Keystone 65 Preferred Rx HMO, Keystone 65 Select Rx HMO, and Personal Choice 65SM Rx PPO

2026 Utilization Management Criteria: Prior Authorization

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT SOME OF THE DRUGS WE COVER IN THIS PLAN

This document was updated on **10/15/2025**. For more recent information or other questions, please contact our Member Help Team: Keystone 65 Rx at **1-800-645-3965**, Personal Choice 65 Rx at **1-888-718-3333**, or, for TTY/TDD users, **711**, seven days a week from 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. Or, visit **www.ibxmedicare.com** to use our *Formulary (List of Covered Drugs)* search tool or view a downloadable document.

When this document refers to "we," "us," or "our," it means Independence Blue Cross. When it refers to "plan" or "our plan," it means Keystone 65 Rx and Personal Choice 65 Rx.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2027, and from time to time during the year.

Independence Blue Cross offers PPO, HMO-POS, and HMO Medicare Advantage plans with a Medicare contract. Enrollment in Independence Blue Cross PPO, HMO-POS, and HMO Medicare Advantage plans depends on contract renewal.

Independence Blue Cross offers products through its subsidiaries Independence Assurance Company, Independence Hospital Indemnity Plan, Keystone Health Plan East, and QCC Insurance Company — independent licensees of the Blue Cross and Blue Shield Association.

There may be restrictions to your drug coverage

Some covered drugs may have additional requirements or limits on coverage. We call this "utilization management." These requirements and limits may include:

- **Prior Authorization (PA):** Our plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, our plan may not cover the drug. Drugs that require prior authorization are listed in this document.
- **Step Therapy (ST):** In some cases, our plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. Drugs that require step therapy are listed in *2026 Utilization Management Criteria: Step Therapy*.
- **Quantity Limits (QL):** For certain drugs, our plan limits the amount of the drug that our plan will cover. Drugs that have quantity limits are listed in the *Keystone 65 Preferred Rx HMO, Keystone 65 Select Rx HMO, and Personal Choice 65 Rx PPO (List of Covered Drugs)*.

You can find out if your drug has any additional requirements or limits by looking in your plan *Formulary (List of Covered Drugs)*. You can also get more information about the restrictions applied to specific covered drugs by visiting www.ibxmedicare.com.

You can ask our plan to make an exception to these restrictions or limits, or for a list of other similar drugs that may treat your health condition. Your *Formulary (List of Covered Drugs)* and *Evidence of Coverage* will have more information about the exception request process.

How to use this document

This document, along with *2026 Utilization Management Criteria: Step Therapy*, is intended to be used with your *Formulary (List of Covered Drugs)*. If your prescription drug has the note "PA" in the "Requirements" column of the *Keystone 65 Preferred Rx HMO, Keystone 65 Select Rx HMO, and Personal Choice 65 Rx PPO Formulary (List of Covered Drugs)*, you can find more information on the restriction(s) in this document.

Locate your drug in the index on page 189. The restriction information includes:

- **Prior Authorization**
  - Covered uses
  - Exclusion criteria
  - Required medical information
  - Age restrictions
  - Prescriber restrictions
  - Coverage duration
  - Other criteria

Be sure to read all the information listed for your affected drug. If you have any questions or need assistance with the information contained in this document, please call our Member Help Team: Keystone 65 Rx at 1-800-645-3965 or Personal Choice 65 Rx at 1-888-718-3333 or, for TTY/TDD users, 711.

acute hae agents 2026

Products Affected

- BERINERT
- FIRAZYR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	No

acute seizure activity agents 2026

Products Affected

- NAYZILAM
- VALTOCO 10 MG DOSE
- VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 2 X 7.5 MG/0.1ML
- VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 2 X 10 MG/0.1ML
- VALTOCO 5 MG DOSE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber is a neurologist/epilepsy specialist
Coverage Duration	Indefinite
Other Criteria	(All Indications): Approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

adalimumab preferred products 2026

Products Affected

- *adalimumab-aacf (2 pen)*
- *adalimumab-aacf (2 syringe)*
- *adalimumab-aacf(cd/uc/hs strt)*
- *adalimumab-aacf(ps/uv starter)*

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

adbry 2026

Products Affected

- ADBRY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Atopic Dermatitis (AD)(Initial): (1) Diagnosis of moderate to severe AD (2) inadequate response or inability to tolerate ONE of the following: (a) one topical steroid (medium potency or higher) (b) topical tacrolimus (c) pimecrolimus cream
Age Restrictions	
Prescriber Restrictions	(AD): Prescribed by or in consultation with a dermatologist, allergist, immunologist
Coverage Duration	12 months
Other Criteria	(AD)(Reauth): Member has had a positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

adempas 2026

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	(PAH, CTEPH) (Initial, Reauth): Concurrent use of phosphodiesterase inhibitors, nitrates or nitric oxide donors, pregnancy, concurrent use with other soluble guanylate cyclase stimulators (e.g. Verquvo)
Required Medical Information	Pulmonary Arterial Hypertension (PAH) (initial): (1) Diagnosis of PAH WHO Group I with New York Heart Association (NYHA) Functional Class II - IV. (2) Diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography. (3) Documentation of all the following: (a) Mean pulmonary arterial pressure is greater than 20 mm Hg. (b) Pulmonary vascular resistance (PVR) is greater than 2.0 Woods Units (WU). (c) The pulmonary capillary wedge pressure or left ventricular end-diastolic pressure is 15 mm Hg or less. Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (initial): (1) Diagnosis of persistent/recurrent CTPH (WHO Group 4) after surgical treatment or inoperable CTEPH.
Age Restrictions	(PAH, CTEPH) Member is 18 years of age or older
Prescriber Restrictions	(PAH, CTEPH): Prescribed by or in consultation with a pulmonologist or cardiologist
Coverage Duration	(Initial): 6 months (Reauth):12 months
Other Criteria	(PAH, CPTEH) (Reauth): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

aimovig 2026

Products Affected

- AIMOVIG

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

allergen specific immunotherapy (sl) 2026

Products Affected

- GRASTEK
- ODACTRA

PA Criteria	Criteria Details
Exclusion Criteria	(1) Severe, unstable or uncontrolled asthma (2) History of eosinophilic esophagitis
Required Medical Information	(Initial): (1) Member has a positive skin test or in vitro test for the listed allergen-specific IgE antibody. (2) Inadequate response or inability to tolerate an intranasal corticosteroid and an oral or intranasal antihistamine.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an allergist or immunologist.
Coverage Duration	Remainder of contract year
Other Criteria	(Reauth): (1) Member has experienced improvement in the symptoms of their allergic rhinitis or a decrease in the number of medications needed to control allergy symptoms
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ambrisentan 2026

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH) (Initial): (1) Documentation of a diagnosis of pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) Functional Class II to IV. (2) Diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography. (3) Documentation of all the following: (a) Mean pulmonary arterial pressure is greater than 20 mm Hg. (b) Pulmonary vascular resistance (PVR) is greater than 2.0 Woods Units (WU). (c) The pulmonary capillary wedge pressure or left ventricular end-diastolic pressure is 15 mm Hg or less.
Age Restrictions	
Prescriber Restrictions	(PAH): Prescribed by or in consultation with a Cardiologist or Pulmonologist.
Coverage Duration	(Initial): 6 months. (Continuation):12 months.
Other Criteria	(PAH)(Continuation): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ampyra 2026

Products Affected

- AMPYRA

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

anticholinergic hrm 2026

Products Affected

- *chlordiazepoxide-clidinium*
- *promethazine hcl oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Risk versus benefit has been assessed for this request of a high risk medication (HRM) in elderly
Age Restrictions	Apply if member is greater than or equal to 65 years
Prescriber Restrictions	
Coverage Duration	2 years
Other Criteria	Subject to additional clinical review for ESRD-related use - if applicable.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

arikayce 2026

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(MAC): (1) Diagnosis of Mycobacterium avium complex (MAC) lung disease (2) Medication is being used as part of a combination antibacterial drug regimen (3) Used in members who have not achieved negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy
Age Restrictions	Member is 18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or an infectious disease specialist
Coverage Duration	Remainder of contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

armodafinil 2026

Products Affected

- *armodafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Obstructive Sleep Apnea (OSA) (Initial) (1) Diagnosis of obstructive sleep apnea defined by ONE of the following: (A) 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible) OR (B) BOTH of the following: (a) 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study is not feasible (b) ONE of the following symptoms: Unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring, breathing interruptions during sleep Narcolepsy (Initial): (1) Diagnosis of narcolepsy as confirmed by sleep study (unless prescriber provides justification confirming a sleep study is not feasible) Shift Work Disorder (SWD)(Initial):(1) Diagnosis of Shift Work Disorder confirmed by ONE of the following: (A) Symptoms of excessive sleepiness or insomnia, for at least 3 months, which is associated with a work period (usually night work) that occurs during the normal sleep period OR (B) Sleep study demonstrating loss of a normal sleep-wake pattern (i.e. disturbed chronobiologic rhythmicity) (2) Confirmation that no other medical conditions or medications are causing the symptoms of excessive sleepiness or insomnia
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or sleep specialist.
Coverage Duration	12 months
Other Criteria	(OSA, Narcolepsy, SWD)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	No

austedo 2026

Products Affected

- AUSTEDO
- AUSTEDO XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Tardive Dyskinesia (TD)(Initial): (1) Diagnosis of TD, (2) Documentation is provided of ONE of the following: (a) Persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering or discontinuation of the offending medication, or (b) Member is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication. Chorea-Huntington's Disease (CHD): (1) Diagnosis of chorea associated with Huntington's disease
Age Restrictions	
Prescriber Restrictions	(CHD): Prescribed by or in consultation with a neurologist or a psychiatrist. (TD): Prescribed by or in consultation with a neurologist or a psychiatrist.
Coverage Duration	(TD)(Initial): 3 months. (TD)(Reauth): Indefinite. (CHD): Indefinite.
Other Criteria	(TD)(Reauth): Positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

auvelity 2026

Products Affected

- AUVELITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Major Depressive Disorder (MDD): (1) Diagnosis of major depressive disorder (MDD) (2) Inadequate response or inability to tolerate two formulary antidepressants indicated for MDD (e.g. bupropion, venlafaxine extended-release tablet or capsule, sertraline tablet, etc.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	(All Indications): Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

benlysta sc 2026

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	Member has severe active central nervous system lupus
Required Medical Information	Systemic Lupus Erythematosus (SLE)(initial): (1) Diagnosis of active, autoantibody-positive SLE confirmed by positive autoantibody test (e.g., antinuclear antibody test [ANA], antibodies to DNA [Anti-dsDNA], Anti-Smith [Anti-Sm]). (2) Member is receiving concurrent treatment with at least ONE of the following: steroids, antimalarials, immunosuppressants, nonsteroidal anti-inflammatory drugs (NSAIDS). Lupus Nephritis (LN): (1) Diagnosis of active lupus nephritis confirmed by kidney biopsy. (2) Member is receiving concurrent standard therapy (e.g. corticosteroids, immunosuppressants, azathioprine).
Age Restrictions	
Prescriber Restrictions	(SLE): Prescribed by or in consultation with a rheumatologist. (LN): Prescribed by or in consultation with a nephrologist or rheumatologist.
Coverage Duration	6 months
Other Criteria	(SLE, LN)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

bosentan 2026

Products Affected

- *bosentan oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH) (Initial): (1) Documentation of a diagnosis of pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) Functional Class II to IV. (2) Diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography. (3) Documentation of all the following: (a) Mean pulmonary arterial pressure is greater than 20 mm Hg. (b) Pulmonary vascular resistance (PVR) is greater than 2.0 Woods Units (WU). (c) The pulmonary capillary wedge pressure or left ventricular end-diastolic pressure is 15 mm Hg or less.
Age Restrictions	
Prescriber Restrictions	(PAH): Prescribed by or in consultation with a Cardiologist or Pulmonologist
Coverage Duration	(Initial): 6 months. (Continuation):12 months.
Other Criteria	(PAH)(Continuation): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

brand antipsychotics ach 2026

Products Affected

- LYBALVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Trial of two generic formulary antipsychotics. Applies to new starts.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

brukinsa 2026

Products Affected

- BRUKINSA ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

caplyta 2026

Products Affected

- CAPLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Schizophrenia: (1) Diagnosis of schizophrenia (2) Inadequate response or inability to tolerate two generic antipsychotic products (e.g. aripiprazole, olanzapine, quetiapine, paliperidone). Bipolar Depression (BD): (1) Diagnosis of bipolar depression (2) Medication will be used as monotherapy or as adjunctive therapy with lithium or valproate (3) Inadequate response or inability to tolerate two medications indicated for bipolar depression (e.g. fluoxetine, Latuda (lurasidone) quetiapine, olanzapine)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	(All Indications): Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

cayston 2026

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cystic Fibrosis (CF): (1) Diagnosis of CF. (2) Evidence of Pseudomonas Aeruginosa in the lungs. (3) Susceptibility results indicating that the Pseudomonas aeruginosa is sensitive to aztreonam. (4) FEV1 between 25% and 75% of predicted, (4) Member not colonized with Burkholderia cepacia.
Age Restrictions	(CF): Member is 7 years of age or older
Prescriber Restrictions	(CF): Prescribed by or in consultation with a pulmonologist OR infectious disease specialist or Specialist affiliated with a CF care center.
Coverage Duration	Remainder of contract year
Other Criteria	Reauth: (1) Evidence of Pseudomonas aeruginosa in the lungs (2) Documentation of positive clinical response to therapy (e.g. improvement in lung function demonstrated by improved FEV1)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

cholbam 2026

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Exclusion Criteria	(BASD, PD): Extrahepatic manifestations of bile acid synthesis disorders due to single enzyme defects or peroxisomal disorders including Zellweger spectrum disorders
Required Medical Information	Bile Acid Synthesis Disorder (BASD) (initial): (1) Diagnosis of bile acid synthesis disorder due to a single enzyme defect. Peroxisomal disorder (PD) (initial): (1) Diagnosis of peroxisomal disorder. (2) Used as adjunctive treatment. (3) Member exhibits manifestations of liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption.
Age Restrictions	
Prescriber Restrictions	(BASD, PD): Hepatologist, Gastroenterologist, Medical geneticist, other specialist that treats inborn errors of metabolism
Coverage Duration	(Initial): 3 months. (Reauth): Indefinite
Other Criteria	(BASD,PD) (Reauth): Documentation of improved liver function tests from the start of treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

cibinqo 2026

Products Affected

- CIBINQO

PA Criteria	Criteria Details
Exclusion Criteria	(AD): Concurrent use with any other biologic immunomodulator, Janus Kinase (JAK) inhibitors, or other immunosuppressants (e.g. azathioprine, cyclosporine)
Required Medical Information	Atopic Dermatitis (AD)(Initial): (1) Diagnosis of refractory, moderate to severe AD (2) Inadequate response or inability to tolerate one systemic drug product, including biologics (e.g. Dupixent, methylprednisolone, prednisone) or member has a contraindication, intolerance, or treatment is inadvisable (3) Inadequate response or inability to tolerate ONE of the following: (a) Adbry (tralokinumab-ldrm) OR (b) Dupixent (dupilumab)
Age Restrictions	
Prescriber Restrictions	(AD): Prescribed by or in consultation with a dermatologist, allergist, immunologist.
Coverage Duration	12 months
Other Criteria	(AD)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

cimzia 2026

Products Affected

- CIMZIA (2 SYRINGE)
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
Required Medical Information	Ankylosing Spondylitis (AS)(Initial): (1) Diagnosis of AS. (2) Inadequate response or inability to tolerate two of the following: (a) secukinumab (Cosentyx), (b) Adalimumab (i.e., Adalimumab-AACF), (c) etanercept (Enbrel), (d) tofacitinib (Xeljanz/Xeljanz XR), (e) upadacitinib (Rinvoq), or documentation demonstrating that a trial may be inappropriate. Psoriatic Arthritis (PsA)(Initial): (1) Diagnosis of PsA. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Enbrel, (c) Xeljanz/Xeljanz XR (d) Rinvoq/Rinvoq LQ, (e) Skyrizi, (f) Cosentyx, (g) Ustekinumab (i.e. Yesintek), (h) Orencia, (i) Otezla OR documentation demonstrating that a trial may be inappropriate. Plaque Psoriasis (PsO)(Initial): (1) Diagnosis of moderate to severe PsO (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Enbrel, (c) Skyrizi (d) Cosentyx, (e) Ustekinumab (i.e. Yesintek), (f) Otezla OR documentation demonstrating that a trial may be inappropriate. Rheumatoid Arthritis (RA): (1) Diagnosis of moderate to severe RA. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Enbrel, (c) Rinvoq, (d) Xeljanz/Xeljanz XR, (e) Orencia OR documentation demonstrating that a trial may be inappropriate. Crohn's Disease (CD)(Initial): (1) Diagnosis of moderate to severe CD. (2) Inadequate response or inability to tolerate two of the following: (a) Adalimumab (i.e., Adalimumab-AACF), (b) ustekinumab (i.e. Yesintek), (c) risankizumab (Skyrizi), (d) upadacitinib (Rinvoq) or documentation demonstrating that a trial may be inappropriate.
Age Restrictions	
Prescriber Restrictions	(CD): Prescribed by or in consultation with a gastroenterologist. (RA, AS, nr-axSpA, PJIA): Prescribed by or in consultation with a rheumatologist. (PsA, PsO): prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	Non-Radiographic Axial Spondyloarthritis (nr-axSpA)(Initial): (1) Diagnosis of nr-axSpA (2) Inadequate response or inability to tolerate Rinvoq OR Cosentyx OR documentation demonstrating that a trial may be inappropriate (3) Inadequate response or inability to tolerate one NSAID (e.g. ibuprofen, meloxicam, naproxen). Polyarticular juvenile idiopathic arthritis (PJIA)(Initial): Diagnosis of active PJIA. (2) Inadequate response or inability to tolerate two of the following: (a) Adalimumab (i.e., Adalimumab-AACF), (b) Enbrel, (c) Xeljanz, (d) Orencia, (e) Rinvoq/Rinvoq LQ, or documentation demonstrating that a trial may be inappropriate. (AS, PsA, PsO, RA, CD, nr-axSpA, PIJA)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

cobenfy 2026

Products Affected

- COBENFY
- COBENFY STARTER PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Schizophrenia: (1) Diagnosis of schizophrenia (2) Inadequate response or inability to tolerate TWO of the following atypical antipsychotic agents: aripiprazole, asenapine, olanzapine, paliperidone, quetiapine IR/ER, risperidone, ziprasidone
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	(Schizophrenia): Indefinite
Other Criteria	(All Indications): Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

corlanor 2026

Products Affected

- CORLANOR ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

cosentyx sq 2026

Products Affected

- COSENTYX (300 MG DOSE)
- COSENTYX SENSOREADY (300 MG)
- COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML
- COSENTYX UNOREADY

PA Criteria	Criteria Details
Exclusion Criteria	(PsA, PsO, AS, nr-axSpA,ERA, HS): Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
Required Medical Information	Psoriatic Arthritis (PsA)(Initial): (1) Diagnosis of PsA Plaque Psoriasis (PsO)(Initial): (1) Diagnosis of moderate to severe plaque psoriasis. Ankylosing Spondylitis (AS): (1) Diagnosis of AS. (2) Inadequate response or inability to tolerate one other treatment such as NSAIDs, COX2 inhibitors or methotrexate. Non-Radiographic Axial Spondyloarthritis (nr-axSpA)(Initial): (1) Diagnosis of nr-axSpA, (2) Inadequate response or inability to tolerate two NSAIDs. Active Enthesitis-related Arthritis (ERA)(Initial): (1) Diagnosis of active enthesitis-related arthritis (ERA), (2) Inadequate response or inability to tolerate methotrexate, (3) Inadequate response or inability to tolerate at least one NSAID (e.g. ibuprofen, naproxen, meloxicam, celecoxib) Hidradenitis Suppurativa (HS)(Initial): (1) Diagnosis of HS.
Age Restrictions	
Prescriber Restrictions	(PsO, HS): Prescribed by or in consultation with a dermatologist. (PsA): Prescribed by or in consultation with a rheumatologist or dermatologist. (AS, nr-axSpA, ERA): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	12 months
Other Criteria	(PsA, PsO, AS, nr-axSpA,ERA, HS)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

crenessity 2026

Products Affected

- CRENESSITY ORAL CAPSULE 100 MG, 50 MG
- CRENESSITY ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	No

cresemba [oral] 2026

Products Affected

- CRESEMBA ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Invasive Aspergillosis (IA): (1) For use in the treatment of invasive aspergillosis after inadequate response or inability to tolerate Voriconazole (oral Vfend). Mucormycosis (MC): (1) Diagnosis of invasive mucormycosis
Age Restrictions	(IA, MC): Member is 6 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist, oncologist, OR prescribed as part of chemotherapy prophylaxis protocol
Coverage Duration	Remainder of contract year
Other Criteria	Subject to additional clinical review for ESRD-related use - if applicable.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

dalfampridine 2026

Products Affected

- *dalfampridine er*

PA Criteria	Criteria Details
Exclusion Criteria	(Initial): Member has history of seizure or moderate to severe renal impairment (CrCL less than or equal to 50 mL/min)
Required Medical Information	Multiple Sclerosis (MS) (Initial): (1) Diagnosis of multiple sclerosis. (2) Confirmation that member has difficulty walking. (3) One of the following: (a) Member has expanded disability status scale (EDSS) score of less than or equal to 7 (b) Member is not restricted to using a wheelchair (if EDSS is not measured)
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	Remainder of contract year
Other Criteria	(MS) (Reauth): Documentation of positive clinical response as evidenced by improvement in walking speed
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

deferasirox 2026

Products Affected

- *deferasirox oral tablet*
- *deferasirox oral tablet soluble*

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	No

deflazacort 2026

Products Affected

- *deflazacort oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

diacomit 2026

Products Affected

- DIACOMIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Dravet syndrome (DS): (1) Diagnosis of seizures associated with Dravet syndrome (DS), (2) Used in combination with clobazam, (3) Member weighs 7kg or more.
Age Restrictions	Member is 6 months of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	Indefinite
Other Criteria	(All Indications): Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

dichlorphenamide 2026

Products Affected

- ORMALVI

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of high dose Aspirin, severe pulmonary disease and hepatic insufficiency
Required Medical Information	Primary hyperkalemic or hypokalemic periodic paralysis (PHPP) (Initial): (1) Diagnosis of Primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, and related variants (e.g., Paramyotonia Congenita) (2) Member has ONE of the following: (a) a positive genetic panel for periodic paralysis or (b) positive test results for periodic paralysis to one of the following tests: (i) EMG/nerve conduction studies, (ii) Long exercise test, (iii) Muscle biopsy, or (iv) Muscle MRI.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	(Initial): 3 months (Reauth):12 months
Other Criteria	(PHPP)(Reauth): Member has had a positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

diclofenac epolamine 2026

Products Affected

- *diclofenac epolamine external*

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

doptelet 2026

Products Affected

- DOPTELET ORAL TABLET 20 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chronic Liver Disease (CLD): (1) Diagnosis of Chronic Liver Disease (CLD) (2) Baseline platelet count less than 50,000/mcL. Member is scheduled to undergo a procedure. Chronic Immune Thrombocytopenia (ITP)(Initial): (1) Baseline platelet count less than 30,000/mcL. (2) Inadequate response or inability to tolerate one of the following: (a) corticosteroids (b) immunoglobulins (c) splenectomy (d) Rituxan (rituximab)
Age Restrictions	
Prescriber Restrictions	(ITP): Prescribed by or in consultation with hematologist/oncologist
Coverage Duration	(CLD): 1 month. (ITP): 12 months
Other Criteria	(ITP)(Continuation): (1) Positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

dupixent 2026

Products Affected

- DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR MG/2ML
- DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

emgality 2026

Products Affected

- EMGALITY
- EMGALITY (300 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

emsam 2026

Products Affected

- EMSAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Major depressive disorder (MDD): (1) Diagnosis of major depressive disorder. (2) Inadequate response or inability to tolerate ONE SSRI or SNRI. (3) 4-5 half-lives (approximately 1 week) has elapsed after discontinuation of antidepressants without long half-lives OR at least 5 weeks has elapsed after discontinuation with antidepressants with long half-lives (e.g. fluoxetine).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	(All Indications): Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

enbrel 2026

Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML
- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	(RA, PsA, PJIA, PsO, AS): Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
Required Medical Information	Rheumatoid Arthritis (RA)(Initial): (1) Diagnosis of moderate to severe RA. (2 Inadequate response or inability to tolerate ONE DMARD: (e.g. Methotrexate, Hydroxychloroquine, Leflunomide, Azathioprine, Sulfasalazine). Psoriatic Arthritis (PsA)(Initial): (1) Diagnosis of PsA. Polyarticular Juvenile Idiopathic Arthritis (PJIA): (1) Diagnosis of moderate to severe PJIA, (2) Inadequate response or inability to tolerate ONE of the following: Methotrexate, Leflunomide, Sulfasalazine. Plaque Psoriasis (PsO) (Initial): (1) Diagnosis of moderate to severe chronic PsO. Ankylosing Spondylitis (AS): (1) Diagnosis of AS, (2) Inadequate response or inability to tolerate one other treatment such as NSAIDs, COX2 inhibitors or methotrexate.
Age Restrictions	
Prescriber Restrictions	(RA, PJIA, AS): Prescribed by or in consultation with a rheumatologist. (PsA): Prescribed by or in consultation with a rheumatologist or dermatologist. (PsO): Prescribed by or in consultation with a dermatologist.
Coverage Duration	12 months
Other Criteria	(RA, PsA, PJIA, PsO, AS)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

endari 2026

Products Affected

- ENDARI
- *l-glutamine oral packet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Sickle Cell Disease (SCD)(Initial): (1) One of the following: (a) Member is using Endari with concurrent hydroxyurea therapy, OR (b) Member has an inadequate response or inability to tolerate hydroxyurea. (2) Member has had 2 or more painful sickle cell crises within the past 12 months. (3) Used to reduce acute complications of sickle cell disease
Age Restrictions	
Prescriber Restrictions	(SCD): Prescribed by or in consultation with a hematologist, oncologist, or sickle cell disease management specialist.
Coverage Duration	12 months
Other Criteria	(SCD)(Reauth): Documentation of positive clinical response to therapy (e.g. reduction in the number of sickle cell crises)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

entyvio sq 2026

Products Affected

- ENTYVIO PEN

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
Required Medical Information	Ulcerative Colitis (UC)(Initial): (1) Diagnosis of moderately to severely active Ulcerative Colitis (2) One of the following: (A) Inadequate response or inability to tolerate two of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) ustekinumab (i.e. Yesintek), (c) upadacitinib (Rinvoq), (d) tofacitinib (Xeljanz/Xeljanz XR), (e) risankizumab (Skyrizi) OR documentation demonstrating that a trial may be inappropriate. (B) One of the following: (a) Medication will be used as a maintenance dose following two doses of Entyvio IV for induction (b) Member is currently established on Entyvio IV. Crohn's Disease (CD)(Initial): (1) Diagnosis of moderately to severely active CD (2) One of the following: (A) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b)Ustekinumab (i.e. Yesintek), (c) Skyrizi, (d) Rinvoq or documentation demonstrating that a trial may be inappropriate. (B) One of the following: (a) Medication will be used as a maintenance dose following two doses of Entyvio IV for induction (b) Member is currently established on Entyvio IV.
Age Restrictions	
Prescriber Restrictions	(UC, CD): Prescribed by or in consultation with a gastroenterologist
Coverage Duration	12 months
Other Criteria	(UC,CD)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

epidiolex 2026

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Dravet Syndrome (DS): (1) Inadequate response or inability to tolerate ONE of the following: (a) clobazam (b) valproic acid or (c) topiramate. (2) Baseline CBC, serum transaminases and total bilirubin prior to initiating therapy. (3) Concurrent use with additional anti-epileptic(s). Lennox-Gastaut Syndrome (LGS): (1) Inadequate response or inability to tolerate ONE of the following: (a) clobazam (b) valproic acid, or (c) topiramate. (2) Baseline CBC, serum transaminases and total bilirubin prior to initiating therapy. (3) Concurrent use with additional anti-epileptic(s). Tuberous Sclerosis Complex (TSC): (1) Concurrent use with additional anti-epileptic(s). (2) Baseline CBC, serum transaminases and total bilirubin prior to initiating therapy
Age Restrictions	(DS, LGS, TCS): Member is 1 year of age or older
Prescriber Restrictions	(DS, LGS, TCS): Prescribed by or in consultation with a neurologist
Coverage Duration	Indefinite
Other Criteria	(All Indications): Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

esbriet 2026

Products Affected

- *pirfenidone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Idiopathic Pulmonary Fibrosis (IPF): (1) Diagnosis of IPF confirmed by high resolution CT scan or biopsy.
Age Restrictions	
Prescriber Restrictions	(IPF): Prescribed by or in consultation a pulmonologist or lung transplant specialist.
Coverage Duration	12 months
Other Criteria	(REAUTH) (IPF): BOTH of the following (1) stabilization from baseline AND (2) no elevations in AST or ALT greater than 5 times upper limit of normal or greater than 3 times upper limit of normal with signs or symptoms of severe liver damage.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

eucrisa 2026

Products Affected

- EUCRISA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Atopic Dermatitis (AD): (1) Diagnosis of mild to moderate atopic dermatitis (2) Inadequate response or inability to tolerate at least TWO of the following in patients 2 years of age or older: (a) topical tacrolimus OR topical pimecrolimus, OR (b) generic, prescription medium potency or higher topical steroid, unless the affected area is sensitive (i.e., face, axillae, groin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

evenity 2026

Products Affected

- EVENITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Part D is medically necessary for: Post Menopausal Osteoporosis (PMO): (1) Diagnosis of PMO defined as ONE of the following: (a) Bone mineral density T-score less than or equal to -2.50 OR (b) Documented history of an osteoporotic non- collision fracture [e.g. vertebral, hip, nonvertebral]) AND (2) Member is at high risk of fracture as defined by one of the following: (a) Member has risk factors for a fracture (e.g. endocrine disorders, gastrointestinal disorders, use of medications associated with low bone mass or bone loss such as corticosteroids) OR (b) Inadequate response or inability to tolerate ONE of the following: (i) bisphosphonates, (ii) hormone replacement therapy, (iii) selective-estrogen receptor modulators (SERMs), OR (iv) Denosumab (Prolia). (3) Cumulative lifetime therapy does not exceed 12 months. (4) Member does NOT have a history of myocardial infarction or stroke within the preceding year or during therapy with Evenity
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Subject to Part B vs Part D review.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

extended release metformin 2026

Products Affected

- *metformin hcl er (mod)*

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

eysuvis 2026

Products Affected

- EYSUVIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Dry Eye Disease (DED)(Initial): (1) Diagnosis of DED (2) Inadequate response or inability to tolerate a minimum of 14 days duration of therapy to 0.5% loteprednol suspension
Age Restrictions	
Prescriber Restrictions	(DED)(Initial, Reauth): Prescribed by or in consultation with an ophthalmologist or optometrist.
Coverage Duration	(Initial, Reauth): 14 days
Other Criteria	(DED)(Reauth): (1) Positive clinical response to therapy (e.g. improvement in dry eye symptoms).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

fasenra 2026

Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	No

ferriprox 2026

Products Affected

- *deferiprone*
- FERRIPROX ORAL TABLET 1000 MG
- FERRIPROX TWICE-A-DAY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Transfusional Iron Overload (TIO)(initial): (1) Diagnosis of transfusional iron overload due to one of the following: (a) Thalassemia syndromes, (b) sickle cell disease, (c) other transfusion-dependent anemias. (2) Inadequate response or inability to tolerate current chelation therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	(TIO) (Reauth): (1) Member demonstrates positive clinical response to therapy (e.g., greater than or equal to 20% decline in serum ferritin levels from baseline).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

fintepla 2026

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Dravet Syndrome (DS): Inadequate response or inability to tolerate ONE of the following: (a) clobazam, (b) valproic acid, (c) divalproex sodium, (d) topiramate. Lennox-Gastaut Syndrome (LGS): (1) Diagnosis of seizures associated with Lennox-Gastaut Syndrome (LGS) (2) Inadequate response or inability to tolerate ONE of the following: valproic acid, lamotrigine, topiramate, felbamate, clobazam.
Age Restrictions	(DS, LGS): Member is 2 years of age or older.
Prescriber Restrictions	(DS, LGS): Prescribed by or in consultation with a neurologist.
Coverage Duration	Indefinite.
Other Criteria	(All Indications): Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

galafold 2026

Products Affected

- GALAFOLD

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Fabry Disease (FD)(Initial): (1) Diagnosis of Fabry disease. (2) Member has amenable galactosidase alpha gene (GLA) variant based on in vitro assay data (3) Will not be used in combination with enzyme replacement therapy for FD (e.g. agalsidase beta or pegunigalsidase alfa)
Age Restrictions	
Prescriber Restrictions	(FD)(Initial, Reauth): Prescribed by or in consultation with a clinical genetics specialist OR a nephrologist
Coverage Duration	12 months
Other Criteria	(FD)(Reauth): (1) Positive clinical response to therapy (2) Will not be used in combination with enzyme replacement therapy for FD (e.g. agalsidase beta or pegunigalsidase alfa)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

gattex 2026

Products Affected

- GATTEX

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	No

generic lidocaine transdermal patch 2026

Products Affected

- *lidocaine external patch 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Post-Herpetic Neuralgia (PHN): (1) Diagnosis of post-herpetic neuralgia. Diabetic Peripheral Neuropathy (DPN): (1) Diagnosis of diabetic peripheral neuropathy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

generic sodium phenylbutyrate 2026

Products Affected

- *sodium phenylbutyrate oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	Acute hyperammonemia. N-acetyl glutamate synthase (NAGS) deficiency
Required Medical Information	Urea Cycle Disorder (UCD): (1) Diagnosis of urea cycle disorder involving deficiencies of carbamoyl phosphate synthetase (CPS), ornithine transcarbamylase (OTC), or argininosuccinic acid synthetase (AAS) confirmed via enzymatic, biochemical, or genetic testing. (2) Inadequate response to one of the following: Dietary protein restriction or Amino acid supplementation
Age Restrictions	
Prescriber Restrictions	(UCD): Prescribed by or in consultation with a specialist focused on the treatment of metabolic disorders
Coverage Duration	Initial: 6 months Reauth: 12 months
Other Criteria	(Reauth) (1) Documentation of positive clinical response to therapy (e.g. plasma ammonia or amino acid levels within normal limits) (2) Will be used concomitantly with dietary protein restriction and, in some cases, dietary supplements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

gocovri 2026

Products Affected

- GOCOVRI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Dyskinesia in Parkinson's disease (DPD): (1) Diagnosis of PD (2) Member is experiencing dyskinesia. (3) Member is receiving levodopa based therapy (4) Inadequate response or inability to tolerate amantadine immediate-release. Parkinson's Disease with OFF episodes (PD with OFF episodes): (1) Diagnosis of Parkinson's disease. (2) Concurrent use of carbidopa/levodopa containing product. (3) Member is experiencing intermittent OFF episodes. (4) Member had inadequate response or inability to tolerate ONE of the following: (a) MAO-B inhibitor (e.g. rasagiline, selegiline), (b) Dopamine agonist (e.g. pramipexole, ropinirole), (c) COMT inhibitor (e.g. entacapone).
Age Restrictions	
Prescriber Restrictions	(DPD, PD with OFF episodes): Prescribed by or in consultation with a neurologist
Coverage Duration	Indefinite
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

growth hormones 2026

Products Affected

- GENOTROPIN SUBCUTANEOUS CARTRIDGE
- HUMATROPE INJECTION CARTRIDGE
- NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(1) Growth Failure in Children (GFC)(Initial): (a) Diagnosis of growth hormone deficiency confirmed by one of the following: (i) Height is documented by one of the following (utilizing age and gender growth charts related to height): (A) Height is greater than 2.0 standard deviations [SD] below midparental height (B) Height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender) (ii) Growth velocity is greater than 2 SD below mean for age and gender (iii) Delayed skeletal maturation of greater than 2 SD below mean for age and gender (e.g., delayed is greater than 2 years compared with chronological age), (b) documentation of bone age, (c) abnormal response from provocative testing, such as insulin-induced hypoglycemia test, levodopa, or clonidine. (2) Small for Gestational Age (SGA)(Initial): (A) Diagnosis of SGA, (B) Clinical documentation of no catch-up growth by 2 to 4 years of age. (3) Growth Failure Associated with Chronic Kidney Disease (GF-CKD) (Initial), (4) Growth failure associated with Noonan Syndrome, Prader-Willi Syndrome, Turner Syndrome or short stature homeobox-containing gene (SHOX) deficiency (Initial), (5) Diagnostically confirmed Growth Hormone Deficiency in adults (GHDA)(Initial), OR (6) Idiopathic Short Stature (ISS)(Initial): (A) Diagnosis of ISS defined by height standard deviation score (SDS) less than or equal to 2.25, (B) Documentation of growth velocity less than 25th percentile for bone age.
Age Restrictions	
Prescriber Restrictions	(All Other Indications)(Initial): Prescribed by or in consultation with an endocrinologist. (GF-CKD)(Initial) : Prescribed by or in consultation with an endocrinologist or nephrologist
Coverage Duration	(Initial, Continuation): 12 months

PA Criteria	Criteria Details
Other Criteria	(GHDA)(Continuation): Annual clinical re-evaluation by the treating endocrinologist. (GFC)(Continuation): (1) Annual clinical re-evaluation by the treating endocrinologist (SGA, ISS)(Continuation): (1) Increase in growth velocity from baseline, (2) Annual clinical re-evaluation by the treating endocrinologist. (GF-CKD)(Continuation): (1) No history of renal transplant, (2) Annual clinical re-evaluation by the treating endocrinologist. (Growth Failure Associated with Noonan Syndrome, Prader-Willi Syndrome, Turner Syndrome or Short Stature Homeobox-Containing Gene (SHOX) Deficiency)(Continuation): (1) Annual clinical re-evaluation by the treating endocrinologist.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

haegarda 2026

Products Affected

- HAEGARDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Hereditary Angioedema (HAE) (Initial): (1) Diagnosis of HAE, (2) For prophylaxis against HAE attacks. (3) Requested drug will not be used in combination with other products indicated for HAE prophylaxis.
Age Restrictions	
Prescriber Restrictions	(HAE): Prescribed by or in consultation with an allergist, immunologist, pulmonologist
Coverage Duration	12 months
Other Criteria	(HAE)(Reauth): Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

high dose opioids 2026

Products Affected

- *fentanyl transdermal patch 72 hour 100 mcg/hr, 25 mcg/hr, 37.5 mcg/hr, 50 mcg/hr, 75 mcg/hr* *100 mg, 60 mg*
- *methadone hcl oral tablet*
- *morphine sulfate er oral tablet extended release*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	NEW TO HIGH DOSE OPIOID THERAPY : ONE of the following (A) pain associated with cancer, (B) chronic non-cancer pain and BOTH of the following (1) member is opioid tolerant (e.g. at least one week where total daily dose is at least one of the following: 30mg of oxycodone, 60mg of oral morphine, 8mg of oral hydromorphone, 25mg of oral oxymorphone or an equianalgesic dose of another opioid) AND (2) the member has been evaluated for non-opioid prescription pharmacologic treatment prior to initiation of high dose opioid therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Remainder of contract year
Other Criteria	Subject to additional clinical review for ESRD-related use - if applicable. CONTINUING HIGH DOSE OPIOID THERAPY (morphine equivalent dose 90mg per day or greater): ONE of the following (1) pain associated with cancer OR (2) chronic non-cancer pain and ALL (a) member's pain has been assessed within the last 6 months AND (b) member has clinically meaningful improvement in pain and functioning that outweighs risks to patient safety AND (c) member is not being treated for substance abuse
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

hrm 2026

Products Affected

- *butalbital-acetaminophen oral tablet 50-325 mg*
- *butalbital-apap-caffeine oral capsule*
- *butalbital-apap-caffeine oral tablet 50-325-40 mg*
- *butalbital-aspirin-caffeine oral capsule*
- *dipyridamole oral*
- *metaxalone oral tablet 400 mg, 800 mg*
- *promethazine hcl oral solution 6.25 mg/5ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Risk versus benefit has been assessed for this request of a high risk medication (HRM) in elderly
Age Restrictions	Apply if member is greater than or equal to 65 years
Prescriber Restrictions	
Coverage Duration	2 years
Other Criteria	Subject to additional clinical review for ESRD-related use - if applicable.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

hrm cyclobenzaprine 2026

Products Affected

- *cyclobenzaprine hcl er oral capsule extended release 24 hour 15 mg*
- *cyclobenzaprine hcl oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Acute Muscle Spasms (AMS): (1) Diagnosis of Acute Muscle Spasms (AMS):(2) Prescriber attestation that drug will be used only for short periods. All Indications: Risk versus benefit has been assessed for this request of a high risk medication (HRM) in elderly.
Age Restrictions	Apply if member is greater than or equal to 65 years
Prescriber Restrictions	
Coverage Duration	AMS: 1 year. All other indications: 2 years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

hrm estrogens 2026

Products Affected

- CLIMARA PRO
- DOTTI
- *estradiol transdermal patch twice weekly*
- *estradiol transdermal patch weekly*
- JINTELI
- MENOSTAR
- PREMARIN ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ONE of the following: (1) Inadequate response or inability to tolerate vaginal estrogen preparations (e.g. vaginal tablets or cream, etc.) OR (2) Risk versus benefit has been assessed for this request of a high risk medication (HRM) in elderly
Age Restrictions	Apply if member is greater than or equal to 65 years
Prescriber Restrictions	
Coverage Duration	2 years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

hrm ketorolac 2026

Products Affected

- *ketorolac tromethamine oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ONE of the following: (1) Inadequate response or inability to tolerate TWO alternative NSAIDs such as meloxicam, naproxen, celecoxib, ibuprofen, etc. OR (2) Risk versus benefit has been assessed for this request of a high risk medication (HRM) in elderly
Age Restrictions	Apply if member is greater than or equal to 65 years
Prescriber Restrictions	
Coverage Duration	One Month
Other Criteria	Subject to additional clinical review for ESRD-related use - if applicable.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

hrm non benzodiazepine hypnotics 2026

Products Affected

- *eszopiclone oral tablet 3 mg*
- *zolpidem tartrate oral tablet 10 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(Initial): Risk versus benefit has been assessed for this request of a high risk medication (HRM) in elderly
Age Restrictions	Apply if member is greater than or equal to 65 years
Prescriber Restrictions	
Coverage Duration	(Initial): 3 months. (Reauth): 2 years
Other Criteria	(Reauth): Prescriber is aware of the risk versus benefit of using the medication chronically (greater than 90 days)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

hrm short term skeletal muscle relaxants 2026

Products Affected

- *carisoprodol oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Acute Muscle Spasms (AMS): (1) Diagnosis of Acute Muscle Spasms (AMS):(2) Prescriber attestation that drug will be used only for short periods. All Indications: Risk versus benefit has been assessed for this request of a high risk medication (HRM) in elderly.
Age Restrictions	Apply if member is greater than or equal to 65 years
Prescriber Restrictions	
Coverage Duration	(AMS): 1 year. (All other indications): 2 years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ilumya 2026

Products Affected

- ILUMYA

PA Criteria	Criteria Details
Exclusion Criteria	(PsO): Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
Required Medical Information	Plaque Psoriasis (PsO)(Initial): (1) Diagnosis of moderate to severe PsO. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. adalimumab-AACF), (b) Enbrel, (c) Skyrizi, (d) Cosentyx, (e) Ustekinumab (i.e. Yesintek), (f) Otezla OR documentation demonstrating that a trial may be inappropriate.
Age Restrictions	
Prescriber Restrictions	(PsO): Prescribed by or in consultation with a dermatologist
Coverage Duration	12 months
Other Criteria	Subject to Part B vs Part D review. (PsO)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

inbrija 2026

Products Affected

- INBRIJA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Parkinson's Disease (PD): (1) Diagnosis of Parkinson's disease. (2) concurrent use of carbidopa/levodopa containing product, (3) Member is experiencing intermittent OFF episodes, (4) member had inadequate response or inability to tolerate ONE of the following: (a) MAO-B inhibitor (e.g. rasagiline, selegiline), (b) Dopamine agonist (e.g. pramipexole, ropinirole), (c) COMT inhibitor (e.g. entacapone)
Age Restrictions	
Prescriber Restrictions	(PD): Prescribed by or in consultation with a neurologist
Coverage Duration	Indefinite
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

increlex 2026

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	(GHGD, PIGF-1D) (Initial and Continuation): Known or suspected malignancy, closed epiphyses, concurrent GH therapy
Required Medical Information	Growth Hormone Gene Deletion (GHGD): (Initial) (1) Diagnosis of growth hormone gene deletion who have developed neutralizing antibodies to growth hormone. Severe Primary IGF-1 Deficiency (PIGF-1D): (Initial) (1) Diagnosis of Severe primary IGF-1 deficiency AND (2) height standard deviation score less than or equal to -3.0 AND (3) basal IGF-1 standard deviation score less than or equal to -3.0 AND normal or elevated growth hormone.
Age Restrictions	(GHGD, PIGF-1D): Member is 2 years of age or older
Prescriber Restrictions	(GHGD, PIGF-1D): Prescribed by or in consultation with an endocrinologist
Coverage Duration	12 months
Other Criteria	(GHGD, PIGF-1D)(CONTINUATION): (1) Documentation of increase in growth velocity from baseline AND (2) Annual clinical re-evaluation by an endocrinologist AND (3) BOTH of the following: (a) Expected adult height is not obtained (b) documentation of expected adult height goal
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

inhaled tobramycin 2026

Products Affected

- TOBI PODHALER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cystic Fibrosis (CF): (1) Diagnosis of cystic fibrosis AND (2) evidence of Pseudomonas aeruginosa in the lungs (3) FEV1 between 25% and 75% of predicted, (4) Member not colonized with Burkholderia cepacia.
Age Restrictions	(CF): Member is 6 years of age or older
Prescriber Restrictions	(CF): Prescribed by or in consultation with a pulmonologist, infectious disease specialist or Specialist affiliated with a CF care center.
Coverage Duration	Remainder of contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

injectable methotrexate 2026

Products Affected

- RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML, 12.5 MG/0.25ML, 15 MG/0.3ML, 17.5 MG/0.35ML, 20 MG/0.4ML, 22.5 MG/0.45ML, 25 MG/0.5ML, 30 MG/0.6ML, 7.5 MG/0.15ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Rheumatoid arthritis (RA) (Initial): (1) Diagnosis of severe, active rheumatoid arthritis (RA), (2) Inadequate response or inability to tolerate oral methotrexate. Psoriatic Arthritis (PsA)(Initial): (1) Diagnosis of PsA, (2) Inadequate response or inability to tolerate oral methotrexate. Polyarticular juvenile idiopathic arthritis (PJIA)(Initial): (1) Diagnosis of PJIA, (2) Inadequate response or inability to tolerate oral methotrexate. Psoriasis (Initial): (1) Diagnosis of severe psoriasis, (2) Inadequate response to BOTH of the following: (a) oral methotrexate AND (b) topical steroids (e.g. clobetasol propionate cream/ointment, betamethasone cream/ointment, etc.).
Age Restrictions	
Prescriber Restrictions	(RA, PJIA): Recommended by rheumatologist. (PSA): Recommended by a rheumatologist or dermatologist. (Psoriasis): Recommended by dermatologist
Coverage Duration	12 months
Other Criteria	(RA, PJIA, PSA, Psoriasis) (Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

intravenous immune globulins (ivig) 2026

Products Affected

- GAMMAGARD INJECTION SOLUTION 2.5 GM/25ML
- GAMMAGARD S/D LESS IGA
- GAMMAKED INJECTION SOLUTION 1 GM/10ML
- GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 5 GM/50ML
- GAMUNEX-C INJECTION SOLUTION 1 GM/10ML
- OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 2 GM/20ML
- PRIVIGEN INTRAVENOUS SOLUTION 20 GM/200ML

PA Criteria	Criteria Details
Exclusion Criteria	(Initial): History of hypersensitivity (including anaphylaxis or severe systemic reaction) to immune globulin or any component of the preparation.
Required Medical Information	Part D is medically necessary when ONE of the following is present: (1) Autoimmune mucocutaneous blistering disease pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane (cicatricial) pemphigoid , benign mucous membrane pemphigoid, epidermolysis bullosa acquisita and ONE of the following: (a) inadequate response or inability to tolerate conventional therapy (i.e. steroids, immunosuppressants) OR (b) rapidly progressive disease in conjunction with conventional therapy (i.e. steroids, immunosuppressants). (2) Acute Idiopathic Thrombocytopenia Purpura (ITP) and ONE of the following (a) management of acute bleeding (b) used to increase platelet count prior to surgical procedures) (c) severe thrombocytopenia (platelets less than 20, 000 per uL) or (d) high risk for intracerebral hemorrhage. (3) Chronic ITP and ALL of the following (a) inadequate response or inability to tolerate corticosteroids (b) duration of illness greater than 6 months (c) platelets persistently less than 20,000/ uL. (4) Chronic B-cell lymphocytic leukemia with IgG less than 600mg/dL and recurrent, serious bacterial infections requiring antibiotic therapy. (5) Hematopoietic stem cell transplant and IgG less than 400mg/dL. (6) HIV and all of the following (a) less than 14 years of age (b) evidence of qualitative or quantitative humoral immunologic defects and (c) current bacterial infection despite antimicrobial prophylaxis. (7) Solid organ transplant. (8) Chronic Inflammatory Demyelinating Polyneuritis confirmed by electrodiagnostic testing or nerve biopsy and an inadequate response or inability to tolerate corticosteroids. (9) Dermatomyositis or Polymyositis diagnosed by laboratory testing (antinuclear or myositis specific antibodies), biopsy, EMG, or MRI) and inadequate response or inability to tolerate steroids or immunosuppressants. (10) Guillain Barre syndrome with impaired function (i.e. unable to stand or walk without aid).
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	Prescribed by or in consultation with a physician who has specialized expertise in managing patients on immune globulin therapy (e.g. immunologist, hematologist, neurologist).
Coverage Duration	6 months
Other Criteria	Subject to Part B vs Part D review. (11) Lambert Eaton myasthenic syndrome and an inadequate response or inability to tolerate steroids, immunosuppressants, or cholinesterase inhibitors (12) Multifocal motor neuropathy diagnosed by electrodiagnostic studies. (13) Acute exacerbations of multiple sclerosis (MS) unresponsive to steroids. (14) Myasthenia gravis and an inadequate response or inability to tolerate at least 8 weeks of standard therapy (e.g. corticosteroids, azathioprine, cyclosporine, cyclophosphamide, cholinesterase inhibitors) (15) Myasthenic crisis (16) Stiff person syndrome and an inadequate response or inability to tolerate standard therapy (e.g. muscle relaxants, benzodiazepines, and gabapentin-related medications) (17) Severe, active SLE and an inadequate response or inability to tolerate steroids (18) Kawasaki disease. (19) Infections in Low-birthweight Neonates when severe hypogammaglobulinemia (IgG greater than or equal to 400 mg/dL) is present. (20) Graves¿ Ophthalmopathy (21) Immune mediated Necrotizing Myopathy when resistant to treatment with glucocorticoids and immunosuppressants (22) Graves disease (All Indications)(CONTINUATION): (1) Documentation of clinical improvement as appropriate to the diagnosis (e.g. clinical improvement in symptoms, Rankin score and Activities of Daily Living (ADL) scores, etc.)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ivabradine 2026

Products Affected

- *ivabradine hcl*

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

jynarque 2026

Products Affected

- JYNARQUE ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(Autosomal Dominant Polycystic Kidney Disease (ADPKD): (Initial): (1) Diagnosis of autosomal dominant polycystic kidney disease with risk of rapidly progressing kidney disease (2) Baseline serum transaminases and bilirubin obtained prior to initiation of therapy.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist or kidney transplant specialist
Coverage Duration	(Initial): 3 months. (Reauth): 12 months.
Other Criteria	(ADPKD)(Reauth): (1) ONE of the following (a) decline in kidney function has slowed or (b) kidney pain has improved and (2) serum transaminase less than 3 times the upper limit of normal and (3) bilirubin less than 2 times upper limit of normal
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

kalydeco 2026

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cystic Fibrosis (CF)(Initial): (1) Diagnosis of Cystic Fibrosis (2) One of the following: (a) Documentation of one mutation in the CFTR gene that is responsive to ivacaftor based on clinical and/or in vitro assay data, (b) If the member's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test
Age Restrictions	(CF): Member is 1 month of age or older for granules. Member is 6 years of age or older for tablets
Prescriber Restrictions	(CF): Prescribed by or in consultation with a pulmonologist or Specialist affiliated with a CF care center
Coverage Duration	12 months
Other Criteria	(CF)(Reauth): Member has had a positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

kerendia 2026

Products Affected

- KERENDIA ORAL TABLET 10 MG, 20 MG

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

kevzara 2026

Products Affected

- KEVZARA

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
Required Medical Information	Rheumatoid arthritis (RA)(Initial): (1) Diagnosis of RA. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) etanercept (Enbrel), (c) Rinvoq, (d) Xeljanz/Xeljanz XR, (e) Orencia OR documentation demonstrating that a trial may be inappropriate. Polymyalgia Rheumatica (PMR)(Initial): (1) Diagnosis of polymyalgia rheumatica (2) Inadequate response or inability to tolerate corticosteroids (e.g. prednisone). Polyarticular Juvenile Idiopathic Arthritis (PJIA)(Initial): (1) Diagnosis of active polyarticular juvenile idiopathic arthritis (PJIA) (2) Member weighs at least 63 kg (3) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF) (b) Enbrel, (c) Xeljanz, (d) Orencia, (e) Rinvoq/Rinvoq LQ OR documentation demonstrating that a trial may be inappropriate.
Age Restrictions	
Prescriber Restrictions	(RA, PMR, PJIA): Prescribed by or in consultation with a rheumatologist
Coverage Duration	12 months
Other Criteria	(RA, PMR, PJIA) (Reauth): (1) Member demonstrates positive clinical response to therapy as evidenced by at least one of the following: (a) Reduction in total active (swollen and tender) joint count from baseline or (b) Improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

kineret 2026

Products Affected

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
Required Medical Information	Rheumatoid Arthritis (RA)(Initial): (1) Diagnosis of RA. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. adalimumab-AACF), (b) etanercept (Enbrel), (c) Rinvoq, (d) Xeljanz/Xeljanz XR, (e) Orencia OR documentation demonstrating that a trial may be inappropriate. Neonatal-Onset Multisystem Inflammatory Disease (NOMID)(Initial): (1) Diagnosis of NOMID. (2) Diagnosis has been confirmed by one of the following: (a) NLRP-3 (nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3] gene (also known as Cold-Induced Auto-inflammatory Syndrome-1 [CIAS1]) mutation (b) Evidence of active inflammation including both of the following: (i) clinical symptoms (e.g. rash, fever, arthralgia) (ii) elevated acute phase reactants (e.g. ESR, CRP). Deficiency of Interleukin-1 Receptor Antagonist (DIRA): (1) Diagnosis of DIRA.
Age Restrictions	
Prescriber Restrictions	(RA, NOMID, DIRA): Prescribed by or in consultation with a rheumatologist or pediatric specialist.
Coverage Duration	12 months
Other Criteria	(RA, NOMID, DIRA)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

klisyri 2026

Products Affected

- KLISYRI (250 MG)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Actinic Keratoses: (1) Diagnosis of Actinic Keratoses (2) Inadequate response or inability to tolerate BOTH of the following generics: Topical fluorouracil and topical imiquimod
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

korlym 2026

Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Hyperglycemia in members with Cushing Syndrome (HCS)(Initial): (1) Hyperglycemia secondary to hypercortisolism in adult member with endogenous Cushing syndrome, (2) member has type 2 diabetes mellitus or glucose intolerance, (3) member has failed surgery or is not a candidate for surgery.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	12 months
Other Criteria	(HCS)(Reauth): Documentation of positive clinical response to therapy (e.g., improved, or stable glucose tolerance while on therapy)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

letairis 2026

Products Affected

- LETAIRIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH) (Initial): (1) Documentation of a diagnosis of pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) Functional Class II to IV. (2) Diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography. (3) Documentation of all the following: (a) Mean pulmonary arterial pressure is greater than 20 mm Hg. (b) Pulmonary vascular resistance (PVR) is greater than 2.0 Woods Units (WU). (c) The pulmonary capillary wedge pressure or left ventricular end-diastolic pressure is 15 mm Hg or less.(4) Inadequate response or inability to tolerate generic ambrisentan
Age Restrictions	
Prescriber Restrictions	(PAH): Prescribed by or in consultation with a Cardiologist or Pulmonologist.
Coverage Duration	(Initial): 6 months. (Continuation):12 months.
Other Criteria	(PAH)(Continuation): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

livtencity 2026

Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cytomegalovirus (CMV): (1) Diagnosis of cytomegalovirus (CMV) infection/disease, (2) Member is a recipient of one of the following (a) Hematopoietic stem cell transplant, (b) solid organ transplant, (3) Inadequate response to a minimum 2 weeks duration or inability to tolerate one prior therapy at an appropriately indicated dose (e.g., oral valganciclovir)(4) For pediatric members 12 years of age or older, Member weighs greater than or equal to 35kg
Age Restrictions	(CMV): Member is 12 years of age or older
Prescriber Restrictions	(CMV): Prescribed by or in consultation with a provider who specializes in one of the following areas (1) transplant, (2) infectious disease (3) Oncology
Coverage Duration	8 weeks
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

modafinil 2026

Products Affected

- *modafinil oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Obstructive Sleep Apnea (OSA) (Initial) (1) Diagnosis of obstructive sleep apnea defined by ONE of the following: (A) 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible) OR (B) BOTH of the following: (a) 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study is not feasible (b) ONE of the following symptoms: Unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomina, waking up breath holding/gasping/choking, loud snoring, breathing interruptions during sleep Narcolepsy (Initial): (1) Diagnosis of narcolepsy as confirmed by sleep study (unless prescriber provides justification confirming a sleep study is not feasible) Shift Work Disorder (SWD)(Initial):(1) Diagnosis of Shift Work Disorder confirmed by ONE of the following: (A) Symptoms of excessive sleepiness or insomnia, for at least 3 months, which is associated with a work period (usually night work) that occurs during the normal sleep period OR (B) Sleep study demonstrating loss of a normal sleep-wake pattern (ie, disturbed chronobiologic rhythmicity) (2) Confirmation that no other medical conditions or medications are causing the symptoms of excessive sleepiness or insomnia Fatigue due to MS (off-label) (Initial): (1) Diagnosis of multiple sclerosis (MS) (2) Member is experiencing fatigue.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or sleep specialist.
Coverage Duration	12 months
Other Criteria	(OSA, Narcolepsy, SWD)(Reauth): (1) Member demonstrates positive clinical response to therapy (MS)(Reauth): (1) Member is experiencing relief of fatigue with modafinil therapy

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

nexletol/nexlizet 2026

Products Affected

- NEXLETOL
- NEXLIZET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Heterozygous Familial Hypercholesterolemia (HeFH) OR Primary hyperlipidemia (PH). (Initial): (1) One of the following: (A) Diagnosis of HeFH, OR (B) Diagnosis of Primary hyperlipidemia (2) ONE of the following: (A) LDL-C 70 mg/dL or greater after at least 8 weeks of one low, moderate or high-intensity statin therapy and member will continue to receive statin therapy at maximally tolerated dose OR (B) Inability to tolerate statin therapy as documented by one of the following: (i) member had rhabdomyolysis or symptoms with creatine kinase (CK) exceeding 10 times the upper limit of normal (ULN) or (ii) either of the following with TWO statins: myalgia (no CK elevation) or myositis (CK less than 10 times ULN or (iii) hepatotoxicity from statin use (increased AST/ALT exceeding 3 times ULN) or (iv) liver disease documented by Child Pugh A or worse OR AST/ALT exceeding 3 times ULN for at least 6 weeks. (3) One of the following: (A) Member has been receiving at least 8 weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy OR (B) Member has contraindication or intolerance to ezetimibe (Zetia).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	(Initial): 6 months. (Continuation): 12 months

PA Criteria	Criteria Details
Other Criteria	Established cardiovascular disease (CVD) or high risk for a CVD event but without established CVD (Initial): (1) One of the following: (A) Diagnosis of established cardiovascular disease (CVD) (e.g., coronary artery disease, symptomatic peripheral arterial disease, cerebrovascular atherosclerotic disease) OR (B) Diagnosis of a high risk for a CVD event but without established CVD [e.g., diabetes mellitus (type 1 or type 2) in females over 65 years of age or males over 60 years of age] (2) One of the following: (A) Member is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase) (B) Member has a contraindication to all statins (3) ONE of the following LDL-C values within the last 120 days (A) LDL-C greater than or equal to 55 mg/dL with ASCVD OR (B) LDL-C greater than or equal to 100 mg/dL without ASCVD (4) One of the following (A) For Nexletol, ONE of the following: (i) Member has been receiving at least 12 weeks of generic ezetimibe therapy (ii) Patient has a history of contraindication, or intolerance to ezetimibe OR (B) For Nexlizet, member has been receiving at least 12 weeks of generic ezetimibe therapy (HeFH, PH) (Continuation): (1) Positive Clinical response to therapy (e.g. reduction in LDL-C levels). (CVD) (Continuation): (1) Positive Clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

non-oral chemo agents 2026

Products Affected

- BESREMI
- TRELSTAR MIXJECT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Part D is medically necessary when ANY of the following inclusion criteria is met: (1) Drug is FDA approved for indication and regimen requested, (2) The indication and regimen is classified as Category 1 or 2A by National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, (3) narrative text in The American Hospital Formulary Service-Drug Information (AHFS-DI) or Clinical Pharmacology Compendium is supportive for the specific condition(s) requested, (4) The Micromedex Compendium and the strength of recommendation is listed as Class I, Class IIa, or Class IIb for the specific condition(s) requested, (5) Indication is listed in Lexi-Drugs as ¿off label¿ with evidence level A, (6) supported by Peer-Reviewed Medical Literature as defined in Chapter 15 Section 50.4.5 of the Medicare Benefit Policy Manual
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	(All Indications): Approve if for continuation of therapy. Subject to Part B vs Part D review.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

non-preferred glp-1 agonists 2026

Products Affected

- *exenatide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(DM2)(Initial): (1) One of the following: (a) For members requiring ongoing treatment for type 2 diabetes mellitus, submission of medical records (e.g. chart notes) confirming diagnosis of type 2 diabetes mellitus (b) Submission of medical records (e.g. chart notes) confirming diagnosis of type 2 diabetes mellites as evidenced by one of the following laboratory values (i) A1C greater than or equal to 6.5 percent (ii) Fasting plasma glucose (FPG) greater than or equal to 126 mg/dL (iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test) (2) Inadequate response or inability to tolerate a minimum 90 day-supply of two of the following preferred brands: Ozempic, Trulicity, Rybelsus, Mounjaro, liraglutide
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	(DM2)(Reauth): Documentation of positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

non-preferred hepatitis c agents 2026

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(1) Documentation of member's Hepatitis C genotype. (2) Prescribed regimen is consistent with the current AASLD/ IDSA guidance. (3) Inability to tolerate ONE of the following when appropriate per the current AASLD/IDSA guidance: Harvoni, Epclusa, or Mavyret.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Duration will be applied consistent with AASLD/ IDSA guidance
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

non-preferred ustekinumab sq 2026

Products Affected

- STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML
- STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- *ustekinumab subcutaneous*

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
Required Medical Information	Part D is medically necessary when: Crohn's Disease (CD)(Initial): (1) Diagnosis of moderate to severe CD (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Skyrizi, (c) Rinvoq (d) Ustekinumab (i.e. Yesintek) or documentation demonstrating that a trial may be inappropriate. Ulcerative Colitis (UC)(Initial): (1) Diagnosis of moderate to severe UC. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Rinvoq, (c) Xeljanz/Xeljanz XR, (d) Skyrizi (e) Ustekinumab (i.e. Yesintek) OR documentation demonstrating that a trial may be inappropriate. Psoriatic arthritis (PsA)(Initial): (1) Diagnosis of PsA. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Enbrel, (c) Xeljanz/Xeljanz XR (d) Rinvoq/Rinvoq LQ, (e) Skyrizi, (f) Cosentyx, (g) Orencia, (h) Otezla, (i) Ustekinumab (i.e. Yesintek) OR documentation demonstrating that a trial may be inappropriate. Plaque psoriasis (PsO)(Initial): Diagnosis of moderate to severe PsO. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Enbrel, (c) Skyrizi (d) Cosentyx, (e)Otezla, (f) Ustekinumab (i.e. Yesintek) OR documentation demonstrating that a trial may be inappropriate.
Age Restrictions	
Prescriber Restrictions	(CD, UC): prescribed by or in consultation with a Gastroenterologist. (PsO): prescribed by or in consultation with a Dermatologist. (PsA): prescribed by or in consultation with a Dermatologist or Rheumatologist
Coverage Duration	(CD, UC, PsA, PsO): 12 months
Other Criteria	(CD, UC, PsA, PsO): (Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

nourianz 2026

Products Affected

- NOURIANZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Parkinson's Disease (PD) (Initial): (1) Diagnosis of Parkinson's disease. (2) concurrent use of carbidopa/levodopa containing product, (3) Member is experiencing intermittent OFF episodes, (4) member had inadequate response or inability to tolerate ONE of the following: (a) MAO-B inhibitor (e.g. rasagiline, selegiline), (b) Dopamine agonist (e.g. pramipexole, ropinirole), (c) COMT inhibitor (e.g. entacapone)
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	12 months
Other Criteria	Parkinson's Disease (PD) (Reauth): (1) Member demonstrates positive response to clinical therapy (2) concurrent use of carbidopa/levodopa containing product
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

noxafil 2026

Products Affected

- *posaconazole oral tablet delayed release*

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

nucala 2026

Products Affected

- NUCALA

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

nuedexta 2026

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	(PBA) 1) Concomitant use with other drugs containing quinidine, quinine, or mefloquine, (2) History of Nuedexta, quinine, mefloquine or quinidine-induced thrombocytopenia, hepatitis, bone marrow depression, or lupus-like syndrome, (3) Known hypersensitivity to dextromethorphan (e.g., rash, hives), (4) Taking monoamine oxidase inhibitors (MAOIs) (e.g., phenelzine, selegiline, tranylcypromine) or have taken MAOIs within the preceding 14 days, (5) Presence of prolonged QT interval, congenital long QT syndrome or a history suggestive of torsades de pointes, or has heart failure, (6) Receiving drugs that both prolong QT interval and are metabolized by CYP2D6 (e.g., thioridazine, pimozide), (7) Has complete atrioventricular (AV) block without implanted pacemakers, or at high risk of complete AV block]
Required Medical Information	Pseudobulbar Affect (PBA) (Initial): (1) Diagnosis of Pseudobulbar affect (2) Member has one of the following underlying conditions: (a) Amyotrophic lateral sclerosis (b) Multiple sclerosis (c) Alzheimer's disease (d) Parkinson's disease (e) Stroke (f) Traumatic brain injury
Age Restrictions	(PBA): Member is 18 years of age or older
Prescriber Restrictions	(PBA): Prescribed by or in consultation with a neurologist or psychiatrist
Coverage Duration	12 months
Other Criteria	(PBA)(Reauth): (1) Documentation of clinical benefit from ongoing therapy (e.g., decrease in laughing or crying episodes)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

nuplazid 2026

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

nurtec 2026

Products Affected

- NURTEC

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ocaliva 2026

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Primary biliary cholangitis (PBC): (1) Diagnosis of Primary biliary cholangitis (PBC) (2) One of the following: (a) Used in combination with ursodeoxycholic acid (e.g. Urso, Urso Forte, ursodiol), OR (b) inability to tolerate ursodeoxycholic acid (3) Member has one of the following: (a) no cirrhosis or (b) compensated cirrhosis with no evidence of portal hypertension. (4) Requested drug will not be used in combination with Livdelzi (seladelpar) or Iqirvo (elafibranor)
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist or gastroenterologist
Coverage Duration	(Initial): 6 months. (Reauth): Indefinite
Other Criteria	(PCB)(Reauth): (1) Positive clinical response to Ocaliva therapy (2) Member does not have evidence of advanced cirrhosis (i.e. cirrhosis with current or prior evidence of hepatic decompensation including encephalopathy or coagulopathy) (3) Member does not have evidence of portal hypertension (e.g., ascites, gastroesophageal varices, persistent thrombocytopenia)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

octreotide 2026

Products Affected

- *octreotide acetate injection solution 100 mcg/ml*

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ofev 2026

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	No

olumiant 2026

Products Affected

- OLUMIANT

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists, JAK inhibitors, or potent immunosuppressants such as azathioprine, cyclosporine
Required Medical Information	Rheumatoid arthritis (RA)(Initial): (1) Diagnosis of RA. (2) Inadequate response or inability to tolerate two of the following: (a) Adalimumab (i.e. adalimumab-AACF), (b) Enbrel (c) Rinvoq, (d) Xeljanz/Xeljanz XR, (e) Orencia OR documentation demonstrating that a trial may be inappropriate. Alopecia Areata (AA)(Initial): (1) Diagnosis of alopecia areata (2) Member has at least 50% scalp hair loss (3) Other causes of hair loss have been ruled out (e.g. androgenetic alopecia, trichotillomania, tinea capitis, psoriasis) (4) Inadequate response or inability to tolerate one previous treatment for alopecia areata (e.g. topical, intralesional, or systemic corticosteroids, topical immunotherapy)
Age Restrictions	
Prescriber Restrictions	(RA): Prescribed by or in consultation with a rheumatologist (AA): Prescribed by or in consultation with a dermatologist
Coverage Duration	12 months
Other Criteria	(RA, Alopecia Areata)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

onychomycosis agents 2026

Products Affected

- JUBLIA
- *tavaborole*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Onychomycosis: (1) Diagnosis of onychomycosis of the toenail(s) due to Trichophyton rubrum and Trichophyton mentagrophytes. (2) Diagnosis confirmed by one of the following: (a) positive potassium hydroxide (KOH) preparation, (b) culture, or (c) histology. (3) Condition is causing debility or a disruption in member's activities of daily living. (4) Inadequate response or inability to tolerate BOTH of the following: (a) oral generic terbinafine, AND (b) oral generic itraconazole OR topical generic ciclopirox.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

opipza 2026

Products Affected

- OPIPZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Schizophrenia: (1) Diagnosis of treatment of schizophrenia (2) Inadequate response or inability to tolerate aripiprazole and an additional generic formulary antipsychotic product. Major depressive disorder (MDD): (1) Diagnosis of adjunctive treatment of MDD (2) Inadequate response or inability to tolerate aripiprazole and quetiapine. Autistic disorder: (1) Diagnosis of irritability associated with autistic disorder (2) Inadequate response or inability to tolerate aripiprazole and risperidone. Tourette¿s disorder: (1) Diagnosis of treatment of Tourette¿s disorder (2) Inadequate response or inability to tolerate aripiprazole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	(All Indications): Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

oral chemo agents 2026

Products Affected

- *abiraterone acetate*
- ABIRTEGA
- AKEEGA
- ALECENSA
- ALUNBRIG
- AUGTYRO
- AVMAPKI FAKZYNJA CO-PACK
- AYVAKIT
- BALVERSA
- *bexarotene*
- BOSULIF ORAL CAPSULE 50 MG
- BOSULIF ORAL TABLET
- BRAFTOVI ORAL CAPSULE 75 MG
- CABOMETYX
- CALQUENCE ORAL TABLET
- CAPRELSA
- COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG
- COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG
- COMETRIQ (60 MG DAILY DOSE)
- COPIKTRA
- COTELLIC
- DANZITEN
- *dasatinib*
- DAURISMO
- ERIVEDGE
- ERLEADA
- *erlotinib hcl*
- *everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *everolimus oral tablet soluble*
- FOTIVDA
- FRUZAQLA
- GAVRETO
- *gefitinib*
- GILOTRIF
- GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG
- GOMEKLI
- IBRANCE
- ICLUSIG
- IDHIFA
- *imatinib mesylate oral*
- IMBRUVICA ORAL CAPSULE
- IMBRUVICA ORAL SUSPENSION
- IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG
- *imkeldi*
- INLYTA
- INQOVI
- INREBIC
- ITOVEBI
- IWILFIN
- JAKAFI
- JAYPIRCA
- KISQALI (200 MG DOSE)
- KISQALI (400 MG DOSE)
- KISQALI (600 MG DOSE)
- KOSELUGO
- KRAZATI
- *lapatinib ditosylate*
- LAZCLUZE
- *lenalidomide*
- LENVIMA (10 MG DAILY DOSE)
- LENVIMA (12 MG DAILY DOSE)
- LENVIMA (14 MG DAILY DOSE)
- LENVIMA (18 MG DAILY DOSE)
- LENVIMA (20 MG DAILY DOSE)
- LENVIMA (24 MG DAILY DOSE)
- LENVIMA (4 MG DAILY DOSE)
- LENVIMA (8 MG DAILY DOSE)
- LONSURF
- LORBRENA
- LUMAKRAS
- LYNPARZA ORAL TABLET
- LYTGOBI (12 MG DAILY DOSE)
- LYTGOBI (16 MG DAILY DOSE)
- LYTGOBI (20 MG DAILY DOSE)
- MEKINIST
- MEKTOVI
- NERLYNX
- *nilotinib hcl*
- NINLARO
- NUBEQA
- ODOMZO

- OGSIVEO
- OJEMDA ORAL SUSPENSION RECONSTITUTED
- OJEMDA ORAL TABLET 100 MG
- OJJAARA
- ONUREG
- ORGOVYX
- ORSERDU
- *pazopanib hcl*
- PEMAZYRE
- PIQRAY (200 MG DAILY DOSE)
- PIQRAY (250 MG DAILY DOSE)
- PIQRAY (300 MG DAILY DOSE)
- POMALYST
- QINLOCK
- RETEVMO ORAL TABLET
- REVUFORJ
- REZLIDHIA
- ROMVIMZA
- ROZLYTREK
- RUBRACA
- RYDAPT
- SCEMBLIX
- *sorafenib tosylate*
- SPRYCEL
- STIVARGA
- *sunitinib malate*
- TABRECTA
- TAFINLAR
- TAGRISSO
- TALZENNA
- TASIGNA
- TAZVERIK
- TEPMETKO
- THALOMID ORAL CAPSULE 100 MG, 50 MG
- TIBSOVO
- TRUQAP ORAL TABLET 200 MG
- TUKYSA
- TURALIO ORAL CAPSULE 125 MG
- VANFLYTA
- VENCLEXTA
- VENCLEXTA STARTING PACK
- VERZENIO
- VITRAKVI
- VIZIMPRO
- VONJO
- VORANIGO
- VOTRIENT
- WELIREG
- XALKORI
- XOSPATA
- XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG
- XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG
- XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG
- XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG
- XPOVIO (60 MG TWICE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG
- XPOVIO (80 MG TWICE WEEKLY)
- XTANDI
- YONSA
- ZEJULA ORAL TABLET
- ZELBORAF
- ZOLINZA
- ZYDELIG
- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	Approved when ANY of the following inclusion criteria is met: (1) Drug is FDA approved for indication and regimen requested, (2) The indication and regimen is classified as Category 1 or 2A by National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, (3) narrative text in The American Hospital Formulary Service-Drug Information (AHFS-DI) or Clinical Pharmacology Compendium is supportive for the specific condition(s) requested, (4) The Micromedex Compendium and the strength of recommendation is listed as Class I, Class IIa, or Class IIb for the specific condition(s) requested, (5) Indication is listed in Lexi-Drugs as ¿off label¿ with evidence level A, (6) supported by Peer-Reviewed Medical Literature as defined in Chapter 15 Section 50.4.5 of the Medicare Benefit Policy Manual
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	(All Indications): Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

oral pah agents 2026

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH) (Initial): (1) Documentation of a diagnosis of pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) Functional Class II to IV. (2) Diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography. (3) Documentation of all the following: (a) Mean pulmonary arterial pressure is greater than 20 mm Hg. (b) Pulmonary vascular resistance (PVR) is greater than 2.0 Woods Units (WU). (c) The pulmonary capillary wedge pressure or left ventricular end-diastolic pressure is 15 mm Hg or less.
Age Restrictions	
Prescriber Restrictions	(PAH): Prescribed by or in consultation with a Cardiologist or Pulmonologist
Coverage Duration	(Initial): 6 months. (Continuation):12 months.
Other Criteria	(PAH)(Continuation): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

orencia sq 2026

Products Affected

- ORENCIA CLICKJECT
- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	(RA, PsA, PJIA): Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
Required Medical Information	Rheumatoid arthritis (RA)(Initial): (1) Diagnosis of RA. (2) Inadequate response or inability to tolerate one DMARD: (e.g. methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine). Psoriatic arthritis (PsA)(Initial): (1) Diagnosis of PsA. Polyarticular Juvenile idiopathic arthritis (PJIA)(Initial): (1) Diagnosis of PJIA. (2) Inadequate response or inability to tolerate one of the following: methotrexate, leflunomide, sulfasalazine.
Age Restrictions	
Prescriber Restrictions	(RA, PJIA): Prescribed by or in consultation with a rheumatologist. (PsA): Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	12 months
Other Criteria	(RA, PsA, PJIA)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

orkambi 2026

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cystic Fibrosis (CF)(Initial): (1) Diagnosis of CF, (2) One of the following: (a) Documentation that member is homozygous for the F508del mutation in the CFTR gene (b) If the member¿s genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of the F508del mutation on both alleles of the CFTR gene
Age Restrictions	(CF): Member is 1 year of age or older for granules. Member is 6 years of age or older for tablets.
Prescriber Restrictions	(CF): Prescribed by or in consultation with pulmonologist or Specialist affiliated with a CF care center
Coverage Duration	12 months
Other Criteria	(CF)(Reauth): Member has had a positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

otezla 2026

Products Affected

- OTEZLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Oral Ulcers Associated with Behcet's Disease (OU-BD)(Initial): (1) Diagnosis of OU-BD. Psoriatic arthritis (PsA)(Initial): (1) Diagnosis of PsA. Plaque psoriasis (PsO)(Initial): (1) Diagnosis of PsO.
Age Restrictions	
Prescriber Restrictions	(PsA, OU-BD): Prescribed by or in consultation with a Rheumatologist or Dermatologist. (PsO): Prescribed by or in consultation with dermatologist.
Coverage Duration	12 months
Other Criteria	(OU-BD, PsA, PsO)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

oxervate 2026

Products Affected

- OXERVATE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Neurotrophic keratitis (NK)(Initial): (1) Diagnosis of NK. (2) Submission of chart documentation indicating treatment of left eye, right eye, or both (3) Member will not exceed 8 weeks of Oxervate therapy per affected eye(s).
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or Optometrist.
Coverage Duration	8 weeks
Other Criteria	(NK)(Reauth): (1) Submission of chart documentation indicating treatment of left eye, right eye, or both with positive clinical response to therapy (2) Member has received less than or equal to 8 weeks of therapy (one course of therapy) per affected eye(s), (3) Documentation of clinical rationale for treatment greater than 8 weeks (e.g. member has a recurrence of neurotrophic keratitis, or treatment of a different eye), (4) Member will not exceed a total of 16 weeks of Oxervate therapy per affected eye(s).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

part d vs excluded 2026

Products Affected

- INTRAROSA
- OSPHENA
- *voriconazole intravenous*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	Subject to additional clinical review for ESRD-related use - if applicable.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

pde inhibitor agents for pah 2026

Products Affected

- *tadalafil (pah)*

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

praluent 2026

Products Affected

- PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Hyperlipidemia (HLA) (Initial): (1) Diagnosis of hyperlipidemia, (2) ONE of the following: (A) LDL-C 70 mg/dL or greater after a minimum 8-week trial of at least moderate-intensity statin therapy OR (B) Inability to tolerate statin therapy as documented by one of the following: (i) member had rhabdomyolysis or symptoms with creatine kinase (CK) exceeding 10 times the upper limit of normal (ULN) or (ii) either of the following with TWO statins: myalgia (no CK elevation) or myositis (CK less than 10 times ULN or (iii) hepatotoxicity from statin use (increased AST/ALT exceeding 3 times ULN) or (iv) liver disease documented by Child Pugh A or worse OR AST/ALT exceeding 3 times ULN for at least 6 weeks Atherosclerotic cardiovascular disease (ASCVD) (Initial): (1) Diagnosis of atherosclerotic cardiovascular disease (ASCVD) as diagnosed by either stress test, angiography, atherosclerotic event (e.g. MI, angina, stroke, claudication, carotid stenosis) or arterial intervention for atherosclerotic disease (e.g. coronary, peripheral, carotid), (2) ONE of the following: (A) LDL-C 70 mg/dL or greater after a minimum 8-week trial of at least moderate-intensity statin therapy OR (B) Inability to tolerate statin therapy as documented by one of the following: (i) member had rhabdomyolysis or symptoms with creatine kinase (CK) exceeding 10 times the upper limit of normal (ULN) or (ii) either of the following with TWO statins: myalgia (no CK elevation) or myositis (CK less than 10 times ULN or (iii) hepatotoxicity from statin use (increased AST/ALT exceeding 3 times ULN) or (iv) liver disease documented by Child Pugh A or worse OR AST/ALT exceeding 3 times ULN for at least 6 weeks
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	(Initial): 6 months (Continuation): 2 years

PA Criteria	Criteria Details
Other Criteria	Homozygous Familial Hypercholesterolemia (HoFH) (Initial): (1) Diagnosis of HoFH. (2) One of the following: (a) Untreated LDL-C greater than 500 mg/dL or (b) Treated LDL-C greater than 300 mg/dL. (3) Member is receiving other lipid-lowering therapy (e.g. statin, ezetimibe). (4) Not used in combination with Juxtapid (lomitapide). (HLA, ASVCD)(CONTINUATION): (1) Positive Clinical response to therapy (e.g. reduction in LDL-C levels). (HoFH)(Continuation): (1) Positive Clinical response to therapy (e.g. reduction in LDL-C levels). (2) Member continues to receive other lipid-lowering therapy (e.g. statin, ezetimibe). (3) Not used in combination with Juxtapid (lomitapide).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

preferred denosumab 2026

Products Affected

- JUBBONTI

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

preferred glp-1 agonists 2026

Products Affected

- *liraglutide*
- MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML
- OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML
- OZEMPIC (2 MG/DOSE)
- RYBELSUS
- TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(DM2)(Initial): (1) One of the following: (a) For members requiring ongoing treatment for type 2 diabetes mellitus, submission of medical records (e.g. chart notes) confirming diagnosis of type 2 diabetes mellitus (b) Submission of medical records (e.g. chart notes) confirming diagnosis of type 2 diabetes mellites as evidenced by one of the following laboratory values (i) A1C greater than or equal to 6.5 percent (ii) Fasting plasma glucose (FPG) greater than or equal to 126 mg/dL (iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	(DM2)(Reauth): Documentation of positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

preferred hepatitis c agents 2026

Products Affected

- EPCLUSA
- HARVONI
- MAVYRET
- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(1) Documentation of member's Hepatitis C Genotype. (2) Prescribed regimen is consistent with the current AASLD/IDSA guidance.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Duration will be applied consistent with AASLD/ IDSA guidance
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

preferred tocilizumab sq 2026

Products Affected

- TYENNE SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

preferred ustekinumab sq 2026

Products Affected

- YESINTEK SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

promacta 2026

Products Affected

- *eltrombopag olamine*
- PROMACTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chronic Idiopathic Thrombocytopenic Purpura (ITP)(Initial): (1) Diagnosis of relapsed/refractory, persistent, or chronic ITP. (2) Baseline platelet count is less than 30,000/mcL. (3) Member's degree of thrombocytopenia and clinical condition increase the risk of bleeding. (4) Inadequate response or inability to tolerate ONE of the following: (a) corticosteroids, (b) immune globulin, (c) splenectomy. First-Line for Severe Aplastic Anemia(FLSAA): (1) Diagnosis of severe aplastic anemia. (2) Used for first-line treatment (i.e., member has not received prior immunosuppressive therapy). (3) Member meets at least TWO of the following: (a) absolute neutrophil count less than 500/mcL, (b) platelet count less than 20,000/mcL, (c) absolute reticulocyte count less than 60,000/mcL. (4) Used in combination with standard immunosuppressive therapy (e.g. Agam [antithymocyte globulin equine] and cyclosporine). Refractory Severe Aplastic Anemia (RSAA)(Initial): (1) Diagnosis of refractory severe aplastic anemia. (2) Member has a platelet count less than 30,000/mcL. (3) Inadequate response or inability to tolerate immunosuppressive therapy with antithymocyte globulin and cyclosporine. Chronic Hepatitis C-Associated Thrombocytopenia (HEPC-TP)(intial): (1) Diagnosis of chronic hepatitis C-associated thrombocytopenia. (2) One of the following: (a) Planning to initiate and maintain interferon-based treatment, or (b) currently receiving interferon-based treatment.
Age Restrictions	
Prescriber Restrictions	(ITP, FLSAA, RSAA): Prescribed by or in consultation with hematologist/oncologist. (HEPC-TP): Prescribed by or in consultation with Hematologist/oncologist, Gastroenterologist, Hepatologist, Infectious disease specialist, HIV specialist.
Coverage Duration	(ITP).=12mo.(FLSAA)=6mo.(RSAA)Initial=6mo.(HEPC-TP)Initial=3mo.(RSAA,HEPC-TP)Cont.=12mo.

PA Criteria	Criteria Details
Other Criteria	(ITP, RSAA)(Continuation): (1) Positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding. (HEPC-TP)(Continuation): (1) ONE of the following: (A) For members that started treatment with Promacta prior to initiation of treatment with interferon, both of the following: (i) Member is currently on antiviral interferon therapy for treatment of chronic hepatitis C, AND (ii) member reached a threshold platelet count that allows initiation of antiviral interferon therapy with Promacta treatment by week 9. (B) For members that started treatment with Promacta while on concomitant treatment with interferon, member is currently on antiviral interferon therapy for treatment of chronic hepatitis C.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

qbrexza 2026

Products Affected

- QBREXZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Primary Axillary Hyperhidrosis (PAH) (Initial) (1) Diagnosis of primary axillary hyperhidrosis: (2) Hyperhidrosis Disease Severity Scale grade 3 or 4 (3) Other causes of axillary hyperhidrosis have been ruled out (e.g., menopause, medications) (4) Disease frequently interferes with daily activities (e.g., daily clothes changes required)
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist, primary care physician, internist, or pediatrician.
Coverage Duration	(Initial, Reauth): 12 months
Other Criteria	(PAH)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

qualaquin 2026

Products Affected

- *quinine sulfate oral*

PA Criteria	Criteria Details
Exclusion Criteria	Use for treatment or prevention of nocturnal leg cramps
Required Medical Information	Uncomplicated Malaria: (1) Diagnosis of uncomplicated malaria due to (a) plasmodium falciparum malaria or (b) plasmodium vivax . (2) One of the following: (a) Both of the following: (i) treatment in areas of chloroquine-sensitive malaria (ii) Inadequate response or inability to tolerate chloroquine or hydroxychloroquine, or (b) treatment in areas of chloroquine-resistant malaria. Babesiosis: (1) Diagnosis of babesiosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Babesiosis: 10 days Uncomplicated Malaria: 14 Days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

radicava 2026

Products Affected

- RADICAVA ORS STARTER KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Amyotrophic Lateral Sclerosis (ALS)(Initial): (1) Diagnosis of definite or probable ALS per the revised El Escorial World Federation of Neurology criteria. (2) Normal respiratory function defined as forced vital capacity (FVC) of greater than or equal to 80% at the start of treatment. (3) Scores of 2 points or greater on each individual item of the ALS Functional Rating Scale-revised (ALSFRS-R).
Age Restrictions	
Prescriber Restrictions	(ALS): Prescribed by or in consultation with a neurologist with expertise in the diagnosis of ALS
Coverage Duration	6 months.
Other Criteria	(ALS)(Reauth): (1) Member shows benefit from therapy (e.g. slowing of decline of functional abilities).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

raldesy 2026

Products Affected

- RALDESY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Major depressive disorder (MDD): (1) Diagnosis of major depressive disorder (MDD) (2) One of the following: (a) inadequate response or inability to tolerate both of the following: (i) generic formulary trazadone tablets (ii) generic formulary serotonin reuptake inhibitors (SSRI) OR (b) Member is unable to swallow tablets.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	(All Indications): Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

repatha 2026

Products Affected

- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

respiratory enzymes 2026

Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	(ATT): (1) IgA deficiency with known anti-IgA antibody. (2) Member is a smoker
Required Medical Information	Part D is medically necessary when there is documentation of: Alpha 1-antitrypsin (AAT) deficiency: (1) Submission of medical records showing diagnosis of congenital alpha1-antitrypsin deficiency as confirmed by ONE of the following: (a) PiZZ, PiZ(null) or Pi(null)(null) protein phenotypes (homozygous) OR (B) Other rare AAT disease-causing alleles associated with serum alpha1-antitrypsin (AAT) level less than 11uM/L (2) Submission of medical records showing clinical evidence of chronic emphysema without evidence of alpha 1-antitrypsin-associated liver disease (3) Member has a low serum concentration of alpha 1-antitrypsin (AAT) less than 80 mg/dL (radial immunodiffusion) or 50 mg/dl (nephelometry) or less than 11 uM/L (nephelometry) or less than 0.8 g/L (35 percent of normal)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	Subject to Part B vs Part D review.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

rexulti 2026

Products Affected

- REXULTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Alzheimer's disease (AD): (1) Diagnosis of agitation associated with dementia due to Alzheimer's disease in adults. Schizophrenia: (1) Diagnosis of schizophrenia (2) Inadequate response or inability to tolerate TWO of the following: aripiprazole, quetiapine, asenapine, olanzapine, paliperidone, risperidone, ziprasidone. Major Depressive Disorder (MDD): (1) Diagnosis of major depressive disorder and as adjunctive therapy to antidepressants (2) Inadequate response or inability to tolerate aripiprazole and quetiapine
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	(All Indications): Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

rezdiffra 2026

Products Affected

- REZDIFFRA

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	No

rezurock 2026

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chronic graft-versus-host disease (cGVHD) (Initial): (1) Diagnosis of chronic graft-versus-host disease, (2) Inadequate response or inability to tolerate two or more lines of systemic therapy (e.g. corticosteroids, mycophenolate, etc.)
Age Restrictions	
Prescriber Restrictions	(cGVHD): Prescribed by or in consultation with one of the following (1) Hematologist, (2) Oncologist, (3) physician experienced in the management of transplant patients
Coverage Duration	12 months
Other Criteria	(cGVHD) (Reauth): (1) Member does not show evidence of progressive disease while on therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

rinvoq 2026

Products Affected

- RINVOQ

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

rinvoq lq 2026

Products Affected

- RINVOQ LQ

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with any other biologic disease modifying antirheumatic drug (DMARD), other JAK inhibitors, or potent immunosuppressants (e.g. azathioprine, cyclosporine).
Required Medical Information	Psoriatic Arthritis (PsA)(Initial): (1) Diagnosis of PsA, (2) Member had an inadequate response or inability to tolerate one or more TNF inhibitors (e.g. Enbrel, Adalimumab-AACF) or documentation demonstrating that a trial may be inappropriate. Polyarticular Juvenile Idiopathic Arthritis (PJIA)(Initial): (1) Diagnosis of active PJIA, (2) Inadequate response or inability to tolerate ONE of the following: Methotrexate, Leflunomide, Sulfasalazine (3) Member had an inadequate response or inability to tolerate one or more TNF inhibitors (e.g. Enbrel, Adalimumab-AACF) or documentation demonstrating that a trial may be inappropriate.
Age Restrictions	
Prescriber Restrictions	(PsA): Prescribed by or in consultation with a rheumatologist or dermatologist. (pJIA): Prescribed by or in consultation with a rheumatologist
Coverage Duration	12 months
Other Criteria	(PsA, pJIA)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

signifor 2026

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cushing's disease (CD)(Initial): (1) Diagnosis of (pituitary) Cushing's disease. (2) Pituitary surgery is not an option or has not been curative
Age Restrictions	
Prescriber Restrictions	(CD) Prescribed by or in consultation with an endocrinologist.
Coverage Duration	12 months
Other Criteria	(CD)(Reauth): Documentation of positive clinical response (e.g. clinically meaningful reduction in 24- hour urinary free cortisol levels, improvement in signs or symptoms of the disease)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

sildenafil 2026

Products Affected

- *sildenafil citrate oral suspension reconstituted*
- *sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
Exclusion Criteria	(PAH, RP): Documentation of concomitant nitrate use
Required Medical Information	Pulmonary Arterial Hypertension (PAH): (1) Diagnosis of PAH WHO Group I with New York Heart Association (NYHA) Functional Class II to IV (2) Diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography (3) Documentation of all the following: (a) Mean pulmonary arterial pressure is greater than 20 mm Hg. (b) Pulmonary vascular resistance (PVR) is greater than 2.0 Woods Units (WU). (c) The pulmonary capillary wedge pressure or left ventricular end-diastolic pressure is 15 mm Hg or less. Raynaud's Phenomenon (RP): (1) Diagnosis of secondary Raynaud's phenomenon. (2) Inadequate response or inability to tolerate a calcium channel blocker.
Age Restrictions	
Prescriber Restrictions	(PAH): Prescribed by or in consultation with a Cardiologist or Pulmonologist
Coverage Duration	Indefinite
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

simponi 2026

Products Affected

- SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
Required Medical Information	Ankylosing Spondylitis (AS)(Initial): (1) Diagnosis of AS. (2) Inadequate response or inability to tolerate two of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) etanercept (Enbrel), (c) secukinumab (Cosentyx), (d) tofacitinib (Xeljanz/Xeljanz XR), (e) upadacitinib (Rinvoq) or documentation demonstrating that a trial may be inappropriate. Psoriatic Arthritis (PsA)(Initial): (1) Diagnosis of PsA. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Enbrel, (c) Xeljanz/Xeljanz XR, (d) Rinvoq/Rinvoq LQ, (e) Skyrizi, (f) Cosentyx, (g) Ustekinumab (i.e. Yesintek), (h) Orencia, (i) Otezla OR documentation demonstrating that a trial may be inappropriate. Rheumatoid arthritis (RA)(Initial): (1) Diagnosis of moderate to severe RA. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Enbrel, (c) Rinvoq, (d) Xeljanz/Xeljanz XR, (e) Orencia OR documentation demonstrating that a trial may be inappropriate. Ulcerative Colitis (UC)(Initial): (1) Diagnosis of moderate to severe UC. (2) Inadequate response or inability to tolerate two of the following: (a) Adalimumab (i.e. Adalimumab-AACF), and (b) Xeljanz/Xeljanz XR, (c) Ustekinumab (i.e. Yesintek), (d) Rinvoq, (e) Skyrizi OR documentation demonstrating that a trial may be inappropriate.
Age Restrictions	
Prescriber Restrictions	(RA, AS): Prescribed by or in consultation with a rheumatologist. (PsA): Prescribed by or in consultation with a rheumatologist or dermatologist. (UC): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	12 months
Other Criteria	(AS, PsA, RA, UC)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

sirturo 2026

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	No

skyrizi sc 2026

Products Affected

- SKYRIZI PEN
- SKYRIZI SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

sotatercept 2026

Products Affected

- WINREVAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH) (Initial): (1) Diagnosis of PAH WHO Group I with New York Heart Association (NYHA) Functional Class II to III (2) inadequate response or inability to tolerate TWO of the following: (a) Endothelin Receptor Antagonist (bosentan, ambrisentan, macitentan) (b) Phosphodiesterase 5 inhibitor (tadalafil, sildenafil) (c) IV prostacyclin therapy (treprostinil, epoprostenol) (3) Member continues to receive other PAH therapies (e.g. ambrisentan, tadalafil)
Age Restrictions	
Prescriber Restrictions	(PAH): Prescribed by or in consultation with cardiologist or pulmonologist.
Coverage Duration	(Initial) 6 months (Reauth) 12 months
Other Criteria	(PAH)(Reauth): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

tadalafil (bph) 2026

Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	(BPH): Concurrent use of nitrates.
Required Medical Information	Benign prostatic hyperplasia (BPH): (1) Diagnosis of BPH. (2) Inadequate response or inability to tolerate an alpha blocker (e.g. tamsulosin, terazosin) or a 5-alpha reductase inhibitor (e.g. dutasteride, finasteride).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

taltz 2026

Products Affected

- TALTZ

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
Required Medical Information	Plaque Psoriasis (PsO)(Initial): (1) Diagnosis of moderate to severe PsO. (2) ONE of the following: (A) For members 6 to 17 years of age: an inadequate response or inability to tolerate two of the following: (a) Enbrel, (b) Cosentyx, (c) Ustekinumab (i.e. Yesintek) or documentation demonstrating that a trial may be inappropriate, OR (B) For members 18 years of age or older: an inadequate response or inability to tolerate two of the following: (a)Cosentyx (b) Enbrel (c) Adalimumab (i.e. Adalimumab-AACF) (d) Skyrizi, (e) Ustekinumab (i.e. Yesintek), (f) Otezla or documentation demonstrating that a trial may be inappropriate. Psoriatic arthritis (PsA)(Initial): (1) Diagnosis of PsA. (2) Inadequate response or inability to tolerate TWO of the following: (a) Enbrel (b) Adalimumab(i.e. Adalimumab-AACF) (c) Cosentyx (d) Rinvoq/Rinvoq LQ (e) Skyrizi (f) Ustekinumab (i.e. Yesintek) (g) Xeljanz/Xeljanz XR, (h) Orencia, (i) Otezla OR documentation demonstrating that a trial may be inappropriate. Ankylosing spondylitis (AS)(Initial): (1) Diagnosis of AS. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e.Adalimumab-AACF), (b) etanercept (Enbrel), (c) secukinumab (Cosentyx), (d) upadacitinib (Rinvoq), (e) tofacitinib (Xeljanz/Xeljanz XR) OR documentation demonstrating that a trial may be inappropriate. Non-Radiographic Axial Spondyloarthritis (nr-axSpA)(Initial): (1) Diagnosis of nr-axSpA. (2) Inadequate response or inability to tolerate Rinvoq OR Cosentyx OR documentation demonstrating that a trial may be inappropriate (3) Inadequate response or inability to tolerate one NSAID (e.g. ibuprofen, meloxicam, naproxen).
Age Restrictions	
Prescriber Restrictions	(PsO): Prescribed by or in consultation with a dermatologist. (PsA): Prescribed by or in consultation with a dermatologist or rheumatologist. (AS, nr-axSpA): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	(PsA, AS, nr-axSpA, PsO)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

tavneos 2026

Products Affected

- TAVNEOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Severe Active Anti-neutrophil Cytoplasmic Autoantibody (ANCA)-associated Vasculitis (granulomatosis with polyangiitis [GPA] and microscopic polyangiitis [MPA]) (ANCA-V(GPA)(MPA))(Initial): (1) Diagnosis of Severe Active Anti-neutrophil Cytoplasmic Autoantibody (ANCA)-associated Vasculitis (granulomatosis with polyangiitis [GPA] or microscopic polyangiitis [MPA]), (2) Used as adjunct to standard therapy, and glucocorticoids (3) Member is on concurrent immunosuppressant therapy with cyclophosphamide or rituximab (Rituxan).
Age Restrictions	
Prescriber Restrictions	(ANCA-V(GPA)(MPA)Prescribed by or in consultation with a nephrologist, pulmonologist, or rheumatologist.
Coverage Duration	(Initial): 6 Months (Reauth): 1 year
Other Criteria	(ANCA-V(GPA)(MPA))(Reauth): (1) Positive clinical response to therapy defined as sustained remission as assessed by the Birmingham Vasculitis Activity Score (BVAS). (2) Reduction in use of glucocorticoids for treatment (3) Member is on concurrent immunosuppressant therapy with cyclophosphamide or rituximab (Rituxan).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

teriparatide 2026

Products Affected

- BONSITY *560 mcg/2.24ml*
- FORTEO SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML
- *teriparatide subcutaneous solution pen-injector*

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

testosterone products 2026

Products Affected

- JATENZO
- *testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml*
- *testosterone enanthate intramuscular solution*
- *testosterone transdermal gel 10 mg/act (2%), 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)*
- *testosterone transdermal solution*
- XYOSTED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Delayed Puberty (DP): (1) Diagnosis of delayed puberty in male members (Applies to Testosterone Enanthate only). Breast Cancer (BC): (1) Diagnosis of inoperable breast cancer in female members (Applies to Testosterone Enanthate only) (2) Used for palliative treatment Hypogonadism (HG)(New starts only): (1) Attestation that diagnosis was initially confirmed by ALL of the following: (A) Two early morning total testosterone levels below 300 ng/dL measured on separate occasions, (B) Normal Prolactin Level, and (C) Physical or cognitive symptoms of testosterone deficiency (e.g. physical: fatigue, sleep disturbances, decreased activity, cognitive: depressive symptoms, cognitive dysfunction, loss of concentration, poor memory, irritability), (2) ONE of the following (A) negative history of prostate and breast cancer OR (B) Both of the following (i) history of prostate cancer with stable PSA less than or equal to 4ng/dL for 2 years and (ii) documentation that the risk versus benefit has been assessed.
Age Restrictions	(HG) Member is 12 years of age or older (applies to generic testosterone cypionate only) and member is 18 years of age or older for all other products
Prescriber Restrictions	
Coverage Duration	(DP, BC): Indefinite (HG)(New Starts, Continuation): Indefinite
Other Criteria	(HG)(Continuation): ONE of the following (1) negative history of prostate and breast cancer OR (2) Both of the following (a) history of prostate cancer with stable PSA less than or equal to 4ng/dL for 2 years and (b) documentation that the risk versus benefit has been assessed
Indications	All Medically-accepted Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	No

tetrabenazine 2026

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Tardive Dyskinesia (TD)(Initial): (1) Diagnosis of TD, (2) Documentation is provided of ONE of the following: (a) Persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering or discontinuation of the offending medication, or (b) Member is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication. Tourette's Syndrome (TS): (1) Diagnosis of TS, (2) Member has tics associated with Tourette's syndrome, (3) Inadequate response or inability to tolerate haloperidol or risperidone. Chorea- Huntington's Disease (CHD): (1) Diagnosis of chorea associated with Huntington's disease
Age Restrictions	
Prescriber Restrictions	(TS, CHD): Prescribed by or in consultation with a neurologist or a psychiatrist. (TD): Prescribed by or in consultation with a neurologist or a psychiatrist.
Coverage Duration	(TD)(Initial): 3 months. (TD)(Reauth): Indefinite. (TS, CHD): Indefinite.
Other Criteria	(TD)(Reauth): Positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

tolvaptan 2026

Products Affected

- *tolvaptan oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	(1) Members who are unable to sense or appropriately respond to thirst, (2) hypovolemic hyponatremia, (3) concomitant use of strong CYP3A inhibitors (4) Anuria (5) Autosomal dominant polycystic kidney disease (ADPKD)
Required Medical Information	Hyponatremia (HN) (1) Diagnosis of clinically significant hypervolemic or euvolemic hyponatremia. (2) One of the following: (a) serum sodium less than 125meq/L or (b) serum sodium 125-134meq/L with symptoms (e.g., nausea, vomiting, headache, lethargy, confusion, etc.) (3) Treatment has been initiated or re-initiated in a hospital setting prior to discharge within the past 30 days. (4) Inadequate response or inability to tolerate therapies to control hyponatremia (e.g., fluid restriction, diuretics, etc.).
Age Restrictions	
Prescriber Restrictions	Hyponatremia: Prescribed by or in consultation with a cardiologist, endocrinologist or nephrologist
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

topical chemo agents 2026

Products Affected

- *bexarotene*
- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Approved when ANY of the following inclusion criteria is met: (1) Drug is FDA approved for indication and regimen requested, (2) The indication and regimen is classified as Category 1 or 2A by National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, (3) narrative text in The American Hospital Formulary Service-Drug Information (AHFS-DI) or Clinical Pharmacology Compendium is supportive for the specific condition(s) requested, (4) The Micromedex Compendium and the strength of recommendation is listed as Class I, Class IIa, or Class IIb for the specific condition(s) requested, (5) Indication is listed in Lexi-Drugs as ¿off label¿ with evidence level A, (6) supported by Peer-Reviewed Medical Literature as defined in Chapter 15 Section 50.4.5 of the Medicare Benefit Policy Manual
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist
Coverage Duration	Indefinite
Other Criteria	(All Indications): Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

topical retinoid products 2026

Products Affected

- *adapalene external gel 0.3 %*
- *tretinoin external*

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic use
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Remainder of contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

tracleer 2026

Products Affected

- TRACLEER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH) (Initial): (1) Documentation of a diagnosis of pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) Functional Class II to IV. (2) Diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography. (3) Documentation of all the following: (a) Mean pulmonary arterial pressure is greater than 20 mm Hg. (b) Pulmonary vascular resistance (PVR) is greater than 2.0 Woods Units (WU). (c) The pulmonary capillary wedge pressure or left ventricular end-diastolic pressure is 15 mm Hg or less. (4) Inadequate response or inability to tolerate generic bosentan.
Age Restrictions	
Prescriber Restrictions	(PAH): Prescribed by or in consultation with a Cardiologist or Pulmonologist
Coverage Duration	(Initial): 6 months. (Continuation):12 months.
Other Criteria	(PAH)(Continuation): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

tremfya sq 2026

Products Affected

- TREMFYA CROHNS INDUCTION
- TREMFYA ONE-PRESS
- TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML
- TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
Required Medical Information	Plaque psoriasis (PsO)(Initial): (1) Diagnosis or moderate to severe PsO. (2) Inadequate response or inability to tolerate two of the following: (a) Cosentyx, (b) Enbrel, (c) Adalimumab (i.e. Adalimumab-AACF), (d) Skyrizi, (e) Ustekinumab (i.e. Yesintek) , (f) Otezla OR documentation demonstrating that a trial may be inappropriate. Psoriatic arthritis (PsA)(Initial): (1) Diagnosis of PsA, (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF) (b) Enbrel (c) Cosentyx (d) Rinvoq/Rinvoq LQ (e) Skyrizi (f) Ustekinumab (i.e. Yesintek) (g) Xeljanz/Xeljanz XR, (h) Orencia, (i) Otezla or documentation demonstrating that a trial may be inappropriate. Ulcerative colitis (UC) (Initial): (1) Diagnosis of moderately to severely active UC (2) ONE of the following: (a) Inadequate response or inability to tolerate two of the following: (i) Adalimumab (i.e. Adalimumab-AACF), (ii) ustekinumab (Stelara i.e. Yesintek), (iii) upadacitinib (Rinvoq), (iv) tofacitinib (Xeljanz/Xeljanz XR), (v) risankizumab (Skyrizi) OR documentation demonstrating that a trial may be inappropriate (b) Will be used as a maintenance dose following the intravenous induction doses. Crohn's Disease (CD)(Initial): (1) Diagnosis of moderately to severely active CD (2) One of the following: (A) Inadequate response or inability to tolerate two of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Ustekinumab (i.e. Yesintek), (c) Skyrizi, (d) Rinvoq or documentation demonstrating that a trial may be inappropriate. (B) Will be used as a maintenance dose following the intravenous induction doses
Age Restrictions	
Prescriber Restrictions	(PsO): Prescribed by or in consultation with a dermatologist. (PsA): Prescribed by or in consultation with a dermatologist or rheumatologist. (UC,CD): Prescribed by or in consultation with a gastroenterologist
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	(PsO, PsA, UC, CD)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

trikafta 2026

Products Affected

- TRIKAFTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cystic Fibrosis (CF)(Initial): (1) Diagnosis of Cystic Fibrosis. (2) One of the following: (a) Documentation that member has at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene as detected by an FDA-cleared cystic fibrosis mutation test (b) A mutation in the CFTR gene that is responsive based on in vitro data. (c) If the member¿s genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of the F508del mutation on both alleles of the CFTR gene
Age Restrictions	
Prescriber Restrictions	(CF): Prescribed by or in consultation with a pulmonologist or Specialist affiliated with a CF care center
Coverage Duration	12 months
Other Criteria	(CF)(Reauth): Member has had a positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

tymlos 2026

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Postmenopausal Osteoporosis (PMO) (Initial): (1) Diagnosis of PMO. (2) Member has severe osteoporosis or is at a high to very high risk for fracture as defined by ONE of the following: (a) Member has a history of multiple vertebral fractures, (b) T score of the individual's bone mineral density (BMD) is at least -2.5 standard deviations below the young adult mean OR (c) history of osteoporotic fracture (i.e. Low-trauma fracture of the hip, spine, pelvis, or distal forearm, etc.) (3) Inadequate response or inability to tolerate ONE of the following: (a) bisphosphonates, (b) hormone replacement therapy, (c) selective-estrogen receptor modulators (SERMs), OR (d) Denosumab (Prolia). Osteoporosis at high risk for fracture in men (OSTm) (Initial): (1) Diagnosis of primary or hypogonadal osteoporosis (2) Both of the following: (a) Bone mineral density (BMD) T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) (b) One of the following (i) History of low-trauma fracture of the hip, spine, pelvis, or distal forearm (ii) inadequate response or inability to tolerate at least one osteoporosis treatment (e.g. alendronate, risedronate, zoledronic acid, Prolia [denosumab])
Age Restrictions	(PMO, OSTm) Member is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	Remainder of contract year
Other Criteria	(PMO, OSTm)(Reauth): Cumulative lifetime therapy does not exceed 2 years
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

tyvaso dpi 2026

Products Affected

- TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG
- TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pulmonary Arterial Hypertension (PAH) (Initial): (1) Diagnosis of pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) Functional Class II to IV. (2) Diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography. (3) Documentation of all the following: (a) Mean pulmonary arterial pressure is greater than 20 mm Hg. (b) Pulmonary vascular resistance (PVR) is greater than 2.0 Woods Units (WU). (c) The pulmonary capillary wedge pressure or left ventricular end-diastolic pressure is 15 mm Hg or less. Pulmonary Hypertension Associated with Interstitial Lung Disease (PH-ILD) (Initial): (1) Diagnosis of pulmonary hypertension associated with interstitial lung disease (PHILD) WHO Group 3. (2) Diagnosis confirmed by diagnostic test(s) (e.g. right heart catheterization, doppler echocardiogram, computerized tomography imaging).
Age Restrictions	
Prescriber Restrictions	(PAH)(PH-ILD): Prescribed by or in consultation with a Cardiologist or Pulmonologist
Coverage Duration	(Initial): 6 months. (Continuation): 12 months.
Other Criteria	(PAH)(PH-ILD)(CONTINUATION): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ubrelvy 2026

Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

veozah 2026

Products Affected

- VEOZAH

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(VMS)(Initial): (1) Diagnosis of moderate to severe vasomotor symptoms due to menopause (2) Inadequate response or inability to tolerate one of the following (a) menopausal hormone therapy (e.g. estradiol tablets) (b) non-hormonal therapy (e.g. paroxetine, venlafaxine, clonidine, etc.) (3) ONE of the following: (a) Aminotransferase is does not exceed 2 x the upper limit of normal (ULN) (b) The total bilirubin does not exceed 2 x the upper limit of normal (ULN) for the evaluating laboratory.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	(VMS)(Initial): 6 months, (Reauth): 12 months
Other Criteria	(VMS)(Reauth): (1) Documentation of positive clinical response to therapy (e.g. decrease in frequency and severity of vasomotor symptoms from baseline, etc.) (2) Member is not experiencing signs or symptoms that may suggest liver injury (new onset fatigue, decreased appetite, nausea, vomiting, pruritus, jaundice, pale feces, dark urine, or abdominal pain) (3) One of the following: (i) Transaminase elevations does not exceed 5 x the upper limit of normal (ULN), OR (ii) Does not exceed 3 x the ULN and the total bilirubin level does not exceed 2 x ULN.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

verquvo 2026

Products Affected

- VERQUVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chronic Heart Failure (CHF) (Initial): (1) Diagnosis of chronic heart failure. (2) Member has New York Heart Association (NYHA) Class II, III, or IV symptoms (3) Ejection fraction less than 45 percent (4) One of the following: (a) Member was hospitalized for heart failure within the last 6 months (b) Member used outpatient intravenous diuretics (e.g., bumetanide, furosemide) for heart failure within the last 3 months (5) Inadequate response or inability to tolerate TWO of the following: (a) Angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril) (b) Angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan) (c) Angiotensin receptor-neprilysin inhibitor (ARNI) [e.g., Entresto (sacubitril and valsartan)] (d) Beta blocker (e.g. bisoprolol, carvedilol, metoprolol succinate ER) (e) Sodium-glucose co-transporter 2 (SGLT2) inhibitor [e.g., Jardiance (empagliflozin), Farxiga (dapagliflozin), Xigduo XR (dapagliflozin and metformin)] (f) Mineralocorticoid receptor antagonist (MRA) [e.g., eplerenone, spironolactone]
Age Restrictions	
Prescriber Restrictions	(CHF) (Initial): Prescribed by or in consultation with a Cardiologist
Coverage Duration	12 months
Other Criteria	(CHF) (Cont): Documentation of positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

vigafyde solution 2026

Products Affected

- VIGAFYDE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Infantile spasm: (1) Diagnosis of infantile spasm (2) Inadequate response or inability to tolerate Vigpoder or Vigabatrin powder for oral solution
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with neurologist/epilepsy specialist
Coverage Duration	Indefinite
Other Criteria	(All Indications): Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

voquezna tablets 2026

Products Affected

- VOQUEZNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(H. pylori): (1) Diagnosis of Helicobacter pylori infection (2) One of the following: (a) Used in combination with amoxicillin and clarithromycin for the treatment of H. pylori infection OR (b) Used in combination with amoxicillin for the treatment of H. pylori infection (3) An inadequate response or inability to tolerate ONE of the following: (a) Clarithromycin based therapy (e.g. clarithromycin based triple therapy, clarithromycin based concomitant therapy) OR (b) Bismuth quadruple therapy (e.g. bismuth and metronidazole and tetracycline and proton pump inhibitor [PPI]). Erosive Esophagitis (EE): (1) ONE of the following: (a) Used for healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis OR (b) Used to maintain healing and relief of heartburn associated with erosive esophagitis (2) An inadequate response or inability to tolerate TWO of the following generic proton pump inhibitors (PPI¿s): omeprazole, esomeprazole, pantoprazole, lansoprazole, rabeprazole, and dexlansoprazole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	H. pylori: 1 month Healing of EE: 8 weeks. Maintenance of EE: 6 month GERD: 1 month
Other Criteria	Heartburn with GERD: (1) Diagnosis of non-erosive Gastroesophageal Reflux Disease (GERD) (2) BOTH of the following: (a) Member has history of heartburn for at least 6 months (b) Heartburn symptoms are present for at least 4 days during any consecutive 7-day period (3) An inadequate response (minimum 8-week supply) or inability to tolerate TWO of the following generic proton pump inhibitors (PPI¿s): omeprazole, esomeprazole, pantoprazole, lansoprazole, rabeprazole, and dexlansoprazole.
Indications	All Medically-accepted Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

vowst 2026

Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prevention of the recurrence of Clostridioides difficile infection (PCDI): (1) Diagnosis of recurrent Clostridioides difficile infection as defined by both of the following: (a) Presence of diarrhea defined as passage of 3 or more loose bowel movements within a 24-hour period for at least 2 consecutive days (b) a positive stool test for C. difficile toxin or toxigenic C. difficile (2) Member has a history of two or more recurrent episodes of CDI within 12 months (3) Member has completed at least 10 consecutive days of one of the following antibiotic therapies 2-4 days prior to initiating Vowst: (a) oral vancomycin (b) Dificid (fidaxomicin) (4) Member has completed the recommended bowel prep (e.g. 296mL of magnesium citrate) the day before and at least 8 hours prior to initiating Vowst (5) Previous episode of CDI is under control (e.g. less than 3 unformed or loose [i.e., Bristol Stool Scale type 6-7] stools per day for at least 2 consecutive days)
Age Restrictions	(PCDI): Member is 18 years of age or older
Prescriber Restrictions	(PCDI): Prescribed by or in consultation with gastroenterologist or infectious disease specialist
Coverage Duration	(PCDI): 14 days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

vraylar 2026

Products Affected

- VRAYLAR ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Bipolar I disorder (BD): (1) Diagnosis of bipolar I disorder (2) Inadequate response or inability to tolerate TWO of the following: aripiprazole, quetiapine, asenapine, olanzapine, paliperidone, risperidone, ziprasidone. Schizophrenia: (1) Diagnosis of schizophrenia (2) Inadequate response or inability to tolerate TWO of the following: aripiprazole, quetiapine, asenapine, olanzapine, paliperidone, risperidone, ziprasidone. Major Depressive Disorder (MDD): (1) Diagnosis of major depressive disorder and as adjunctive therapy to antidepressants (2) Inadequate response or inability to tolerate aripiprazole and quetiapine
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	(All Indications): Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

wainua 2026

Products Affected

- WAINUA

PA Criteria	Criteria Details
Exclusion Criteria	(1) A history of liver transplant or is likely to be a candidate and (2) used in combination with any other RNA interference agents or transthyretin stabilizers
Required Medical Information	(hATTR amyloidosis)(Initial): (1) Submission of medical records (e.g. chart notes) confirming diagnosis of hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) with polyneuropathy (2) Member has a transthyretin (TTR) mutation (e.g., V30M) (3) One of the following: (a) Member has a baseline familial amyloidotic polyneuropathy (FAP) stage of 1 or 2 (b) member has a baseline neuropathy impairment score (NIS) greater than or equal to 10 and less than or equal to 130 (c) Member has a baseline Karnofsky Performance Status score greater than 50 percent (4) Presence of clinical signs and symptoms of the disease (e.g., neuropathy)
Age Restrictions	
Prescriber Restrictions	(hATTR amyloidosis): Prescribed by or in consultation with a neurologist, geneticist, or professional provider specializing in the treatment of amyloidosis
Coverage Duration	12 months
Other Criteria	(hATTR amyloidosis)(Cont): (1) Member demonstrates positive clinical response to therapy (2) One of the following: (a) Member continues to have a baseline familial amyloidotic polyneuropathy (FAP) stage of 1 or 2 (b) member continues to have a baseline neuropathy impairment score (NIS) greater than or equal to 10 and less than or equal to 130 (c) Member continues to have a baseline Karnofsky Performance Status score greater than 50 percent
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

wilsons disease 2026

Products Affected

- *trientine hcl oral capsule 500 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Wilson¿s disease (WD)(initial): (1) Diagnosis of Wilson¿s disease (i.e., hepatolenticular degeneration) (2) Inadequate response or inability to tolerate a penicillamine product
Age Restrictions	
Prescriber Restrictions	(WD): Prescribed by or in consultation with gastroenterologist, hepatologist, or liver transplant specialist.
Coverage Duration	12 months
Other Criteria	(WD) (Reauth): (1) Member demonstrates positive clinical response to therapy (e.g., reduction in 24-hour urinary copper excretion levels from baseline)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

xdemvy 2026

Products Affected

- XDEMVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of treatment of demodex blepharitis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist
Coverage Duration	6 weeks
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

xeljanz 2026

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

xermelo 2026

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Carcinoid Syndrome Diarrhea (CSD)(Initial): (1) Diagnosis of carcinoid syndrome diarrhea, (2) Diarrhea is inadequately controlled by a stable dose of somatostatin analog (SSA) therapy (e.g. octreotide [Sandostatin, Sandostatin LAR], lanreotide [Somatuline Depot]) for at least 3 months, (3) Used in combination with SSA therapy
Age Restrictions	(CSD): Member is 18 years of age or older
Prescriber Restrictions	(CSD): Prescribed by or in consultation with an Oncologist, Endocrinologist, or Gastroenterologist
Coverage Duration	(Initial): 12 months (Reauth): Indefinite
Other Criteria	(CSD)(Reauth): (1) Positive clinical response to Xermelo therapy, (2) Xermelo will continue to be used in combination with SSA therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

xgeva 2026

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	No

xifaxan 550mg 2026

Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prophylaxis for Hepatic Encephalopathy (HE): (1) Diagnosis of hepatic disease with risk for hepatic encephalopathy (i.e. previous episode of hepatic encephalopathy, advanced liver disease, hepatocellular carcinoma), (2) Inadequate response or inability to tolerate lactulose. Irritable Bowel Syndrome (IBS): (1) Diagnosis of irritable bowels syndrome- diarrhea, (2) Inadequate response or inability to tolerate BOTH of the following: (A) ONE of the following: (i) ONE Tricyclic antidepressant or (ii)selective serotonin reuptake inhibitor and (B) dicyclomine (3): BOTH of the following: (A) Member does not exceed 3 total courses (42 days in total) of therapy, (B) Member experiences irritable bowel syndrome with diarrhea (IBS-D) symptoms. Small Bowel Bacterial Overgrowth (SBBO)/Small Intestinal Bacterial Overgrowth (SIBO) (Initial): (1) Diagnosis of Small Bowel Bacterial Overgrowth (SBBO)/Small Intestinal Bacterial Overgrowth (SIBO).
Age Restrictions	
Prescriber Restrictions	:
Coverage Duration	(HE): Indefinite. (IBS): 2 weeks. (SBBO/SIBO): Initial and Reauth: 2 weeks.
Other Criteria	(SBBO/SIBO) (Reauth): (1) Documentation of Small Bowel Bacterial Overgrowth (SBBO)/Small Intestinal Bacterial Overgrowth (SIBO) recurrence following successful initial treatment
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

xolair 2026

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent therapy with any other biologic agents for asthma/allergic conditions (e.g., benralizumab [Fasenra], dupilumab [Dupixent], mepolizumab [Nucala])
Required Medical Information	Part D is medically necessary for: Moderate to Severe Persistent Allergic Asthma (PAA)(Initial): (1) Diagnosis of moderate to severe persistent allergic asthma (2) The individual has a positive skin test or in vitro reactivity to a perennial aeroallergen, (3) The individual has a baseline serum IgE level of between 30 IU/mL and 1300 IU/mL, (4) Inadequate response or inability to tolerate a combination of high-dose inhaled corticosteroids (ICS) with a long-acting beta-agonist (LABA). Chronic Urticaria (CU)(Initial): (1) Diagnosis of chronic urticaria (2) an inadequate response, contraindication or inability to tolerate ONE second-generation H1 antihistamine at the maximally tolerated dose in addition to ANY of the following: (a) leukotriene receptor antagonist (e.g. montelukast) (b) histamine H2-receptor antagonist (e.g. ranitidine, cimetidine, famotidine), (c) substituting to a different second- generation antihistamine, (d) systemic glucocorticosteroids or (e) cyclosporine, (3) will be used concurrently with an h1 antihistamine, unless there is contraindication or intolerance to H1 antihistamines. Nasal Polyps (NP)(Initial): (1) Diagnosis of nasal polyps. (2) Member will use concurrently with nasal corticosteroid. (3) Member had inadequate response or inability to tolerate an intranasal corticosteroid. (4) Member has a baseline serum IgE level of between 30 IU/mL and 1500 IU/mL
Age Restrictions	
Prescriber Restrictions	(PAA): Prescribed by or in consultation with an Allergist, Immunologist, or Pulmonologist. (CU):Prescribed by or in consultation with allergist/immunologist, dermatologist. (NP): Prescribed by or in consultation with an allergist, immunologist, pulmonologist, or ENT specialist. (IMFA): Prescribed by or in consultation with an Allergist or Immunologist
Coverage Duration	12 months.

PA Criteria	Criteria Details
Other Criteria	Subject to Part B vs Part D review. IgE-Mediated Food Allergy (IMFA) (initial): (1) One of the following: (A) Both of the following (i) Diagnosis of IgE-Mediated Food Allergy (ii) Clinical history of IgE Mediated Food Allergy (B) Documentation that the member has a history of severe allergic response, including anaphylaxis, following exposure to one or more foods (2) Used in conjunction with food allergen avoidance (3) Both of the following (A) Baseline (pre- Xolair treatment) serum total IgE level is greater than or equal to 30 IU/mL and less than or equal to 1850 IU/mL (B) Dosing is according to serum total IgE levels and body weight (PAA)(Reauth): (1) Documentation of positive clinical response to therapy (e.g., reduction in number of asthma exacerbations, improvement in forced expiratory volume in 1 second (FEV1), or decreased use of rescue medications). (CU)(Reauth): (1) Member's disease status has been re- evaluated since the last authorization to confirm the member's condition warrants continued treatment (2) member has experienced one or both of the following:(a) Reduction in itching severity from baseline (b) Reduction in number of hives from baseline. (NP)(Reauth): (1) Documentation of positive clinical response to therapy (e.g., reduction in nasal polyps score [NPS: 0-8 scale], improvement in nasal congestion/obstruction score [NCS: 0-3 scale]) (2) Used in combination with another agent for nasal polyps. (IMFA)(Reauth) (1) Documentation of positive clinical response to therapy (2) Used in conjunction with food allergen avoidance. (3) Dosing will continue to be based on body weight and pretreatment total IgE serum levels
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

xyrem 2026

Products Affected

- XYREM

PA Criteria	Criteria Details
Exclusion Criteria	CN, EDSN: Concurrent use of sedative hypnotics and alcohol
Required Medical Information	Cataplexy in Narcolepsy (CN)(Initial): (1) Diagnosis of cataplexy with narcolepsy, (2) Diagnosis Confirmed by Polysomnography (PSG) or Multiple sleep latency test (MSLT) or prescriber provides justification that a sleep study is not feasible. Excessive Daytime Sleepiness in Narcolepsy (EDSN)(Initial): (1) Diagnosis of EDSN (Narcolepsy Type 2), (2) Diagnosis Confirmed by Polysomnography (PSG) or Multiple sleep latency test (MSLT) or prescriber provides justification that a sleep study is not feasible and (3) Inadequate response or inability to tolerate modafinil or armodafinil. (adult use only)
Age Restrictions	
Prescriber Restrictions	(CN, EDSN): Prescribed by or in consultation with a neurologist, psychiatrist, or sleep specialist.
Coverage Duration	12 months
Other Criteria	(CN, EDSN)(Reauth): (1) Documentation to support the efficacy associated with the current regimen (including but not limited to reduction in the frequency of cataplexy attacks or an improvement in the Epworth sleepiness scale), (2) Member is re-evaluated every 12 months.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

xywav 2026

Products Affected

- XYWAV

PA Criteria	Criteria Details
Exclusion Criteria	CN, EDSN: Concurrent use of sedative hypnotics and alcohol
Required Medical Information	Cataplexy in Narcolepsy (CN)(Initial): (1) Diagnosis of cataplexy with narcolepsy. Excessive Daytime Sleepiness in Narcolepsy (EDSN)(Initial): (1) Diagnosis of EDSN (Narcolepsy Type 2), (2) Inadequate response or inability to modafinil. Idiopathic Hypersomnia (IH) (Initial): (1) Diagnosis of Idiopathic Hypersomnia as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), (2) Symptoms of excessive daytime sleepiness (e.g. nap duration of longer than 60 minutes) are present
Age Restrictions	
Prescriber Restrictions	(CN, EDSN, IH): Prescribed by or in consultation with a neurologist, psychiatrist, or sleep specialist.
Coverage Duration	12 months
Other Criteria	(CN, EDSN)(Reauth): (1) Documentation to support the efficacy associated with the current regimen (including but not limited to reduction in the frequency of cataplexy attacks or an improvement in the Epworth sleepiness scale), (2) Member is re-evaluated every 12 months. (IH) (Reauth): (1) Documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

zavesca 2026

Products Affected

- *miglustat*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Type 1 Gaucher's Disease (T1GD)(Initial): (1) Diagnosis of mild to moderate T1GD, (2) enzyme replacement therapy is not a therapeutic option (e.g. because of allergy, hypersensitivity, or poor venous access).
Age Restrictions	(T1GD): Member is 18 years of age or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	(T1GD)(Reauth): Documentation of positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ztalmy 2026

Products Affected

- ZTALMY

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

zurzuvae 2026

Products Affected

- ZURZUVAE

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Index

abiraterone acetate 110
ABIRTEGA 110
adalimumab-aacf (2 pen) 5
adalimumab-aacf (2 syringe) 5
adalimumab-aacf(cd/uc/hs strt) 5
adalimumab-aacf(ps/uv starter) 5
adapalene external gel 0.3 % 157
ADBRY 6
ADEMPAS 7
AIMOVIG 8
AKEEGA 110
ALECENSA 110
ALUNBRIG 110
ambrisentan 10
AMPYRA 11
ARIKAYCE 13
armodafinil 14
AUGTYRO 110
AUSTEDO 16
AUSTEDO XR 16
AUVELITY 17
AVMAPKI FAKZYNJA CO-PACK 110
AYVAKIT 110
BALVERSA 110
BENLYSTA SUBCUTANEOUS 18
BERINERT 3
BESREMI 93
bexarotene 110, 156
BONSITY 151
bosentan oral tablet 19
BOSULIF ORAL CAPSULE 50 MG 110
BOSULIF ORAL TABLET 110
BRAFTOVI ORAL CAPSULE 75 MG 110
BRUKINSA ORAL CAPSULE 21
butalbital-acetaminophen oral tablet 50-325 mg 65
butalbital-apap-caffeine oral capsule 65
butalbital-apap-caffeine oral tablet 50-325-40 mg 65
butalbital-aspirin-caffeine oral capsule 65
CABOMETYX 110
CALQUENCE ORAL TABLET 110
CAPLYTA 22
CAPRELSA 110
carisoprodol oral 70
CAYSTON 23
chlordiazepoxide-clidinium 12
CHOLBAM 24
CIBINQO 25
CIMZIA (2 SYRINGE) 26
CIMZIA SUBCUTANEOUS KIT 2 X 200 MG 26
CLIMARA PRO 67
COBENFY 28
COBENFY STARTER PACK 28
COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG 110
COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG 110
COMETRIQ (60 MG DAILY DOSE) 110
COPIKTRA 110
CORLANOR ORAL SOLUTION 29
COSENTYX (300 MG DOSE) 30
COSENTYX SENSOREADY (300 MG) 30
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML 30
COSENTYX UNOREADY 30
COTELLIC 110
CRENESSITY ORAL CAPSULE 100 MG, 50 MG 31
CRENESSITY ORAL SOLUTION 31
CRESEMBA ORAL 32
cyclobenzaprine hcl er oral capsule extended release 24 hour 15 mg 66
cyclobenzaprine hcl oral 66
dalfampridine er 33
DANZITEN 110
dasatinib 110
DAURISMO 110
deferasirox oral tablet 34
deferasirox oral tablet soluble 34
deferiprone 54
deflazacort oral tablet 35
DIACOMIT 36
diclofenac epolamine external 38
dipyridamole oral 65
DOPTELET ORAL TABLET 20 MG 39
DOTTI 67
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML 40
eltrombopag olamine 127

EMGALITY 41
EMGALITY (300 MG DOSE) 41
EMSAM 42
ENBREL MINI 43
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML 43
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 43
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 43
ENDARI 44
ENTYVIO PEN 45
EPCLUSA 124
EPIDIOLEX 47
ERIVEDGE 110
ERLEADA 110
erlotinib hcl 110
estradiol transdermal patch twice weekly 67
estradiol transdermal patch weekly 67
eszopiclone oral tablet 3 mg 69
EUCRISA 49
EVENITY 50
everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg 110
everolimus oral tablet soluble 110
exenatide 94
EYSUVIS 52
FASENRA 53
FASENRA PEN 53
fentanyl transdermal patch 72 hour 100 mcg/hr, 25 mcg/hr, 37.5 mcg/hr, 50 mcg/hr, 75 mcg/hr 64
FERRIPROX ORAL TABLET 1000 MG 54
FERRIPROX TWICE-A-DAY 54
FINTEPLA 55
FIRAZYR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 3
FORTEO SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML 151
FOTIVDA 110
FRUZAQLA 110
GALAFOLD 56
GAMMAGARD INJECTION SOLUTION 2.5 GM/25ML 76
GAMMAGARD S/D LESS IGA 76
GAMMAKED INJECTION SOLUTION 1 GM/10ML 76
GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 5 GM/50ML 76
GAMUNEX-C INJECTION SOLUTION 1 GM/10ML 76
GATTEX 57
GAVRETO 110
gefitinib 110
GENOTROPIN SUBCUTANEOUS CARTRIDGE 61
GILOTRIF 110
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG 110
GOCOVRI 60
GOMEKLI 110
GRASTEK 9
HAEGARDA 63
HARVONI 124
HUMATROPE INJECTION CARTRIDGE 61
IBRANCE 110
ICLUSIG 110
IDHIFA 110
ILUMYA 71
imatinib mesylate oral 110
IMBRUVICA ORAL CAPSULE 110
IMBRUVICA ORAL SUSPENSION 110
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG 110
imkeldi 110
INBRIJA 72
INCRELEX 73
INLYTA 110
INQOVI 110
INREBIC 110
INTRAROSA 118
ITOVEBI 110
ivabradine hcl 78
IWILFIN 110
JAKAFI 110
JATENZO 152
JAYPIRCA 110
JINTELI 67
JUBBONTI 122
JUBLIA 108
JYNARQUE ORAL TABLET 79
KALYDECO 80
KERENDIA ORAL TABLET 10 MG, 20 MG 81
ketorolac tromethamine oral 68

KEVZARA 82
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 84
KISQALI (200 MG DOSE) 110
KISQALI (400 MG DOSE) 110
KISQALI (600 MG DOSE) 110
KLISYRI (250 MG) 85
KOSELUGO 110
KRAZATI 110
lapatinib ditosylate 110
LAZCLUZE 110
lenalidomide 110
LENVIMA (10 MG DAILY DOSE) 110
LENVIMA (12 MG DAILY DOSE) 110
LENVIMA (14 MG DAILY DOSE) 110
LENVIMA (18 MG DAILY DOSE) 110
LENVIMA (20 MG DAILY DOSE) 110
LENVIMA (24 MG DAILY DOSE) 110
LENVIMA (4 MG DAILY DOSE) 110
LENVIMA (8 MG DAILY DOSE) 110
LETAIRIS 87
l-glutamine oral packet 44
lidocaine external patch 5 % 58
liraglutide 123
LIVTENCITY 88
LONSURF 110
LORBRENA 110
LUMAKRAS 110
LYBALVI 20
LYNPARZA ORAL TABLET 110
LYTGOBI (12 MG DAILY DOSE) 110
LYTGOBI (16 MG DAILY DOSE) 110
LYTGOBI (20 MG DAILY DOSE) 110
MAVYRET 124
MEKINIST 110
MEKTOVI 110
MENOSTAR 67
metaxalone oral tablet 400 mg, 800 mg 65
metformin hcl er (mod) 51
methadone hcl oral tablet 64
mifepristone oral tablet 300 mg 86
miglustat 185
modafinil oral 89
morphine sulfate er oral tablet extended release 100 mg, 60 mg 64
MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 123
NAYZILAM 4
NERLYNX 110
NEXLETOL 91
NEXLIZET 91
nilotinib hcl 110
NINLARO 110
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 61
NOURIANZ 98
NUBEQA 110
NUCALA 100
NUEDEXTA 101
NUPLAZID ORAL CAPSULE 102
NUPLAZID ORAL TABLET 10 MG 102
NURTEC 103
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR 61
NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR 61
NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR 61
OCALIVA 104
OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 2 GM/20ML 76
octreotide acetate injection solution 100 mcg/ml 105
ODACTRA 9
ODOMZO 110
OFEV 106
OGSIVEO 110
OJEMDA ORAL SUSPENSION RECONSTITUTED 110
OJEMDA ORAL TABLET 100 MG 110
OJJAARA 110
OLUMIANT 107
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML 61
ONUREG 110
OPIPZA 109
OPSUMIT 113
ORENCIA CLICKJECT 114
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 114
ORGOVYX 110
ORKAMBI 115
ORMALVI 37
ORSERDU 110

OSPHENA 118
OTEZLA 116
OXERVATE 117
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML 123
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML 123
OZEMPIC (2 MG/DOSE) 123
pazopanib hcl 110
PEMAZYRE 110
PIQRAY (200 MG DAILY DOSE) 110
PIQRAY (250 MG DAILY DOSE) 110
PIQRAY (300 MG DAILY DOSE) 110
pirfenidone 48
POMALYST 110
posaconazole oral tablet delayed release 99
PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120
PREMARIN ORAL 67
PRIVIGEN INTRAVENOUS SOLUTION 20 GM/200ML 76
PROLASTIN-C INTRAVENOUS SOLUTION 134
PROMACTA 127
promethazine hcl oral solution 6.25 mg/5ml 65
promethazine hcl oral tablet 12
QBREXZA 129
QINLOCK 110
quinine sulfate oral 130
RADICAVA ORS STARTER KIT 131
RALDESY 132
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML, 12.5 MG/0.25ML, 15 MG/0.3ML, 17.5 MG/0.35ML, 20 MG/0.4ML, 22.5 MG/0.45ML, 25 MG/0.5ML, 30 MG/0.6ML, 7.5 MG/0.15ML 75
REPATHA 133
REPATHA PUSHTRONEX SYSTEM 133
REPATHA SURECLICK 133
RETEVMO ORAL TABLET 110
REVUFORJ 110
REXULTI 135
REZDIFFRA 136
REZLIDHIA 110
REZUROCK 137
RINVOQ 138
RINVOQ LQ 139
ROMVIMZA 110
ROZLYTREK 110
RUBRACA 110
RYBELSUS 123
RYDAPT 110
SCEMBLIX 110
SIGNIFOR 140
sildenafil citrate oral suspension reconstituted 141
sildenafil citrate oral tablet 20 mg 141
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 142
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 142
SIRTURO 144
SKYRIZI PEN 145
SKYRIZI SUBCUTANEOUS 145
sodium phenylbutyrate oral tablet 59
sofosbuvir-velpatasvir 124
sorafenib tosylate 110
SPRYCEL 110
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML 96
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 96
STIVARGA 110
sunitinib malate 110
TABRECTA 110
tadalafil (pah) 119
tadalafil oral tablet 2.5 mg, 5 mg 147
TAFINLAR 110
TAGRISSO 110
TALTZ 148
TALZENNA 110
TASIGNA 110
tavaborole 108
TAVNEOS 150
TAZVERIK 110
TEPMETKO 110
teriparatide subcutaneous solution pen-injector 560 mcg/2.24ml 151
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml 152
testosterone enanthate intramuscular solution 152
testosterone transdermal gel 10 mg/act (2%), 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%) 152

testosterone transdermal solution 152
tetrabenazine 154
THALOMID ORAL CAPSULE 100 MG, 50 MG ... 110
TIBSOVO 110
TOBI PODHALER 74
tolvaptan oral tablet 155
TRACLEER 158
TRELSTAR MIXJECT 93
TREMFYA CROHNS INDUCTION 159
TREMFYA ONE-PRESS 159
TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML 159
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 159
tretinoin external 157
trientine hcl oral capsule 500 mg 175
TRIKAFTA 161
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 123
TRUQAP ORAL TABLET 200 MG 110
TUKYSA 110
TURALIO ORAL CAPSULE 125 MG 110
TYENNE SUBCUTANEOUS 125
TYMLOS 162
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG 164
TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG 164
UBRELVY 165
ustekinumab subcutaneous 96
VALCHLOR 156
VALTOCO 10 MG DOSE 4
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 2 X 7.5 MG/0.1ML 4
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 2 X 10 MG/0.1ML 4
VALTOCO 5 MG DOSE 4
VANFLYTA 110
VENCLEXTA 110
VENCLEXTA STARTING PACK 110
VEOZAH 166
VERQUVO 167
VERZENIO 110
VIGAFYDE 168
VITRAKVI 110
VIZIMPRO 110
VONJO 110
VOQUEZNA 169
VORANIGO 110
voriconazole intravenous 118
VOSEVI 95
VOTRIENT 110
VOWST 171
VRAYLAR ORAL CAPSULE 172
WAINUA 173
WELIREG 110
WINREVAIR 146
XALKORI 110
XDEMVY 176
XELJANZ 177
XELJANZ XR 177
XERMELO 178
XGEVA 179
XIFAXAN ORAL TABLET 550 MG 180
XOLAIR 181
XOSPATA 110
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG 110
XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG 110
XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 40 MG 110
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 60 MG 110
XPOVIO (60 MG TWICE WEEKLY) 110
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 40 MG 110
XPOVIO (80 MG TWICE WEEKLY) 110
XTANDI 110
XYOSTED 152
XYREM 183
XYWAV 184
YESINTEK SUBCUTANEOUS 126
YONSA 110
ZEJULA ORAL TABLET 110
ZELBORAF 110
ZOLINZA 110
zolpidem tartrate oral tablet 10 mg 69
ZTALMY 186
ZURZUVAE 187
ZYDELIG 110
ZYKADIA ORAL TABLET 110