



Bulletin

To: All Providers

From: HPM Pharmacy & Utilization Management Departments

Bulletin #: 052109-03

Date: 3-Jun-09

Re: PRIOR AUTHORIZATION CRITERIA ADOPTED

Medical Utilization Criteria have been developed for the following products. When authorization is requested for these products, they will be reviewed by the pharmacy department prior to approval. Review process will begin 7/1/2009. Clinical review criteria is available upon request

Remicade® (Infliximab)

J1745

IVIG

J1459, J1561, J1566, J1568, J1569,
J1571, J1572, J1573, J2791

SCIG

J1562

Xolair® (omalizumab)

J2357

Prolastin® (Alpha-1 Antitrypsin)

J0256

Boniva® (ibandronate) injection

J1740

Reclast® / Zometa® (zoledronic acid) injection

J3487

Synagis® (palivizumab)

If you should have any questions please feel free to contact the Pharmacy Department at 1-313-324-3700.