

### 2010 Medicare part D Prior Authorizations

Medication Name/Route	Prior Approval Class	Prior Approval Description
Tobramycin Sulfate In Ns Solution / Intravenous Tobramycin Sulfate Vial / Injectable	Aminoglycosides	<b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D. <b>Exclusion Criteria-</b> None <b>Required Medical Information-</b> None <b>Age Restrictions-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> Benefit year
Thalomid Capsule / Oral	Antileptotics	<b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D. <b>Exclusion Criteria-</b> None <b>Required Medical Information-</b> None <b>Age Restrictions-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> Benefit year
Quaalquin Capsule / Oral	Antimalarial Drugs	<b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D. <b>Exclusion Criteria-</b> None <b>Required Medical Information-</b> Patient Chart Notes with diagnosis <b>Age Restrictions-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> Patients 16 years and older 2 capsules every 8 hours for 7 days.
Herceptin Vial / Intravenous	Antineoplast Egf Receptor Blocker Rcmb Mc Antibody	<b>Covered Uses-</b> All medically accepted indications not otherwise excluded from Part D. <b>Exclusion Criteria-</b> None <b>Required Medical Information-</b> HER 2 test positive with

		<p>level 2 or 3 and/or FISH technique ratio greater than 2 on a pathbysion test</p> <p><b>Age Restriction-</b> None</p> <p><b>Prescriber Restrictions-</b> None</p> <p><b>Coverage Duration-</b> 30 days - Re-evaluate based on Required medical information</p>
Revlimid Capsule / Oral	Antineoplastic Immunomodulator Agents	<p><b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D.</p> <p><b>Exclusion Criteria-</b> None</p> <p><b>Required Medical Information-</b> Myelodysplastic Syndrome (MDS) diagnosis</p> <p><b>Age Restriction-</b> None</p> <p><b>Prescriber Restrictions-</b> None</p> <p><b>Coverage Duration-</b> Benefit year</p>
Sutent Capsule / Oral Tarceva Tablet / Oral	Antineoplastic Systemic Enzyme Inhibitors	<p><b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D.</p> <p><b>Exclusion Criteria-</b> None</p> <p><b>Required Medical Information-</b> None</p> <p><b>Age Restriction-</b> None</p> <p><b>Prescriber Restrictions-</b> None</p> <p><b>Coverage Duration-</b> Benefit year</p>
Rituxan Vial / Intravenous	Antineoplastics Antibody/Antibody-Drug Complexes	<p><b>Covered Uses-</b> All medically accepted indications not otherwise excluded from Part D.</p> <p><b>Exclusion Criteria-</b> None</p> <p><b>Required Medical Information-</b> Chart notes showing pharmacological treatments and the severity of rheumatoid arthritis must be moderate to severe. Evidence of Methotrexate treatment and inadequate response to 1 or more TNF antagonist.</p> <p><b>Age Restrictions-</b> None</p> <p><b>Prescriber Restrictions-</b> None</p>

		<b>Coverage Duration-</b> 30 days - Re-evaluate based on Required medical information
Soriatane Ck Kit / Oral	Antipsoriatic Agents, Systemic	<b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D. <b>Exclusion Criteria-</b> None <b>Required Medical Information-</b> Negative pregnancy test <b>Age Restriction-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> Benefit year
Atgam Ampule / Intravenous Carimune Nf Nanofiltered Vial / Intravenous Flebogamma Vial / Intravenous Gamastan S-D Vial / Intramuscular Gammagard Liquid Vial / Intravenous Gamunex Vial / Intravenous Octagam Vial / Intravenous Polygam S-D Vial / Intravenous Thymoglobulin Vial / Intravenous Vivaglobin Vial / Subcutaneous Privigen Vial/ Intravenous	Antisera	<b>Covered Uses-</b> All medically accepted indications not otherwise excluded from Part D <b>Exclusion Criteria-</b> Conditions- Acquired factor VIII inhibitors, Acquired von Willebrand's disease, Acute lymphoblastic leukemia, Adrenoleukodystrophy, Amyotrophic lateral sclerosis, Angioedema, Antiphospholipid syndrome, Aplastic anemia, Asthma, Autism, Autoimmune chronic urticaria, Autoimmune hemolytic anemia, Behcet's syndrome, acute Cardiomyopathy, Chronic fatigue syndrome, Chronic sinusitis, Congenital heart block, Cystic fibrosis, Dermatitis autoimmune blistering, Diabetes mellitus, Diamond Blackfan anemia, acute idiopathic Dysautonomia, Eczema, acute disseminated Encephalomyelitis, Encephalopathy, Endotoxemia, Epilepsy, Goodpasture's syndrome, Hemolytic transfusion reaction, Hemolytic uremic syndrome, Hemophagocytic syndrome, Idiopathic lumbosacral plexopathy, Immune mediated neutropenia, Inclusion body myositis, Infection prevention and control in newborns, Intractable seizures, acute lymphoblastic leukemia, lower motor neuron syndrome, primary progressive or secondary types relapsing remitting type permitted Multiple Sclerosis, Myalgia myositis

		<p>unspecified, Myelopathy HTLV-1 associated, Nephropathy membranous, Nephritic syndrome, Nonimmune thrombocytopenia, Ophthalmopathy euthyroid, Opsoclonus myoclonus, Oral use of IVIG, Otitis media recurrent, Paraneoplastic cerebella degeneration, Paraneoplastic syndromes, Paraproteinemic neuropathy, PANDAS, POEMS syndrome, Polyarteritis nodosa, Progressive lumbosacral plexopathy, Radiculoneuritis lyme, Rasmussen's syndrome, Recurrent otitis media, recurrent spontaneous pregnancy loss, red cell aplasia, refractoriness to platelet transfusion, Reiter's syndrome, Acute Renal Failure, Rheumatoid arthritis, scleroderma, secondary thrombocytopenia, sensory neuropathy, systemic vasculitides, nonimmune thrombocytopenia, Toxic shock syndrome streptococcal, Uveitis, Vasculitis associated with other connective tissue disease, Vogt Koyanagi Harada syndrome, Wegener's granulomatosis.</p> <p><b>Required Medical Information-</b> Serum trough and IgG levels below 600, platelet counts, CD4 counts and lymphocyte counts. Chart notes of past illness and for multiple myeloma, any infections in the past year. Evidence of positive GMI antibodies.</p> <p><b>Age Restrictions-</b> None</p> <p><b>Prescriber Restrictions-</b> None</p> <p><b>Coverage Duration-</b> 30 days then re-evaluate with new Lab work</p>
Synagis Vial / Intamuscular	Antiviral Monoclonal Antibodies	<p><b>Covered Uses-</b> All FDA approved indications not otherwise excluded from Part D.</p> <p><b>Exclusion Criteria-</b> None</p> <p><b>Required Medical Information-</b> Charts notes and risk</p>

		<p>factors required - Gestational age required- diagnosis of CLD or evidence of exposure of RSV- Patient Age at start of RSV season.</p> <p><b>Age Restriction-</b> None</p> <p><b>Prescriber Restrictions-</b> None</p> <p><b>Coverage Duration-</b> Prior Approval for 30 days intervals up to 6 months of therapy</p>
Remicade Vial / Intravenous	Drugs To Tx Chronic Inflamm. Disease Of Colon	<p><b>Covered Uses-</b> All medically accepted indications not otherwise excluded from Part D.</p> <p><b>Exclusion Criteria-</b> None</p> <p><b>Required Medical Information-</b> Chart notes with disease manifestation and sign and symptoms, pharmacological treatment and non pharmacological treatment</p> <p><b>Age Restriction-</b> None</p> <p><b>Prescriber Restrictions-</b> None</p> <p><b>Coverage Duration-</b> 30 days - then re-evaluate based on physician notes</p>
<p>Aciphex Tablet / Oral</p> <p>Kapidex Capsule / Oral</p> <p>Lansoprazole Capsule / Oral</p> <p>Nexium Capsule / Oral</p> <p>Nexium I.V. Vial / Intravenous</p> <p>Nexium Packet / Oral</p> <p>Nexium Suspension / Oral</p> <p>Omeprazole Capsule / Oral</p> <p>Pantoprazole Sodium Tablet / Oral</p> <p>Prevacid Capsule / Oral</p> <p>Prevacid Tablet / Oral</p> <p>Prilosec Capsule / Oral</p> <p>Protonix Iv Vial / Intravenous</p>	Gastric Acid Secretion Reducers	<p><b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D.</p> <p><b>Exclusion Criteria-</b> None</p> <p><b>Required Medical Information-</b> Chart Notes with diagnosis</p> <p><b>Age Restriction-</b> None</p> <p><b>Prescriber Restrictions-</b> None</p> <p><b>Coverage Duration-</b> Ulcers 4 wks. H.Pylori 10 days all other FDA indications approved for the benefit year.</p>

Protonix Suspension / Oral Protonix Tablet / Oral Zegerid Capsule / Oral Zegerid Packet / Oral		
Genotropin Cartridge / Subcutaneous Genotropin Syringe / Subcutaneous Humatrope Cartridge / Injectable Humatrope Vial / Injectable Norditropin Nordiflex Pen / Subcutaneous Norditropin Cartridge/ Subcutaneous Nutropin Cartridge/ Subcutaneous Nutropin Aq Vial / Subcutaneous Nutropin Vial / Subcutaneous Omnitrope Cartridge / Subcutaneous Omnitrope Vial / Subcutaneous Saizen Cartridge / Subcutaneous Saizen Vial / Subcutaneous Tev-Tropin Vial / Subcutaneous Zorbtive Vial / Subcutaneous	Growth Hormones	<p><b>Covered Uses-</b> All FDA approved indications not otherwise excluded from Part D.</p> <p><b>Exclusion Criteria-</b> None</p> <p><b>Required Medical Information-</b> Growth chart for children with short stature for initial therapy and every 12 months. Child: positive growth more than 2.5cm/year or epiphyseal closure occurs or when the bone age is 16 years (in females) or 18 years (in males).</p> <p><b>Age Restriction-</b> None</p> <p><b>Prescriber Restrictions-</b> None</p> <p><b>Coverage Duration-</b> PA provided for benefit year. Based on required Medical information.</p>
Serostim Vial / Subcutaneous	Growth Hormones -	<b>Covered Uses-</b> All FDA approved indications not otherwise

	Serostim	<p>excluded from Part D.</p> <p><b>Exclusion Criteria-</b> None</p> <p><b>Required Medical Information-</b> Cachexia associated with AIDS wasting</p> <p><b>Age Restriction-</b> None</p> <p><b>Prescriber Restrictions-</b> None</p> <p><b>Coverage Duration-</b> Up to 48 weeks</p>
<p>Aranesp Syringe / Injectable</p> <p>Aranesp Vial / Injectable</p> <p>Epogen Vial / Injectable</p> <p>Procrit Vial / Injectable</p>	Hematinics,Other	<p><b>Covered Uses-</b> All medically accepted indications not otherwise excluded from Part D</p> <p><b>Exclusion Criteria-</b> Condition - Iron deficiency, Underlying infection or inflammatory process, Underlying hematological disease, Hemolysis, Vitamin deficiencies, Blood loss, Aluminum intoxication.</p> <p><b>Required Medical Information-</b> Chart notes - diagnosis. Labs - Tranferrin at least 20 percent, Ferritin at least 100 ng per ml. Labs- Hb less than 10 gm per dl and HCT less than 30 percent at initiation therapy. Serum Creatinine equal to or greater than 3, Creatinine clearance less than 60 ml per min per 1.73 m2. Post 60 days therapy labs- Hb/HCT less than 10/30 and rise in Hb/HCT is greater than 1/3. For perisurgical adjuvant therapy Hb between 10 and 13 gm per dl.</p> <p><b>Age Restriction-</b> None</p> <p><b>Prescriber Restrictions-</b> None</p> <p><b>Coverage Duration-</b> 60 day intervals then re-evaluate with new Lab work</p>
<p>Lovenox Syringe / Subcutaneous</p> <p>Lovenox Vial / Subcutaneous</p> <p>Enoxaparin Syringes/ Subcutaneous</p>	Heparin And Related Preparations	<p><b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D.</p> <p><b>Exclusion Criteria-</b> None</p> <p><b>Required Medical Information-</b> After 7 days of therapy diagnosis required.</p>

		<b>Age Restriction-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> Total of 60 days
Istodax Vial/ Intravenous	HDAC Inhibitor	<b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D. <b>Exclusion Criteria-</b> None <b>Required Medical Information -</b> None <b>Age Restrictions-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> Benefit year
Copegus Tablet / Oral Infergen Vial / Subcutaneous Pegasys Kit / Subcutaneous Pegintron Kit / Subcutaneous Pegintron Redipen Pen / Subcutaneous Rebetol Capsule / Ora Rebetol Solution / Oral Ribapak Tablet / Oral Ribasphere Capsule / Oral Ribasphere Tablet / Oral Ribavirin Capsule / Oral Ribavirin Tablet / Oral	Hepatitis C Treatment Agents	<b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D. <b>Exclusion Criteria-</b> None <b>Required Medical Information-</b> Hepatitis C diagnosis, genotype: 1, 2, 3 or 4 and detectable viral load <b>Age Restriction-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> Up to 24 wks, re-evaluate. Additional 24 wks for genotypes 1 / 4 if decrease of 1 log in viral load.
Alferon N Vial / Injectable Intron A Pen / Subcutaneous Intron A Vial / Injectable Proleukin Vial / Intravenous	Immunomodulators	<b>Covered Uses-</b> All FDA approved indications not otherwise excluded from Part D. <b>Exclusion Criteria-</b> None <b>Required Medical Information-</b> Chart notes of direct exposure <b>Age Restriction-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> Up to 16 weeks

Cyclosporine Ampule / Intravenous Cyclosporine Capsule / Oral Cyclosporine Solution / Oral Gengraf Capsule / Oral Gengraf Solution / Oral Neoral Capsule / Oral Neoral Solution / Oral Sandimmune Ampule / Intravenous Sandimmune Capsule / Oral Sandimmune Solution / Oral	Immunosuppressives	<b>Covered Uses-</b> All FDA approved indications not otherwise excluded from Part D. <b>Exclusion Criteria-</b> None <b>Required Medical Information-</b> Chart notes and diagnosis <b>Age Restriction-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> Benefit year
Intralipid Emulsion / Intravenous Liposyn II Emulsion / Intravenous Liposyn III Emulsion / Intravenous	IV Fat Emulsions	<b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D. <b>Exclusion Criteria-</b> None <b>Required Medical Information-</b> Chart notes status of gut function and percentage of body mass loss in a given duration. Abnormal Albumin levels <b>Age Restriction-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> 30 days then re-evaluate based on required medical information
Kepivance Vial / Intravenous	Keratinocyte Growth Factor (Kgf)	<b>Covered Uses-</b> All FDA approved indications not otherwise excluded from Part D. <b>Exclusion Criteria-</b> None <b>Required Medical Information-</b> Chart notes and diagnosis <b>Age Restriction-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> 30 days
Leukine Vial / Injectable Neulasta Syringe /	Leukocyte (Wbc) Stimulants	<b>Covered Uses-</b> All medically accepted indications not otherwise excluded from Part D.

<p>Subcutaneous Neupogen Syringe / Injectable Neupogen Vial / Injectable</p>		<p><b>Exclusion Criteria-</b> None  <b>Required Medical Information-</b> Neutrophil count less than 1000000000 per liter  <b>Age Restriction-</b> None  <b>Prescriber Restrictions-</b> None  <b>Coverage Duration-</b> 60 day intervals then re-evaluate with new Lab work.</p>
<p>Arzerra Vial / Intravenous</p>	<p>Monoclonal Antibody</p>	<p><b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D <b>Exclusion Criteria-</b> None <b>Required Medical Information-</b> None <b>Age Restriction-</b> None  <b>Prescriber Restrictions-</b> None  <b>Coverage Duration-</b> Benefit year</p>
<p>Xolair Vial / Subcutaneous</p>	<p>Monoclonal Antibodies To Immunoglobulin E(Ige)</p>	<p><b>Covered Uses-</b> All FDA approved indications not otherwise excluded from Part D.  <b>Exclusion Criteria-</b> None  <b>Required Medical Information-</b> Labs - Positive RAST test or evidence of positive skin test. Labs- IgE level greater than or equal to 30 IU per ml to less than or equal to 700 IU per ml. Chart notes - Failure to response to treatment for moderate, persisitent asthma greater than or equal to 6 months with either moderate dose ICS and long acting beta agonist to low to moderate dose ICS, long acting inhaled beta 2 agonist and leukotriene modifiers. Chart notes - Failure to respond to treatment for severe persistent asthma for greater than or equal to 6 months with high dose ICS, long acting inhaled beta 2 agonist and leukotriene modifiers. Chart notes - Evidence of reversible disease (such as greater than or equal to 12 percent improvement in FEV1.  <b>Age Restriction-</b> Not covered for children less than 12 years  <b>Prescriber Restrictions-</b> None</p>

		<b>Coverage Duration-</b> Benefit year
Botox Vial / Intramuscular Myobloc Vial / Intramuscular	Neuromuscular Blocking Agents	<b>Covered Users-</b> All medically accepted indications not otherwise excluded from Part D. <b>Exclusion Criteria-</b> None <b>Required Medical Information-</b> Chart notes with injection sites <b>Age Restriction-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> 90 Days
Prevacid Naprapac Package / Oral	Nsaid, Cox Inhibitor-Type / Proton Pump Inhib Comb	<b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D. <b>Exclusion Criteria-</b> None <b>Required Medical Information-</b> Chart Notes with diagnosis <b>Age Restriction-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> Ulcers 4 wks. H.Pylori 10 days all other FDA indications approved for the benefit year.
Ketorolac Tromethamine Vial / Injectable	Nsaids, Cyclooxygenase Inhibitor - Type	<b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D. <b>Exclusion Criteria-</b> None <b>Required Medical Information-</b> Patient Chart Notes - Patient should not have GI bleeds/Ulcers <b>Age Restriction-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> 5 day supply
Zyvox Solution / Intravenous Zyvox Suspension / Oral Zyvox Tablet / Oral	Oxazolidinones	<b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D. <b>Exclusion Criteria-</b> None <b>Required Medical Information-</b> Culture and sensitivity and CBC within normal limits

		<b>Age Restriction-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> Up to 28 days
Adcirca Tablet / Oral Revatio Vial / Intravenous	Phosphodiesterase Inhibitor	<b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D <b>Exclusion Criteria-</b> None <b>Required Medical Information-</b> None <b>Age Restriction-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> Benefit year
Kuvan Tablet / Oral	Pku Tx Agent-Cofactor Of Phenylalanine Hydroxylase	<b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D. <b>Exclusion Criteria-</b> None <b>Required Medical Information-</b> Positive PKU test and patient's weight (to calculate dose). <b>Age Restriction-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> Benefit year
Ticlid Tablet / Oral	Platelet Aggregation Inhibitors	<b>Covered Users-</b> All FDA-approved indications not otherwise excluded from Part D. <b>Exclusion Criteria-</b> None <b>Required Medical Information-</b> CBC within normal limits <b>Age Restriction-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> Benefit year
Crinone Gel / Vaginal Endometrin Insert / Vaginal Prochieve Gel / Vaginal	Pregnancy Facilitating/Maintaining Agent,Hormonal	<b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D. <b>Exclusion Criteria-</b> None <b>Required Medical Information-</b> Chart Notes with diagnosis <b>Age Restriction-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> Duration of Pregnancy

Ventavis Ampule / Inhalation	Pulmonary Antihypertensives, Prostacyclin-Type	<p><b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D.</p> <p><b>Exclusion Criteria-</b> None</p> <p><b>Required Medical Information-</b> Chart Notes with diagnosis</p> <p><b>Age Restriction-</b> None</p> <p><b>Prescriber Restrictions-</b> None</p> <p><b>Coverage Duration-</b> Benefit year</p>
<p>Octreotide Acetate Ampule / Injectable</p> <p>Octreotide Acetate Vial / Injectable</p> <p>Sandostatin Ampule / Injectable</p> <p>Sandostatin Lar Kit / Intramuscular</p> <p>Sandostatin Vial / Injectable</p>	Somatostatic Agents	<p><b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D.</p> <p><b>Exclusion Criteria-</b> None</p> <p><b>Required Medical Information-</b> None</p> <p><b>Age Restriction-</b> None</p> <p><b>Prescriber Restrictions-</b> None</p> <p><b>Coverage Duration-</b> Benefit year</p>
Votrient Tablet / Oral	Tyrosine Kinase Inhibitor	<p><b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D</p> <p><b>Exclusion Criteria-</b>Condition - History of hemoptysis, cerebral, or serious gastrointestinal hemorrhage in the previous 6 months. History of arterial thrombotic events (eg myocardial infarction, angina, ischemic stroke or transient ischemic attack) in the previous 6 months.</p> <p><b>Required Medical Information-</b> None</p> <p><b>Age Restriction-</b> None</p> <p><b>Prescriber Restrictions-</b> None</p> <p><b>Coverage Duration-</b> Benefit year</p>
<p>Atralin Gel / Topical</p> <p>Avita Cream / Topical</p> <p>Avita Gel / Topical</p> <p>Retin-A Cream / Topical</p>	Vitamin A Derivatives	<p><b>Covered Uses-</b> All FDA-approved indications not otherwise excluded from Part D.</p> <p><b>Exclusion Criteria-</b> None</p> <p><b>Required Medical Information-</b> Diagnosis of acne required</p>

Retin-A Gel / Topical Retin-A Micro Gel / Topical Tretinoin Cream / Topical Tretinoin Gel / Topical Tretin-X Package / Topical Tretin-X Powder / Topical		in patients over 35 years old. <b>Age Restriction-</b> None <b>Prescriber Restrictions-</b> None <b>Coverage Duration-</b> Benefit year
---	--	--

H3330\_121561r 11/17/2009

S5741\_121561 1/4/2010