon (IFN) therapy and either did not respond or relapsed after IFN discontinuation	Please submit PA with diagnosis and documentation of trial/failure of prior treatments.
Intron A <s>	interferon alfa 2b	Dx- For the treatment of hairy-cell leukemia, For the adjuvant treatment of malignant melanoma in patients who are disease free and at high risk for systemic recurrence within 56 days of surgery, For the treatment of non-Hodgkin's lymphoma (NHL), For the treatment of condylomata acuminata (genital or venereal warts) involving the external surfaces of the genital and perianal areas, For the treatment of AIDS-related Kaposi's sarcoma, For the treatment of chronic hepatitis B infection in patients with compensated liver disease, For the treatment of hepatitis C infection in patients with compensated liver disease. OR a diagnosis supported by the compendia of literature.	Please submit PA with documentation of diagnosis and current/past treatments.
Iressa <S>	Gefitinib	Dx- metastatic non-small cell lung cancer (NSCLC) Failure of both platinum- and docetaxel-based chemotherapies, in those patients showing benefit from current or past gefitinib. Enrollment in Iressa® Access Program.	Please submit PA with documentation of diagnosis and current/past treatments.
Isentress	Raltegravir	Dx- HIV. Requires use of classic HAART (Highly Active Anti-Retroviral Therapy) agents first. Must be prescribed by Infectious Disease specialist.	Please consider formulary antiretroviral agents as first line per SGRX guidelines.
Januvia/ Janumet	Sitagliptin	Dx- Type 2 diabetes. Requires trial/failure to reach HbA1c goal or intolerance to all of the following: Metformin; sulfonylureas (glipizide, glyburide); thiazolidinediones, TZDs (Actos, Avandia)	Please submit PA with diagnosis, HbA1c lab results and documentation of trial/failure of prior treatments.

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Kaletra	lopinavir, ritonavir	Dx- For the treatment of human immunodeficiency virus (HIV) infection in combination with other antiretroviral agents.	Please submit PA with diagnosis and documentation of current treatment/s.
Kytril	Granisetron	Dx- chemotherapy induced nausea and vomiting; radiation induced N/V, post operative N/V. Trial/failure on Zofran (ondansetron)	Please submit PA with diagnosis and documentation of trial/failure of prior treatments.
Leucovorin(g) <s>	leucovorin	Dx- For the treatment of fluorouracil therapy, macrocytic anemia, megaloblastic anemia, MTX (methotrexate) toxicity prophylaxis, pyrimethamine toxicity/prophylaxis, trimethoprim toxicity/prophylaxis, trimetrexate toxicity/prophylaxis.	Please submit PA with diagnosis.
Leukeran <s>	chlorambucil	Dx- For the treatment of chronic lymphocytic leukemia (CLL), For the treatment of Hodgkin's disease, For the treatment of non-Hodgkin's lymphoma (NHL), OR a diagnosis supported by the compendia of literature.	Please submit PA with diagnosis.
Lexiva	fosamprenavir	Dx- For the treatment of human immunodeficiency virus (HIV) infection in combination with other antiretroviral agents.	Please submit PA with diagnosis and documentation of current treatment/s.
Lovenox <s>	enoxaparin	Dx- For the treatment of venous thromboembolism (VTE) including acute deep venous thrombosis (DVT) or pulmonary embolism (PE), for thrombosis prophylaxis in patients undergoing joint replacement surgery.	Please submit PA with diagnosis and documentation of current treatment/s.
Lupron Depot <s>	Leuprolide	Dx- Palliative treatment of advanced prostate cancer, particularly when orchiectomy or estrogen therapy are not indicated or are unacceptable; Management of endometriosis ; Treatment of central precocious puberty (idiopathic or neurogenic) in children less than 9 years old; Preoperative treatment of anemia due to uterine leiomyomata (fibroids) in combination with iron supplementation when iron therapy alone fails to correct the anemia. Covered for members who meet the following criteria: The documented diagnosis is one of the FDA approved indications listed above. If the diagnosis is endometriosis the patient has completed documented trial and failures of oral contraceptives and medroxyprogesterone.	Please submit PA with documentation of diagnosis and current/past treatments.
Marinol	Dronabinol	Dx- For the treatment of anorexia-associated weight loss in HIV patients after failure of covered agent Megace. Also approved for nausea and vomiting associated with cancer chemotherapy in patients who have failed to respond adequately to conventional antiemetic treatments.	Please evaluate the patient for the formulary alternatives.
Matulane <s>	procarbazine	Dx- For the treatment of Hodgkin's disease OR a diagnosis supported by the compendia of literature.	Please submit PA with documentation of diagnosis and current/past treatments.
Mepron liquid	Atovaquone	Dx- For the treatment/prophylaxis of PCP in HIV patients intolerant to SMZ/TMP; treatment/prophylaxis of toxoplasma encephalitis in HIV patients	Please submit PA with diagnosis and documentation of current treatments.
Myleran <s>	busulfan	Dx- For the treatment of chronic myelogenous leukemia (CML) in chronic phase OR a diagnosis supported by the compendia of literature.	Please submit PA with documentation of diagnosis and current/past treatments.
Namenda	Memantine	Dx- Alzheimer's disease confirmed by a Neurologist. Requires members to be currently on Aricept for past 3 months. Aricept must be continued for a ST to be extended.	Please submit PA with diagnosis and documentation of current treatments.
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Neoral(g) <s>	cyclosporine	Dx- For kidney transplant rejection prophylaxis, heart transplant rejection prophylaxis, liver transplant rejection prophylaxis, and the treatment of acute and chronic graft-versus-host disease (GVHD) and graft-versus-host disease (GVHD) prophylaxis, For the treatment of severe, plaque-type psoriasis in immunocompetent patients who failed to respond to at least one systemic therapy (e.g., PUVA, retinoids, methotrexate) or in patients for whom other systemic therapies are contraindicated or cannot be tolerated, OR For the treatment of severe rheumatoid arthritis (RA) in patients unresponsive to conventional therapy, alone or in combination with methotrexate when the disease has not adequately responded to methotrexate.	Please submit PA with diagnosis and documentation of current treatments.
Neupogen <s>	filgrastim	Dx- For the treatment neutropenia, For chemotherapy-induced neutropenia prophylaxis in patients receiving myelosuppressive chemotherapy and to decrease the incidence of febrile neutropenia, OR For peripheral blood stem cell (PBSC) mobilization prior to and during leukapheresis in cancer patients preparing to undergo bone marrow ablation.	Please submit PA with documentation of diagnosis and current/past treatments.
Nexavar <S>	Sorafenib	Dx- Unresectable hepatocellular carcinoma; Advanced renal cell carcinoma. Covered for members who meet the following criteria: The prescribing physician is a board certified oncologist or nephrologist.	Please submit PA with diagnosis and prescribing physician specialty.
Nilandron <s>	nilutamide	Dx- For the treatment of metastatic prostate cancer in combination with orchiectomy.	Please submit PA with diagnosis and prescribing physician specialty.
Norvir	ritonavir	Dx- For the treatment of human immunodeficiency virus (HIV) infection in combination with other antiretroviral agents.	Please submit PA with diagnosis and documentation of current treatment/s.
Novarel	Human chorionic gonadotropin	Novarel is covered for members who meet either of the following criteria: A. In a Male patient 1. If the patient has a diagnosis of prepubertal cryptorchidism not due to anatomic obstruction or hypogonadism secondary to a pituitary deficiency. 2. AND If the patient does not have any signs of the following diagnoses: a. Precocious puberty, or b. Prostatic carcinoma or other androgen dependent neoplasm 3. And is not being used in the treatment of obesity.	Please submit PA with diagnosis and documentation of trial/failure of prior treatments.
Nutropin <S>	Somatropin	Dx: growth failure due to an inadequate secretion of endogenous growth hormone or replacement therapy in adults with growth hormone deficiency of either childhood or adult-onset etiology.	Please submit PA with diagnosis and documentation of trial/failure of prior treatments. Must include growth hormone stimulus test results and growth charts when appropriate.
Pegasys <s>	peginterferon alfa 2a	Dx- For the treatment of chronic hepatitis C infection in adults with compensated liver disease who have not been previously treated with interferon alfa OR For the treatment of HBeAg-positive and HBeAg-negative chronic hepatitis B infection in patients with compensated liver disease and evidence of viral replication and liver inflammation.	Please submit PA with diagnosis and documentation of trial/failure of prior treatments.
Peg-Intron, Redipen <s>	peginterferon alfa 2b	Dx- For treatment of hepatitis C infection.	Please submit PA with diagnosis and documentation of trial/failure of prior treatments.
Plavix	Clopidogrel	Requires documentation of one of the following: aspirin allergy, carotid stent, intracranial stent, brachytherapy, renal stent, inguinal/popliteal/peripheral stent, or cerebrovascular disease with recurrent ischemia with documentation.	Please evaluate patient for the covered alternative of aspirin or dipyridamole.
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Pregnyl	Human chorionic gonadotropin	Pregnyl is covered for members who meet either of the following criteria: A. In a Male patient 1. If the patient has a diagnosis of prepubertal cryptorchidism not due to anatomic obstruction or hypogonadism secondary to a pituitary deficiency. 2. AND If the patient does not have any signs of the following diagnoses: a. Precocious puberty, or b. Prostatic carcinoma or other androgen dependent neoplasm 3. And is not being used in the treatment of obesity	Please submit PA with diagnosis and documentation of trial/failure of prior treatments.
Prezista	Darunavir	Dx- HIV. Must be used as part of combination treatment	Please submit PA with diagnosis and documentation of current treatments.
Procrit <s>	Epoetin alpha	Dx- anemia associated with ONE of the following conditions: Chronic renal failure (CRF), <u>or</u> Solid tumors or multiple myeloma or lymphoma or lymphocytic leukemia who are currently undergoing myelosuppressive chemotherapy. <u>Or</u> HIV/AIDS Zidovudine therapy. Must have maintained adequate iron stores (transferrin saturation > 20%) or ferritin >100ng/ml. Must have Hgb < 10 g/dL or Hct < 30%	Please submit PA with documentation of diagnosis and lab results including hemoglobin and hematocrit; transferrin sats and/or ferritin levels.
Profasi (g)	Human chorionic gonadotropin	Human chorionic gonadotropin is covered for members who meet either of the following criteria: A. In a Male patient 1. If the patient has a diagnosis of prepubertal cryptorchidism not due to anatomic obstruction or hypogonadism secondary to a pituitary deficiency. 2. AND If the patient does not have any signs of the following diagnoses: a. Precocious puberty, or b. Prostatic carcinoma or other androgen dependent neoplasm 3. And is not being used in the treatment of obesity.	Please submit PA with diagnosis and documentation of trial/failure of prior treatments.
Prograf <s>	tacrolimus	Dx- For liver, kidney, or heart transplant rejection prophylaxis.	Please submit PA with diagnosis.
Pulmozyme	dornase alfa	Dx- Cystic fibrosis	Please submit PA with diagnosis and prescribing physician specialty.
Purinethol(g) <s>	mercaptopurine	Dx- For the treatment of acute lymphocytic leukemia (ALL) OR a diagnosis supported by the compendia of literature.	Please submit PA with diagnosis and documentation of trial/failure of prior treatments.
Rapamune tabs, solution <s>	sirolimus	Dx- For the prophylaxis of organ rejection in patients aged 13 years or older receiving renal transplants.	Please submit PA with diagnosis and documentation of trial/failure of prior treatments.
Renvela	Sevelamer carbonate	Requires trial/failure of formulary agents: Phoslo, Renagel.	Please evaluate patient for formulary alternatives.
Revatio	Sildenafil	Dx- PAH (Pulmonary Arterial Hypertension). Consult with pulmonologist, and/or cardiologist.	Please submit PA with documentation of diagnosis.
Roferon-A <s>	interferon alfa 2a	Dx- For the treatment of chronic phase Philadelphia chromosome-positive chronic myelogenous leukemia (CML) in patients who are within 1 year of diagnosis and minimally pretreated, For induction and maintenance of remission of hairy-cell leukemia, or For the treatment of chronic hepatitis C infection.	Please submit PA with documentation of diagnosis and current/past treatments.
Saizen <S>	Somatropin	Dx: growth failure due to an inadequate secretion of endogenous growth hormone or replacement therapy in adults with growth hormone deficiency of either childhood or adult-onset etiology.	Please submit PA with diagnosis and documentation of trial/failure of prior treatments. Must include growth hormone stimulus test results and growth charts when appropriate.

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Sandimmune(g) <s>	cyclosporine	Dx- For kidney transplant rejection prophylaxis, heart transplant rejection prophylaxis, liver transplant rejection prophylaxis, and the treatment of acute and chronic graft-versus-host disease (GVHD) and graft-versus-host disease (GVHD) prophylaxis, For the treatment of severe, plaque-type psoriasis in immunocompetent patients who failed to respond to at least one systemic therapy (e.g., PUVA, retinoids, methotrexate) or in patients for whom other systemic therapies are contraindicated or cannot be tolerated, OR For the treatment of severe rheumatoid arthritis (RA) in patients unresponsive to conventional therapy, alone or in combination with methotrexate when the disease has not adequately responded to methotrexate.	Please submit PA with diagnosis and documentation of current treatments.
Singular	montelukast	Dx- Asthma. Requires trial/failure to manage asthma symptoms on a inhaled corticosteroid. Dx- Allergies. Requires trial failure on oral antihistamines and formulary nasal steroid.	Please submit PA with diagnosis and documentation of trial/failure of prior treatments.
Sustiva	efavirenz	Dx- For the treatment of human immunodeficiency virus (HIV) infection in combination with other antiretroviral agents.	Please submit PA with diagnosis and documentation of current treatment/s.
Sutent <S>	Sunitinib	Dx: Gastrointestinal stromal tumor after disease progression on or intolerance to imatinib mesylate; Advanced renal cell carcinoma. Covered for members who meet the following criteria: The prescribing physician is a board certified oncologist, gastroenterologist or nephrologist. AND the patient does NOT have clinical manifestations of congestive heart failure (CHF).	Please submit PA with diagnosis, prescribing physician specialty, and chart notes on current heart health.
Tarceva <S>	Erlotinib	Dx- Requires patient diagnosis with refractory non small cell lung cancer (NSCLC) at later stages in the disease (Stage IIIB/IV); Second line therapy for patients with NSCLC.	Please submit PA with documentation of diagnosis and current/past treatments.
Tasigna <S>	Nilotinib	Dx- Philadelphia chromosome positive (Ph+) Chronic myelogenous leukemia (CML) in adult patients resistant or intolerant to prior therapy that included imatinib (Gleevec). Requires use of Gleevec, documented failure must be provided.	Please submit PA with documentation of trial/failure of Gleevec for diagnosis of Ph+ CML.
Temodar <s>	temozolomide	Dx- For the treatment of malignant glioma.	Please submit PA with documentation of diagnosis and current/past treatments.
Thalomid <s>	thalidomide	Dx- For the management of erythema nodosum leprosum (ENL) or For the treatment of multiple myeloma.	Please submit PA with documentation of diagnosis and current/past treatments.
Ticlid (g)	Ticlopidine	Dx- Antiplatelet agent for patients with a history of thrombotic stroke who are intolerant to aspirin, or who have failed aspirin therapy. Monitor for life-threatening hematologic reactions- neutropenia, aplastic anemia, thrombotic thrombocytopenia purpura (TTP).	Submit PA with chart notes documenting evaluation of patient ruling out drug usage contraindications.
Trelstar Depot, LA <s>	triptorelin	Dx- For the palliative treatment of advanced prostate cancer OR a diagnosis supported by the compendia of literature.	Please submit PA with documentation of diagnosis and current/past treatments.
Tricor	Fenofibrate	Dx- High cholesterol, high triglycerides. Use formulary fenofibrate.	Please use formulary alternative per SGRX guidelines.
Trizivir	abacavir, lamivudine, zidovudine	Dx- For the treatment of human immunodeficiency virus (HIV) infection in combination with other antiretroviral agents.	Please submit PA with diagnosis and documentation of current treatment/s.
Truvada	emtricitabine, tenofovir	Dx- For the treatment of human immunodeficiency virus (HIV) infection in combination with other antiretroviral agents.	Please submit PA with diagnosis and documentation of current treatment/s.
Tykerb <S>	Lapatinib	Dx- advanced or metastatic HER2 positive breast cancer. Requires trial /failure of prior therapy with a regimen including all of the following. 1. Anthracycline (doxorubicin, daunorubicin, epirubicin, idarubicin) 2. Taxane (docetaxel, paclitaxel) 3. Trastuzumab (Herceptin)	Please submit PA with diagnosis and documentation of trial/failure of prior treatments.
Ventavis <s>	lloprost	Dx- Treatment of pulmonary hypertension in patients with NYHA Class III or IV symptoms	Please submit PA with diagnosis.
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Xanax XR (g)	Alprazolam ER	Dx- Panic Disorder and Anxiety Disorder. Must have documented failure of formulary alternatives: alprazolam (immediate release), lorazepam, diazepam, chlordiazepoxide.	Please consider formulary alternatives per SGRX guidelines.
Xeloda <s>	capecitabine	Dx- For the treatment of breast cancer or For the treatment of colorectal cancer.	Please submit PA with diagnosis and documentation of trial/failure of prior treatments.
Zolinza <S>	Vorinostat	Dx- Treatment of cutaneous T-cell lymphoma (CTCL) in patients who have progressive, persistent, or recurrent disease on or following 2 systemic therapies	Please submit PA with diagnosis and documentation of trial/failure of prior treatments.
Zyvox	Linezolid	Dx- For coverage of vancomycin-resistant <i>Enterococcus faecium</i> infections, nosocomial pneumonia, community acquired pneumonia, both complicated and uncomplicated skin and skin structure infections, including diabetic foot infections, with concomitant osteomyelitis. (Linezolid is not approved for the treatment of catheter-related bloodstream infections or catheter-site infections; Linezolid is not indicated for the treatment of Gram negative infections. If infection with Gram negative bacteria is known or suspected, appropriate therapy should be started immediately.)	Please submit PA with diagnosis and documentation of trial/failure of prior treatments, or sensitivity testing indicating susceptibility to Zyvox.
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STEP THERAPY

Drug Class	Diagnosis	Criteria/conditions for approval	Standard Response
BENICAR/HCT, MICARDIS/HCT, HYZAAR, COZAAR	Hypertension	Requires documentation that the member has experienced treatment failure or intolerance to ACE inhibitors including Captopril, Enalapril, Lisinopril, Benazepril, Quinapril, Ramipril, or Trandolapril	Please submit documentation of trial/failure or intolerance to ACE inhibitors including Captopril, Enalapril, Lisinopril, Benazepril, Quinapril, Ramipril, or Trandolapril
ACTONEL	Osteoporosis	Requires documentation that the member has experienced treatment failure or intolerance to alendronate (generic Fosamax)	Please submit documentation of trial/failure or intolerance to alendronate (generic Fosamax)
AVANDIA, AVANDAMET, AVANDARYL, ACTOS, ACTOPLUSMET, DUETACT	Type 2 Diabetes	Requires documentation that the member has experienced treatment failure or intolerance to metformin	Please submit documentation of trial/failure or intolerance to metformin
CRESTOR, VYTORIN	High Cholesterol	Requires documentation that the member has experienced treatment failure or intolerance to generic formulary statin agents: lovastatin, simvastatin, or pravastatin (40mg and above)	Please submit documentation of trial/failure or intolerance to generic formulary statin agents: lovastatin, simvastatin, or pravastatin (40mg and above)
VYVANSE	ADHD	Requires documentation that the member has experienced treatment failure or intolerance to methyphenidate IR*, amphetamine IR*.	Please submit documentation of trial/failure or intolerance to methyphenidate IR*, amphetamine IR*.
NASACORT AQ, NASONEX	Allergic Rhinitis	Requires documentation that the member has experienced treatment failure or intolerance to formulary nasal steroid agents fluticasone or flunisolide	Please submit documentation of trial/failure or intolerance to formulary nasal steroid agents fluticasone or flunisolide

* IR= immediate release formulations