



**Keystone 65 Rx HMO  
Personal Choice 65<sup>SM</sup> Rx PPO  
Select Option<sup>®</sup> Rx PDP  
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 **3/24/2026**. For more recent information or other questions, please contact our Member Help Team: Keystone 65 Rx at **1-844-352-1699**, Personal Choice 65 Rx at **1-888-879-4293**, Select Option Rx at **1-888-678-7009** 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](http://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, Personal Choice 65 Rx, and Select Option 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 Rx, Personal Choice 65 Rx, and Select Option Rx Formulary (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](http://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 Rx, Personal Choice 65 Rx, and Select Option Rx 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 205. 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 **1-844-352-1699**, Personal Choice 65 Rx at **1-888-879-4293**, or Select Option Rx at **1-888-678-7009** or, for TTY/TDD users, **711**.

# ACUTE HAE AGENTS 2026

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## Products Affected

- BERINERT *syringe*
- FIRAZYR SUBCUTANEOUS SOLUTION  
PREFILLED SYRINGE
- *icatibant acetate subcutaneous solution prefilled*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Hereditary Angioedema (HAE): (1) Used for the treatment of acute attacks of HAE.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(HAE): Prescribed by or in consultation with an allergist, pulmonologist, or immunologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# ACUTE SEIZURE ACTIVITY AGENTS 2026

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## 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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescriber is a neurologist/epilepsy specialist
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	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
<b>Exclusion Criteria</b>	(RA, AS, JIA, PsA, PsO, CD, UC, HS, UV): Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
<b>Required Medical Information</b>	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). Ankylosing Spondylitis (AS)(Initial): (1) Diagnosis of AS. (2) Inadequate response or inability to tolerate one other treatment such as NSAIDs, COX2 inhibitors or methotrexate. Juvenile Idiopathic Arthritis (JIA)(Initial): (1) Diagnosis of moderate to severe JIA. (2) Inadequate response or inability to tolerate one of the following: methotrexate, leflunomide, sulfasalazine. Psoriatic Arthritis (PsA): (1) Diagnosis of PsA. Plaque Psoriasis (PsO): (1) Diagnosis of moderate to severe chronic PsO.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(RA, JIA, AS): Prescribed by or in consultation with a rheumatologist. (PsA): Prescribed by or in consultation with a dermatologist or rheumatologist. (PsO, HS): Prescribed by or in consultation with a dermatologist. (CD, UC): Prescribed by or in consultation with a gastroenterologist. (UV): Prescribed by or in consultation with a rheumatologist or ophthalmologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Crohn's Disease (CD) (Initial): (1) Diagnosis of CD. Ulcerative Colitis (UC) (Initial): (1) Diagnosis of UC. Hidradenitis Suppurativa (HS) (Initial): (1) Diagnosis of HS. Uveitis (UV): (1) Diagnosis of non-infectious intermediate, posterior, or pan- uveitis. (2) Inadequate response or inability to tolerate corticosteroids and at least one immunosuppressive drug (e.g. azathioprine, cyclosporine, methotrexate, mycophenolate). (RA, JIA, AS, PsA, PsO, HS, CD, UC, UV)(Reauth): Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.

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

# ADBRY 2026

## Products Affected

- ADBRY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 pimecrolimus cream
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(AD): Prescribed by or in consultation with a dermatologist, allergist, immunologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(AD)(Reauth): Member has had a positive clinical response to therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# ADEMPAS 2026

## Products Affected

- ADEMPAS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(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)
<b>Required Medical Information</b>	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). 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.
<b>Age Restrictions</b>	(PAH, CTEPH) Member is 18 years of age or older
<b>Prescriber Restrictions</b>	(PAH, CTEPH): Prescribed by or in consultation with a pulmonologist or cardiologist
<b>Coverage Duration</b>	(Initial): 6 months (Reauth):12 months
<b>Other Criteria</b>	(PAH, CPTEH) (Reauth): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# AIMOVIG 2026

## Products Affected

- AIMOVIG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use with another CGRP inhibitor for the preventative treatment of migraines.
<b>Required Medical Information</b>	Migraines (Initial): Approved when ONE of the following inclusion criteria are met: (1) Diagnosis of episodic migraines defined as 4 to 14 headache days per month OR (2) Diagnosis of chronic migraines defined as greater than or equal to 15 headache days per month.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist, headache specialist certified by the United Council for Neurologic Subspecialties, or pain specialist
<b>Coverage Duration</b>	(Initial): 6 months (Reauth): 12 months
<b>Other Criteria</b>	(Migraines)(Reauth): (1) Response to therapy as defined by a reduction in headache days per month (defined as at least 4 hours duration and moderate intensity).
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# ALLERGEN SPECIFIC IMMUNOTHERAPY (SL) 2026

## Products Affected

- GRASTEK
- ODACTRA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(1) Severe, unstable or uncontrolled asthma (2) History of eosinophilic esophagitis
<b>Required Medical Information</b>	(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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an allergist or immunologist.
<b>Coverage Duration</b>	Remainder of contract year
<b>Other Criteria</b>	(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
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# AMBRISENTAN 2026

## Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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). The pulmonary capillary wedge pressure or left ventricular end-diastolic pressure is 15 mm Hg or less.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PAH): Prescribed by or in consultation with a Cardiologist or Pulmonologist.
<b>Coverage Duration</b>	(Initial): 6 months. (Continuation):12 months.
<b>Other Criteria</b>	(PAH)(Continuation): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# AMPYRA 2026

## Products Affected

- AMPYRA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(Initial): Member has history of seizure or moderate to severe renal impairment (CrCL less than or equal to 50 mL/min)
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(MS): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Remainder of contract year
<b>Other Criteria</b>	(MS) (Reauth): Documentation of positive clinical response as evidenced by improvement in walking speed
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# ANTICHOLINERGIC HRM 2026

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## Products Affected

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

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

# ARIKAYCE 2026

## Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(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
<b>Age Restrictions</b>	Member is 18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or an infectious disease specialist
<b>Coverage Duration</b>	Remainder of contract year
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# ARMODAFINIL 2026

## Products Affected

- *armodafinil*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>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</p> <p>Narcolepsy (Initial): (1) Diagnosis of narcolepsy as confirmed by sleep study (unless prescriber provides justification confirming a sleep study is not feasible)</p> <p>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</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or sleep specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(OSA, Narcolepsy, SWD)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	

PA Criteria	Criteria Details
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# AUSTEDO 2026

## Products Affected

- AUSTEDO
- AUSTEDO XR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(CHD): Prescribed by or in consultation with a neurologist or a psychiatrist. (TD): Prescribed by or in consultation with a neurologist or a psychiatrist.
<b>Coverage Duration</b>	(TD)(Initial): 3 months. (TD)(Reauth): Indefinite. (CHD): Indefinite.
<b>Other Criteria</b>	(TD)(Reauth): Positive clinical response to therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# AUVELITY 2026

## Products Affected

- AUVELITY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# BENLYSTA SC 2026

## Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Member has severe active central nervous system lupus
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(SLE): Prescribed by or in consultation with a rheumatologist. (LN): Prescribed by or in consultation with a nephrologist or rheumatologist.
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	(SLE, LN)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# BOSENTAN 2026

## Products Affected

- *bosentan*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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). The pulmonary capillary wedge pressure or left ventricular end-diastolic pressure is 15 mm Hg or less.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PAH): Prescribed by or in consultation with a Cardiologist or Pulmonologist
<b>Coverage Duration</b>	(Initial): 6 months. (Continuation):12 months.
<b>Other Criteria</b>	(PAH)(Continuation): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# BRAND ANTIPSYCHOTICS ACH 2026

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## 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 TABLET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 (7) Inadequate response or inability to tolerate Calquence.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# CAPLYTA 2026

## Products Affected

- CAPLYTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# CAYSTON 2026

## Products Affected

- CAYSTON

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	(CF): Member is 7 years of age or older
<b>Prescriber Restrictions</b>	(CF): Prescribed by or in consultation with a pulmonologist OR infectious disease specialist or Specialist affiliated with a CF care center.
<b>Coverage Duration</b>	Remainder of contract year
<b>Other Criteria</b>	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)
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# CHOLBAM 2026

## Products Affected

- CHOLBAM

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(BASD, PD): Extrahepatic manifestations of bile acid synthesis disorders due to single enzyme defects or peroxisomal disorders including Zellweger spectrum disorders
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(BASD, PD): Hepatologist, Gastroenterologist, Medical geneticist, other specialist that treats inborn errors of metabolism
<b>Coverage Duration</b>	(Initial): 3 months. (Reauth): Indefinite
<b>Other Criteria</b>	(BASD,PD) (Reauth): Documentation of improved liver function tests from the start of treatment.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# CIBINQO 2026

## Products Affected

- CIBINQO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(AD): Concurrent use with any other biologic immunomodulator, Janus Kinase (JAK) inhibitors, or other immunosuppressants (e.g. azathioprine, cyclosporine)
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(AD): Prescribed by or in consultation with a dermatologist, allergist, immunologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(AD)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# CIMZIA 2026

## Products Affected

- CIMZIA (1 SYRINGE)
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG
- CIMZIA-STARTER

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
<b>Required Medical Information</b>	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), 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, 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, 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, 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), risankizumab (Skyrizi), (d) upadacitinib (Rinvoq) or documentation demonstrating that a trial may be inappropriate.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(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.
<b>Coverage Duration</b>	12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	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, Xeljanz, (d) Orencia, (e) Rinvoq/Rinvoq LQ, or documentation demonstrating that a trial may be inappropriate. (AS, PsA, PsO, RA, CD, nr-axSpA, PJIA)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# COBENFY 2026

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## Products Affected

- COBENFY
- COBENFY STARTER PACK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	(Schizophrenia): Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	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
<b>Exclusion Criteria</b>	(PsA, PsO, AS, nr-axSpA, ERA, HS): Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(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.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(PsA, PsO, AS, nr-axSpA, ERA, HS)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# CRENESSITY 2026

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Congenital Adrenal Hyperplasia (CAH)(Initial): (1) Submission of medical records confirming diagnosis of classic 21-hydroxylase deficiency congenital adrenal hyperplasia (2) Member is receiving chronic treatment with glucocorticoid (GC) replacement therapy (e.g., hydrocortisone, methylprednisolone) for adrenal insufficiency.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(CAH)(Reauth): (1) Member demonstrates positive clinical response to therapy (e.g., lowered androgen levels, reduced daily dose of steroids) (2) Member continues to receive chronic treatment with glucocorticoid (GC) replacement therapy (e.g., hydrocortisone, methylprednisolone)
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# CRESEMBA [ORAL] 2026

## Products Affected

- CRESEMBA ORAL

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	(IA, MC): Member is 6 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist, oncologist, OR prescribed as part of chemotherapy prophylaxis protocol
<b>Coverage Duration</b>	Remainder of contract year
<b>Other Criteria</b>	Subject to additional clinical review for ESRD-related use - if applicable.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# DALFAMPRIDINE 2026

## Products Affected

- *dalfampridine er*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(Initial): Member has history of seizure or moderate to severe renal impairment (CrCL less than or equal to 50 mL/min)
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Remainder of contract year
<b>Other Criteria</b>	(MS) (Reauth): Documentation of positive clinical response as evidenced by improvement in walking speed
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# DEFERASIROX 2026

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(NTDT, CIO-BT): GFR is less than 40mL/min/1.73m, platelet counts less than 50,000/mcL
<b>Required Medical Information</b>	Chronic Iron Overload in Non transfusion-dependent thalassemia (NTDT) (Initial): (1) Diagnosis of Chronic iron overload in Non transfusion-dependent thalassemia syndromes, (2) liver iron concentration (LIC) of at least 5 mg of iron per gram of liver dry weight (mg Fe/g dw), (3) Serum ferritin levels consistently greater than 300 mcg/L (as demonstrated with at least two lab values within the previous two months). Chronic Iron Overload Caused by Blood Transfusions (CIO-BT)(Initial): (1) Diagnosis of chronic iron overload caused by blood transfusions (transfusional hemosiderosis). (2) Serum ferritin levels consistently greater than 1,000 mcg/L.
<b>Age Restrictions</b>	(NTDT): Member is 10 years of age or older. (CIO-BT): Member is 2 years of age or older.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	(NTDT, CIO-BT) (Continuation): Decreased serum ferritin level compared with the baseline level or reduction in LIC (liver iron concentration).
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# DEFLAZACORT 2026

## Products Affected

- *deflazacort oral tablet*
- *jaythari oral tablet*
- KYMBEE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Duchenne Muscular Dystrophy (DMD)(Initial): (1) Diagnosis of Duchenne Muscular Dystrophy (DMD) (2) Diagnosis confirmed by ONE of the following: (a) Mutation of the dystrophin gene (b) Absence of the dystrophin protein confirmed by muscle biopsy (3) Inadequate response or inability to tolerate prednisone or prednisolone
<b>Age Restrictions</b>	(DMD): Member is 2 years of age or older
<b>Prescriber Restrictions</b>	(DMD): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(DMD) (Reauth): Member has experienced a benefit from therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# DIACOMIT 2026

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## Products Affected

- DIACOMIT

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

# DICHLORPHENAMIDE 2026

## Products Affected

- ORMALVI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use of high dose Aspirin, severe pulmonary disease and hepatic insufficiency
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	(Initial): 3 months (Reauth):12 months
<b>Other Criteria</b>	(PHPP)(Reauth): Member has had a positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# DICLOFENAC EPOLAMINE 2026

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## Products Affected

- *diclofenac epolamine external*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Previously experienced asthma, urticaria, or allergic-type reactions after taking aspirin or other NSAIDs. Use for the treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG) surgery.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Remainder of contract year
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# DOPTELET 2026

## Products Affected

- DOPTELET ORAL TABLET 20 MG
- DOPTELET SPRINKLE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 splenectomy (d) Rituxan (rituximab)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(ITP): Prescribed by or in consultation with hematologist/oncologist
<b>Coverage Duration</b>	(CLD): 1 month. (ITP): 12 months
<b>Other Criteria</b>	(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.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	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
<b>Exclusion Criteria</b>	Concurrent therapy with any other biologic agents
<b>Required Medical Information</b>	<p>Atopic Dermatitis (AD)(initial):(1) Diagnosis of moderate-severe AD.</p> <p>Asthma(Initial): (1)ONE of the following: (a) Member has oral corticosteroid-dependent asthma or (b) Member has blood eosinophil levels of at least 150 cells/mcL at baseline or at least 300 cells/mcL within the past 12 months (2)ONE of the following:(a) Member has had at least one asthma exacerbation requiring systemic corticosteroids within the past 12 months, or (b)Any prior intubation for asthma exacerbation, or prior asthma-related hospitalization within the past 12 months (3) the requested medication will be used in addition to BOTH of the following: (a) medium to high dose inhaled corticosteroid (e.g. greater than or equal to 500mcg fluticasone propionate equivalent/day) AND (b) one additional controller medication. Chronic Rhinosinusitis with Nasal Polyposis(CRSwNP)(Initial):(1) Diagnosis of CRSwNP (2) concurrent use of intranasal corticosteroid. Eosinophilic esophagitis(EoE)(Initial):(1) Diagnosis of EoE (2) Member has symptoms of esophageal dysfunction (e.g. dysphagia, food impaction, gastroesophageal reflux disease [GERD]/heartburn symptoms, chest pain, abdominal pain (3) Member has at least 15 intraepithelial eosinophils per high power(HPF) (4) Other causes of EoE have been excluded (5) Member weighs at least 15 kg (b) (6) Inadequate response or inability to tolerate at least an 8-week trial of one of the following: (a) proton pump inhibitors (e.g. pantoprazole, omeprazole (b) Topical (esophageal) corticosteroids (e.g. budesonide, fluticasone). Bullous Pemphigoid(BP)(Initial): (1) Diagnosis of bullous pemphigoid (BP) as confirmed by skin biopsy (2) Will be used in combination with a tapering course of oral corticosteroids until disease control has occurred.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(Initial/Reauth) Prescribed by/in consultation with: (AD): Dermatologist, allergist, or immunologist (Asthma)(COPD): Allergist, immunologist or pulmonologist (CRSwNP): Allergist, immunologist or ENT specialist (EoE): Gastroenterologist, allergist, or immunologist (PN)(CSU)(BP): Allergist/immunologist or dermatologist

PA Criteria	Criteria Details
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<p>Prurigo Nodularis (PN)(Initial): (1)Diagnosis of PN. Chronic obstructive pulmonary disease (COPD)(Initial): (1)Diagnosis of COPD (2)Presence of Type 2 inflammation evidenced by blood eosinophils greater than or equal to 300 cells/mcL at baseline (3)Member is receiving ONE of the following therapies for at least 3 months: (a)Triple therapy (i.e., an inhaled corticosteroid (ICS), a long-acting muscarinic antagonist (LAMA) and a long-acting beta agonist (LABA) (b) If ICS are contraindicated, a LAMA and a LABA (4)Member has had ONE of the following within the past 12 months: (a)At least two exacerbations where systemic corticosteroids were required at least once (b)COPD-related hospitalization (5)Member experiences dyspnea during everyday activities</p> <p>Chronic Spontaneous Urticaria (CSU)(Initial): (1)Diagnosis of CSU (2)Persistent symptoms with a second generation H1 antihistamine, unless there is a contraindication or intolerance to H1 antihistamines (3)Used concurrently with an H1 antihistamine, unless there is a contraindication or intolerance to H1 antihistamines. (AD)(Reauth): Documentation of positive clinical response to therapy (e.g., reduction i body surface area involvement, reduction in pruritus severity). Asthma (Reauth): (1)Documentation of positive clinical response to therapy (e.g. reduction in exacerbations, improvement in forced expiratory volume in 1 second [FEV1], decreased use of rescue medications) (2)The requested medication will be used in addition to BOTH of the following: (a) medium to high dose inhaled corticosteroid AND (b) one additional controller medication. CRSwNP (Reauth): (1)Documentation of positive clinical response to therapy (e.g. reduction of nasal polyps score [NPS: 0-8 scale], improvement in nasal congestion/obstruction score [NC: 0-3 scale]), (2) Used in combination with another agent for CRSwNP. EoE (Reauth): (1)Documentation of a positive clinical response to therapy as evidenced by improvement of at least one of the following from baseline: (a)Symptoms (e.g. dysphagia, food impaction, heartburn, chest pain), (b) Histologic measures (e.g. esophageal intraepithelial eosinophil count), Endoscopic measures (e.g. edema, furrows, exudates, rings, strictures). PN (Reauth): (1)Documentation of a positive clinical response to therapy (e.g. reduction in the number of nodular lesions from baseline, or improvement in symptoms from baseline) COPD (Reauth): (1)Member demonstrates a positive clinical response to therapy (e.g., improved lung function, a reduction in COPD exacerbations) (2) Member continues to receive ONE of the following therapies: (a) Triple therapy (i.e.,</p>
	<p>ICS, LAMA and LABA) (b) If ICS are contraindicated, a LAMA and a LABA CSU (Reauth): (1)Member demonstrates positive clinical response to therapy as evidenced by a reduction from baseline in itching severity or the number of hives. BP (Reauth): (1)Patient demonstrates positive clinical response to therapy.</p>

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# EMGALITY 2026

## Products Affected

- EMGALITY
- EMGALITY (300 MG DOSE)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use with another CGRP inhibitor for the preventative treatment of migraines.
<b>Required Medical Information</b>	Migraines (Initial): Approved when ONE of the following inclusion criteria are met: (1) Diagnosis of episodic migraines defined as 4 to 14 headache days per month OR (2) Diagnosis of chronic migraines defined as greater than or equal to 15 headache days per month. Episodic Cluster Headaches (ECH) (Initial): (1) Diagnosis of episodic cluster headache, (2) Member has experienced at least 2 cluster periods lasting 6 days to 365 days, separated by pain-free periods lasting at least three months.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist, headache specialist certified by the United Council for Neurologic Subspecialties, or pain specialist
<b>Coverage Duration</b>	(Initial): 6 months, (Reauth):12 months
<b>Other Criteria</b>	(Migraine)(REAUTH): (1) Response to therapy as defined by a reduction in headache days per month (defined as at least 4 hours duration and moderate intensity). (ECH)(REAUTH): (1) Response to therapy as defined by a reduction in weekly cluster headache attacks.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# EMSAM 2026

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## Products Affected

- EMSAM

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# ENBREL 2026

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(RA, PsA, PJIA, PsO, AS): Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(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.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(RA, PsA, PJIA, PsO, AS)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# ENDARI 2026

## Products Affected

- ENDARI
- *l-glutamine oral packet*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(SCD): Prescribed by or in consultation with a hematologist, oncologist, or sickle cell disease management specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(SCD)(Reauth): Documentation of positive clinical response to therapy (e.g. reduction in the number of sickle cell crises)
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# ENTYVIO SQ 2026

## Products Affected

- ENTYVIO PEN

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
<b>Required Medical Information</b>	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), 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), 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(UC, CD): Prescribed by or in consultation with a gastroenterologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(UC,CD)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	Yes

# EPIDIOLEX 2026

## Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Dravet Syndrome (DS): (1) Inadequate response or inability to tolerate ONE of the following: (a) clobazam (b) valproic acid or 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 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
<b>Age Restrictions</b>	(DS, LGS, TCS): Member is 1 year of age or older
<b>Prescriber Restrictions</b>	(DS, LGS, TCS): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# ESBRIET 2026

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## Products Affected

- *pirfenidone*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Idiopathic Pulmonary Fibrosis (IPF): (1) Diagnosis of IPF confirmed by high resolution CT scan or biopsy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(IPF): Prescribed by or in consultation a pulmonologist or lung transplant specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(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.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# EUCRISA 2026

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## Products Affected

- EUCRISA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# EVENITY 2026

## Products Affected

- EVENITY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 (i.e. Jubbonti). (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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Subject to Part B vs Part D review.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

## EXTENDED RELEASE METFORMIN 2026

### Products Affected

- *metformin hcl er (mod)*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(1) Member does not have an EGFR below 30 mL/min/1.73 m <sup>2</sup> . (2) Hepatic impairment. (3) Metabolic acidosis, including diabetic ketoacidosis. (4) Used for preventing weight gain.
<b>Required Medical Information</b>	Diabetes Mellitus Type 2 (DM2)(Initial): (1) Diagnosis of DM2. (2) Member has a HgbA1C greater than 6.5%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	End of contract year.
<b>Other Criteria</b>	(DM2)(Reauth): Member has had a positive clinical response to therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# EYSUVIS 2026

## Products Affected

- EYSUVIS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(DED)(Initial, Reauth): Prescribed by or in consultation with an ophthalmologist or optometrist.
<b>Coverage Duration</b>	(Initial, Reauth): 14 days
<b>Other Criteria</b>	(DED)(Reauth): (1) Positive clinical response to therapy (e.g. improvement in dry eye symptoms).
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# FASENRA 2026

## Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with any other biologic agents for asthma/allergic conditions (e.g. dupilumab [Dupixent], mepolizumab [Nucala], omalizumab [Xolair], reslizumab [Cinqair])
<b>Required Medical Information</b>	Part D is medically necessary when there is a documentation of the following: Severe Asthma (SA)(Initial): (1) Diagnosis of severe asthma with eosinophilic phenotype as defined by ONE of the following at initiation of therapy (a) blood eosinophil levels are at least 150 cells/microliter if dependent on daily oral corticosteroids or (b) blood eosinophil levels are at least 300 cells/microliter AND, (2) ONE of the following: (a) Member has had at least one asthma exacerbation requiring systemic corticosteroids within the past 12 months, or (b) Any prior intubation for asthma exacerbation, or prior asthma-related hospitalization within the past 12 months, AND (3) Member is currently treated with ONE of the following unless there is a contraindication or intolerance to these medications: (a) high-dose inhaled corticosteroids (ICS) (e.g. greater than or equal to 500 mcg fluticasone propionate equivalent/day) AND an additional asthma controller medication (e.g. leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline) OR (b) one maximally-dosed combination ICS/LABA product). Eosinophilic Granulomatosis with Polyangiitis (EGPA)(Initial): (1) Diagnosis of EGPA (2) Member's disease has relapsed or is refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy) (3) Member is currently receiving corticosteroid therapy (e.g., prednisolone, prednisone) unless there is a contraindication or intolerance to corticosteroid therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(SA):Prescribed by or in consultation with pulmonologist or allergy/immunology specialist. (EGPA):Prescribed by or in consultation with pulmonologist, Rheumatologist or allergy/immunology specialist
<b>Coverage Duration</b>	12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	Subject to Part B vs Part D review (SA) (Reauth): (1) Member is currently treated with ONE of the following unless there is a contraindication or intolerance to these medications: (a) high-dose inhaled corticosteroids (ICS) (e.g. greater than or equal to 500 mcg fluticasone propionate equivalent/day) AND an additional asthma controller medication (e.g. leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline) OR (b) one maximally-dosed combination ICS/LABA product). (2) Positive clinical response to therapy (e.g. reduction in exacerbations, decreased use of rescue medications) (EGPA) (Reauth): (1) Member demonstrates a positive clinical response to therapy (e.g. increase in remission time).
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# FERRIPROX 2026

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Transfusional Iron Overload (TIO)(initial): (1) Diagnosis of transfusional iron overload due to one of the following: (a) Thalassemia syndromes, (b) sickle cell disease, other transfusion-dependent anemias. (2) Inadequate response or inability to tolerate current chelation therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(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).
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# FINTEPLA 2026

## Products Affected

- FINTEPLA

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

# GALAFOLD 2026

## Products Affected

- GALAFOLD

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(FD)(Initial, Reauth): Prescribed by or in consultation with a clinical genetics specialist OR a nephrologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(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)
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# GATTEX 2026

## Products Affected

- GATTEX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Short Bowel Syndrome (SBS)(Initial): (1) Diagnosis of Short Bowel Syndrome, (2) individual receives parenteral support at least three times per week
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(SBS): Prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	(SBS)(Reauth): (1) Reduction in parenteral support from baseline (prior to initiation of Gattex therapy)
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# GENERIC LIDOCAINE TRANSDERMAL PATCH 2026

## Products Affected

- *lidocaine external patch 5 %*

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

# GENERIC SODIUM PHENYLBUTYRATE 2026

## Products Affected

- *sodium phenylbutyrate oral tablet*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Acute hyperammonemia. N-acetyl glutamate synthase (NAGS) deficiency
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(UCD): Prescribed by or in consultation with a specialist focused on the treatment of metabolic disorders
<b>Coverage Duration</b>	Initial: 6 months Reauth: 12 months
<b>Other Criteria</b>	(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.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# GOCOVRI 2026

## Products Affected

- GOCOVRI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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), COMT inhibitor (e.g. entacapone).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(DPD, PD with OFF episodes): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# GROWTH HORMONES 2026

## Products Affected

- GENOTROPIN SUBCUTANEOUS CARTRIDGE MG/1.5ML, 5 MG/1.5ML
- HUMATROPE INJECTION CARTRIDGE
- NORDITROPIN FLEXPLO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15
- OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(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, 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(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
<b>Coverage Duration</b>	(Initial, Continuation): 12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	(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.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# HAEGARDA 2026

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## Products Affected

- HAEGARDA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(HAE): Prescribed by or in consultation with an allergist, immunologist, pulmonologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(HAE)(Reauth): Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Remainder of contract year
<b>Other Criteria</b>	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 member is not being treated for substance abuse
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Risk versus benefit has been assessed for this request of a high risk medication (HRM) in elderly
<b>Age Restrictions</b>	Apply if member is greater than or equal to 65 years
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	2 years
<b>Other Criteria</b>	Subject to additional clinical review for ESRD-related use - if applicable.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# HRM CYCLOBENZAPRINE 2026

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## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Apply if member is greater than or equal to 65 years
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	AMS: 1 year. All other indications: 2 years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	Apply if member is greater than or equal to 65 years
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	2 years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# HRM KETOROLAC 2026

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## Products Affected

- *ketorolac tromethamine oral*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	Apply if member is greater than or equal to 65 years
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	One Month
<b>Other Criteria</b>	Subject to additional clinical review for ESRD-related use - if applicable.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# HRM NON BENZODIAZEPINE HYPNOTICS 2026

## Products Affected

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

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

# HRM SHORT TERM SKELETAL MUSCLE RELAXANTS 2026

## Products Affected

- *carisoprodol oral*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Apply if member is greater than or equal to 65 years
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	(AMS): 1 year. (All other indications): 2 years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# ILUMYA 2026

## Products Affected

- ILUMYA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(PsO): Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
<b>Required Medical Information</b>	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, Skyrizi, (d) Cosentyx, (e) Ustekinumab (i.e. Yesintek), (f) Otezla OR documentation demonstrating that a trial may be inappropriate.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PsO): Prescribed by or in consultation with a dermatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Subject to Part B vs Part D review. (PsO)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# INBRIJA 2026

## Products Affected

- INBRIJA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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), COMT inhibitor (e.g. entacapone)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PD): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# INCRELEX 2026

## Products Affected

- INCRELEX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(GHGD, PIGF-1D) (Initial and Continuation): Known or suspected malignancy, closed epiphyses, concurrent GH therapy
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	(GHGD, PIGF-1D): Member is 2 years of age or older
<b>Prescriber Restrictions</b>	(GHGD, PIGF-1D): Prescribed by or in consultation with an endocrinologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(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
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# INHALED TOBRAMYCIN 2026

## Products Affected

- TOBI PODHALER

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	(CF): Member is 6 years of age or older
<b>Prescriber Restrictions</b>	(CF): Prescribed by or in consultation with a pulmonologist, infectious disease specialist or Specialist affiliated with a CF care center.
<b>Coverage Duration</b>	Remainder of contract year
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(RA, PJIA): Recommended by rheumatologist. (PSA): Recommended by a rheumatologist or dermatologist. (Psoriasis): Recommended by dermatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(RA, PJIA, PSA, Psoriasis) (Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# INTRAVENOUS IMMUNE GLOBULINS (IVIG) 2026

## Products Affected

- GAMMAGARD INJECTION SOLUTION 10 GM/100ML, 2.5 GM/25ML, 5 GM/50ML
- 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
<b>Exclusion Criteria</b>	(Initial): History of hypersensitivity (including anaphylaxis or severe systemic reaction) to immune globulin or any component of the preparation.
<b>Required Medical Information</b>	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 (cicatrical) 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).
<b>Age Restrictions</b>	

PA Criteria	Criteria Details
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a physician who has specialized expertise in managing patients on immune globulin therapy (e.g. immunologist, hematologist, neurologist).
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	Subject to Part B vs Part D review. (11) Primary Immunodeficiency defined as common variable immunodeficiency, congenital agammaglobulinemia, severe combined immunodeficiencies, Wiskott-Aldrich syndrome, or other primary immunodeficiencies, AND one of the following: (a) member is in long-term care facility or (b) does not meet criteria for Part B coverage (12) Lambert Eaton myasthenic syndrome and an inadequate response or inability to tolerate one standard therapy (e.g. steroids, immunosuppressants, or cholinesterase inhibitors) (13) Multifocal motor neuropathy diagnosed by electrodiagnostic studies. (14) Acute exacerbations of multiple sclerosis (MS) unresponsive to steroids. (15) Myasthenia gravis and an inadequate response or inability to tolerate at least 8 weeks of one standard therapy (e.g. corticosteroids, azathioprine, cyclosporine, cyclophosphamide, cholinesterase inhibitors) (16) Myasthenic crisis (17) Stiff person syndrome and an inadequate response or inability to tolerate one standard therapy (e.g. muscle relaxants, benzodiazepines, and gabapentin-related medications) (18) Severe, active SLE and an inadequate response or inability to tolerate steroids (19) Kawasaki disease. (20) Infections in Low-birthweight Neonates when severe hypogammaglobulinemia (IgG greater than or equal to 400 mg/dL) is present. (21) Graves' Ophthalmopathy (22) Immune mediated Necrotizing Myopathy when resistant to treatment with one glucocorticoid and one immunosuppressant (23) 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.)
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# IVABRADINE 2026

## Products Affected

- *ivabradine hcl*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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) stable, symptomatic chronic heart failure (4) left ventricular ejection fraction less than or equal to 35% and (5) sinus rhythm with resting heart rate greater than or equal to 70 beats per minute. (6) Member is clinically stable for at least 4 weeks which includes 2 of the following therapies: (a) maximally tolerated doses of beta blockers or inability to tolerate beta blockers, (b) ACE inhibitors or ARBs or inability to tolerate ACE inhibitor or ARB. maximally tolerated doses of Sodium-glucose co-transporter 2 (SGLT2) inhibitor [e.g. Jardiance (empagliflozin), Farxiga (dapagliflozin), Xigduo XR (dapagliflozin and metformin)] (d) maximally tolerated doses of mineralocorticoid receptor antagonist (MRA) [e.g. eplerenone, spironolactone]. Chronic Heart Failure due to Dilated Cardiomyopathy in pediatric patients ages 6 months and older (CHF-DC)(Initial): (1) Diagnosis of chronic heart failure due to dilated cardiomyopathy (2) Member is in sinus rhythm with an elevated heart rate.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(CHF, CHF-DC): Prescribed by or in consultation with a cardiologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(CHF, CHF-DC) (Cont): Documentation of positive clinical response to therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	Yes

# JYNARQUE 2026

## Products Affected

- JYNARQUE ORAL TABLET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a nephrologist or kidney transplant specialist
<b>Coverage Duration</b>	(Initial): 3 months. (Reauth): 12 months.
<b>Other Criteria</b>	(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
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# KALYDECO 2026

## Products Affected

- KALYDECO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	(CF): Member is 1 month of age or older for granules. Member is 6 years of age or older for tablets
<b>Prescriber Restrictions</b>	(CF): Prescribed by or in consultation with a pulmonologist or Specialist affiliated with a CF care center
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(CF)(Reauth): Member has had a positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# KERENDIA 2026

## Products Affected

- KERENDIA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Chronic kidney disease associated with type 2 diabetes (CKD with T2D) (Initial): (1) Diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes (T2D), (2) One of the following (a) Minimum 30-day trial and member will continue therapy with ONE of the following (i) generic angiotensin-converting enzyme (ACE) inhibitor (e.g. benazepril, lisinopril), (ii) generic angiotensin II receptor blocker (ARB) (e.g. losartan, valsartan), (b) Member has contraindication or intolerance to ACE inhibitors, ARBs, or SGLT2. Heart Failure with Left Ventricular Ejection Fraction (LVEF) (initial): (1)Diagnosis of Heart Failure, (2) Member has LVEF greater than or equal to 40%, (3) Member has New York Heart Association Class II, III, or IV symptoms, (4) Member has an estimated glomerular filtration rate (eGFR) greater than or equal to 25 mL/min/1.73 m <sup>2</sup> (5)Member has a serum potassium level less than or equal to 5.0 mEq/L prior to initiating treatment, (6)Both of the following: (a) Member is on diuretic treatment (e.g., bumetanide, furosemide) for the management of symptoms of heart failure for at least 30 days prior to initiating treatment, (b) Member is not receiving drug in combination with spironolactone or eplerenone, (7) One of the following: (a) Member is receiving drug in combination with a sodium-glucose cotransporter-2 (SGLT2) inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]), (b) Member has a contraindication or intolerance to an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(HF with LVEF): Prescribed by or in consultation with a cardiologist
<b>Coverage Duration</b>	12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	(CKD with T2D)(Reauth): (1) Documentation of positive clinical response to therapy (e.g., reduced incidence of a sustained decline in eGFR, kidney failure, or renal death). (HF with LVEF) (Reauth): (1) Member demonstrates positive clinical response to therapy and (2) one of the following: (a) Member continues to be on an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]) or (b) Member has a contraindication or intolerance to an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin])
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# KEVZARA 2026

## Products Affected

- KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
<b>Required Medical Information</b>	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), 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, Xeljanz, (d) Orencia, (e) Rinvoq/Rinvoq LQ OR documentation demonstrating that a trial may be inappropriate.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(RA, PMR, PJIA): Prescribed by or in consultation with a rheumatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(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
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	Yes

# KINERET 2026

## Products Affected

- KINERET SUBCUTANEOUS SOLUTION  
PREFILLED SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
<b>Required Medical Information</b>	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), 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(RA, NOMID, DIRA): Prescribed by or in consultation with a rheumatologist or pediatric specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(RA, NOMID, DIRA)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# KLISYRI 2026

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## 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
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(HCS)(Reauth): Documentation of positive clinical response to therapy (e.g., improved, or stable glucose tolerance while on therapy)
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# LETAIRIS 2026

## Products Affected

- LETAIRIS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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). 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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PAH): Prescribed by or in consultation with a Cardiologist or Pulmonologist.
<b>Coverage Duration</b>	(Initial): 6 months. (Continuation):12 months.
<b>Other Criteria</b>	(PAH)(Continuation): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# LIVTENCITY 2026

## Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	(CMV): Member is 12 years of age or older
<b>Prescriber Restrictions</b>	(CMV): Prescribed by or in consultation with a provider who specializes in one of the following areas (1) transplant, (2) infectious disease (3) Oncology
<b>Coverage Duration</b>	8 weeks
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# MODAFINIL 2026

## Products Affected

- *modafinil oral*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>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</p> <p>Narcolepsy (Initial): (1) Diagnosis of narcolepsy as confirmed by sleep study (unless prescriber provides justification confirming a sleep study is not feasible)</p> <p>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</p> <p>Fatigue due to MS (off-label) (Initial): (1) Diagnosis of multiple sclerosis (MS) (2) Member is experiencing fatigue.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or sleep specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(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
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# NEXLETOL/NEXLIZET 2026

## Products Affected

- NEXLETOL
- NEXLIZET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	(Initial): 6 months. (Continuation): 12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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</p>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# NON-ORAL CHEMO AGENTS 2026

## Products Affected

- BESREMI
- TRELSTAR MIXJECT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy. Subject to Part B vs Part D review.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# NON-PREFERRED GLP-1 AGONISTS 2026

## Products Affected

- *exenatide*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(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 mellitus 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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(DM2)(Reauth): Documentation of positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# NON-PREFERRED HEPATITIS C AGENTS 2026

## Products Affected

- VOSEVI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Duration will be applied consistent with AASLD/ IDSA guidance
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	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
<b>Exclusion Criteria</b>	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
<b>Required Medical Information</b>	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, 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, 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, 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, Skyrizi (d) Cosentyx, (e)Otezla, (f) Ustekinumab (i.e. Yesintek) OR documentation demonstrating that a trial may be inappropriate.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(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
<b>Coverage Duration</b>	(CD, UC, PsA, PsO): 12 months
<b>Other Criteria</b>	(CD, UC, PsA, PsO): (Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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), COMT inhibitor (e.g. entacapone)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Parkinson's Disease (PD) (Reauth): (1) Member demonstrates positive response to clinical therapy (2) concurrent use of carbidopa/levodopa containing product
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# NOXAFIL 2026

## Products Affected

- *posaconazole oral tablet delayed release*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Treatment of invasive aspergillosis (TAI): Diagnosis of TAI. Prophylaxis of Invasive Aspergillus Infections (AI): (1) For use in prophylaxis of invasive Aspergillus infection due to being severely immunocompromised after inadequate response or inability to tolerate voriconazole (Vfend). Prophylaxis of Invasive Candida Infections(CI): (1) For use in prophylaxis of invasive Candida infection due to being severely immunocompromised after inadequate response or inability to tolerate voriconazole (Vfend).
<b>Age Restrictions</b>	(TAI): Member is 13 years of age or older. (AI, CI): Member is 2 years of age or older
<b>Prescriber Restrictions</b>	(All Indications): Prescribed by or in consultation with an infectious disease specialist, transplant specialist, hematologist, oncologist, OR prescribed as part of chemotherapy prophylaxis protocol
<b>Coverage Duration</b>	Remainder of contract year
<b>Other Criteria</b>	Subject to additional clinical review for ESRD-related use - if applicable.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# NUCALA 2026

## Products Affected

- NUCALA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with any other biologics for asthma/allergic conditions (e.g. benralizumab [Fasenra], dupilumab [Dupixent], omalizumab [Xolair], reslizumab [Cinqair])
<b>Required Medical Information</b>	Part D is medically necessary when there is documentation of ONE of the following: Severe Asthma with Eosinophilic Phenotype (SA) (Initial): (1) Diagnosis of severe asthma with eosinophilic phenotype as defined by one of the following: a) blood eosinophil levels are at least 150 cells/microliter at initiation of therapy (measured within 6 weeks of dosing), or b) blood eosinophil levels at least 300 cells/microliter within the past 12 months. (2) Member has had at least two or more asthma exacerbations requiring systemic corticosteroids within the past 12 months OR member has had any prior intubation for an asthma exacerbation OR Member has had a prior asthma-related hospitalization within the past 12 months, AND Member is currently treated with high-dose inhaled corticosteroids (ICS) (e.g. greater than or equal to 500 mcg fluticasone propionate equivalent/day) AND an additional controller medication (e.g. long-acting beta agonist, leukotriene inhibitor, theophylline), unless the individual is intolerant of or has a contraindication to two of the additional controller agents. Hyper eosinophilic Syndrome (HES)(Initial): (1) Diagnosis of HES. (2) All of the following: (a) Member has been diagnosed for at least 6 months, (b) Verification that other non-hematologic secondary causes have been ruled out (e.g. drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy), member is FIP1-like1-platelet derived growth factor receptor alpha kinase (FIP1L1-PDGFRα kinase)-negative. (3) Member has uncontrolled HES defined by Pre-treatment blood eosinophil count greater than or equal to 1000 cells/microliter (4) Inadequate response or inability to tolerate one of the following: (a) corticosteroid therapy (e.g. prednisone), (b) cytotoxic/immunosuppressive therapy (e.g. hydroxyurea, cyclosporine, imatinib).
<b>Age Restrictions</b>	

PA Criteria	Criteria Details
<b>Prescriber Restrictions</b>	(SA)(COPD): Prescribed by or in consultation with pulmonologist or allergy/immunology specialist. (EGPA): Prescribed by or in consultation with a rheumatologist, pulmonologist, or allergy/immunology specialist. (HES): Prescribed by or in consultation with either allergist/immunologist or hematologist. (CRSwNP): Prescribed by or in consultation with allergist, immunologist, otolaryngologist or pulmonologist.
<b>Coverage Duration</b>	12 months.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>Subject to Part B vs Part D review. Eosinophilic Granulomatosis with Polyangiitis (EGPA) (Initial): (1) Diagnosis of EGPA (2) Member's disease has relapsed or is refractory to standard of care therapy (i.e., corticosteroid treatment) (3) Member is currently receiving corticosteroid therapy Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) (Initial): (1) Diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) (2) Unless contraindicated, the member has had an inadequate response to at least a 2 month treatment with an intranasal corticosteroid (e.g. fluticasone, mometasone) (3) Used in combination with intranasal corticosteroid for CRSwNP. Chronic Obstructive Pulmonary Disease (COPD)(Initial): (1) Diagnosis of COPD (2) Presence of Type 2 inflammation evidenced by one of the following: (a) Blood eosinophils greater than or equal to 150 cells per microliter at baseline (b) Blood eosinophils greater than or equal to 300 cells per microliter in the last 12 months (3) Member is receiving one of the following therapies: (a) Triple therapy (i.e., an inhaled corticosteroid (ICS) [e.g., budesonide], a long-acting muscarinic antagonist (LAMA) [e.g., tiotropium, umeclidinium] and a long-acting beta agonist (LABA) [e.g., salmeterol, arformoterol, formoterol] (b) If ICS are contraindicated, a LAMA and a LABA (4) Member has had one of the following within the past 12 months: (a) At least two exacerbations where systemic corticosteroids [intramuscular, intravenous, or oral (e.g., prednisone)] were required at least once (b) COPD-related hospitalization (SA)(Reauth): (1) Member is currently treated with high-dose inhaled corticosteroids (ICS) (e.g. greater than or equal to 500mcg fluticasone propionate equivalent/day) AND an additional controller medication (e.g. long-acting beta agonist such as salmeterol or formoterol, leukotriene inhibitor such as montelukast, theophylline), unless the individual is intolerant of or has a contraindication to two of the additional controller agents. (EGPA)(Reauth): (1) Positive clinical response to therapy (e.g. increase in remission time). (HES)(Reauth): (1) Positive clinical response (e.g. reduction in corticosteroid use, reduction of blood eosinophil count, reduction in flares). (CRSwNP) (Reauth): (1) Documentation of positive clinical response to therapy (e.g. reduction of nasal polyps score [NPS: 0-8 scale], improvement in nasal obstruction symptoms via visual analog scale [VAS: 0-10 scale]), (2) Used in combination with intranasal corticosteroid for CRSwNP. (COPD)(Reauth): (1) Member demonstrates positive clinical response to therapy (2) Member</p>
	<p>continues to receive one of the following therapies: (a) Triple therapy (i.e., an inhaled corticosteroid (ICS) [e.g., budesonide], a long-acting muscarinic antagonist (LAMA) [e.g., tiotropium, umeclidinium] and a long-acting beta agonist (LABA) [e.g., salmeterol, arformoterol, formoterol] (b) If ICS are contraindicated, a LAMA and a LABA.</p>
<b>Indications</b>	All Medically-accepted Indications.

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

# NUEDEXTA 2026

## Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(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 ]
<b>Required Medical Information</b>	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 Alzheimer's disease (d) Parkinson's disease (e) Stroke (f) Traumatic brain injury
<b>Age Restrictions</b>	(PBA): Member is 18 years of age or older
<b>Prescriber Restrictions</b>	(PBA): Prescribed by or in consultation with a neurologist or psychiatrist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(PBA)(Reauth): (1) Documentation of clinical benefit from ongoing therapy (e.g., decrease in laughing or crying episodes)
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	No

# NUPLAZID 2026

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## Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Hallucinations and Delusions Parkinson Disease Psychosis (HDPDP): (1) Diagnosis of HDPDP.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# NURTEC 2026

## Products Affected

- NURTEC

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(AM): Medication will be used in combination with another CGRP inhibitor for the treatment of acute migraines. (MP): Medication used in combination with another CGRP inhibitor for the preventive treatment of migraines.
<b>Required Medical Information</b>	Acute Treatment of Migraines (AM)(Initial): (1) Diagnosis of migraine with or without aura in adults. (2) Member has fewer than 15 headache days per month. (3) One of the following: (a) inadequate response or inability to tolerate ONE generic formulary triptan or (b) member has a history of coronary artery disease, peripheral vascular disease, uncontrolled hypertension, or other vascular risk factors or disorder and is unable to tolerate triptans. Preventative Treatment of Episodic Migraines (MP) (Initial): (1) Diagnosis of episodic migraines defined as 4 to 18 migraine days per month
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(AM)(MP) Prescribed by or in consultation with a neurologist, headache specialist certified by the United Council for Neurologic Subspecialties, or pain specialist.
<b>Coverage Duration</b>	(Initial): 6 months. (Reauth): 12 months
<b>Other Criteria</b>	(AM)(Reauth): (1) Positive response to therapy (e.g. reduction in pain, photophobia, phonophobia, nausea). (MP)(Reauth): (1) Positive clinical response to therapy (e.g. reduction in headache frequency and/or intensity, use of acute migraine medications [e.g. nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g. ibuprofen, naproxen), triptans (e.g. eletriptan, rizatriptan, sumatriptan)] has decreased since the start of CGRP therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	Yes

# OCTREOTIDE 2026

## Products Affected

- *octreotide acetate injection solution 100 mcg/ml*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Acromegaly (Initial): (1) Diagnosis of acromegaly. (2) One of the following: (a) Inadequate response to surgical resection and/or pituitary irradiation, (b) Member is not a candidate for surgical resection or pituitary irradiation (3) Inadequate response or inability to tolerate a dopamine agonist (e.g., bromocriptine or cabergoline). Carcinoid Tumors (CT)(Initial): (1) Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea or flushing episodes. Vasoactive Intestinal Peptide Tumors (VIPT)(Initial): (1) Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in conjunction with an endocrinologist or oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(Acromegaly) (Reauth): (1) Member demonstrates positive clinical response to therapy (e.g., reduction or normalization of IFG-1 or growth hormone (GH) level for same age and sex) (CT)(Reauth): (1) Member has improvement in number of diarrhea or flushing episodes (VIPT)(Reauth): (1) Member has improvement in number of diarrhea episodes
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# OFEV 2026

## Products Affected

- OFEV

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Idiopathic Pulmonary Fibrosis (IPF): (1) Diagnosis of IPF confirmed by high resolution CT scan or biopsy. Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD): (1) Diagnosis of SSc-ILD confirmed by a high resolution CT scan or biopsy. Chronic Fibrosing Interstitial Lung Disease (ILDs) with progressive phenotype (Initial): (1) Confirmed by high resolution CT scan (HRCT) showing at least 10% of lung volume with fibrotic features, (2) Disease has a progressive phenotype as observed by one of the following: (a) decline of forced vital capacity (FVC), (b) worsening of respiratory symptoms, increased extent of fibrosis seen on imaging.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(IPF, SSc-ILD, ILDs): Prescribed by or in consultation with a rheumatologist, pulmonologist or lung transplant specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(REAUTH) (IPF, ILDs, SSc-ILD): 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
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# OLUMIANT 2026

## Products Affected

- OLUMIANT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	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
<b>Required Medical Information</b>	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 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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(RA): Prescribed by or in consultation with a rheumatologist (AA): Prescribed by or in consultation with a dermatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(RA, Alopecia Areata)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# ONYCHOMYCOSIS AGENTS 2026

## Products Affected

- JUBLIA
- *tavaborole*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Onychomycosis: (1) Diagnosis of onychomycosis of the toenail(s) due to <i>Trichophyton rubrum</i> and <i>Trichophyton mentagrophytes</i> . (2) Diagnosis confirmed by one of the following: (a) positive potassium hydroxide (KOH) preparation, (b) culture, or 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# OPIPZA 2026

## Products Affected

- OPIPZA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# ORAL CHEMO AGENTS 2026

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## 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
- ENSACOVE
- 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
- HERNEXEOS
- HYRNUO
- IBRANCE
- IBTROZI
- ICLUSIG
- IDHIFA
- *imatinib mesylate oral*
- IMBRUVICA ORAL CAPSULE
- IMBRUVICA ORAL SUSPENSION
- IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG
- *imkeldi*
- INLURIYO
- 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)
- *lomustine*
- LONSURF
- LORBRENA
- LUMAKRAS
- LYNPARZA ORAL TABLET
- LYTGOBI (12 MG DAILY DOSE)
- LYTGOBI (16 MG DAILY DOSE)
- LYTGOBI (20 MG DAILY DOSE)
- MEKINIST

- MEKTOVI
- MODEYSO
- NERLYNX
- *nilotinib d-tartrate*
- *nilotinib hcl*
- NINLARO
- NUBEQA
- ODOMZO
- OGSIVEO ORAL TABLET 100 MG, 150 MG
- OJEMDA ORAL SUSPENSION RECONSTITUTED
- OJEMDA ORAL TABLET 100 MG
- OJJAARA
- ONUREG
- ORGOVYX
- ORSERDU
- *pazopanib hcl oral tablet 200 mg*
- PEMAZYRE
- PHYRAGO
- 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
- 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
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# ORAL PAH AGENTS 2026

## Products Affected

- OPSUMIT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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). The pulmonary capillary wedge pressure or left ventricular end-diastolic pressure is 15 mm Hg or less.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PAH): Prescribed by or in consultation with a Cardiologist or Pulmonologist
<b>Coverage Duration</b>	(Initial): 6 months. (Continuation):12 months.
<b>Other Criteria</b>	(PAH)(Continuation): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# ORENCIA SQ 2026

## Products Affected

- ORENCIA CLICKJECT
- ORENCIA SUBCUTANEOUS SOLUTION  
PREFILLED SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(RA, PsA, PJIA): Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(RA, PJIA): Prescribed by or in consultation with a rheumatologist. (PsA): Prescribed by or in consultation with a dermatologist or rheumatologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(RA, PsA, PJIA)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# ORKAMBI 2026

## Products Affected

- ORKAMBI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	(CF): Member is 1 year of age or older for granules. Member is 6 years of age or older for tablets.
<b>Prescriber Restrictions</b>	(CF): Prescribed by or in consultation with pulmonologist or Specialist affiliated with a CF care center
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(CF)(Reauth): Member has had a positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# OTEZLA 2026

## Products Affected

- OTEZLA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PsA, OU-BD): Prescribed by or in consultation with a Rheumatologist or Dermatologist. (PsO): Prescribed by or in consultation with dermatologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(OU-BD, PsA, PsO)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# OXERVATE 2026

## Products Affected

- OXERVATE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an ophthalmologist or Optometrist.
<b>Coverage Duration</b>	8 weeks
<b>Other Criteria</b>	(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).
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

## PART D VS EXCLUDED 2026

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### 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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Pulmonary Arterial Hypertension (PAH)(Initial): (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). The pulmonary capillary wedge pressure or left ventricular end-diastolic pressure is 15 mm Hg or less.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PAH): Prescribed by or in consultation with a Cardiologist or Pulmonologist
<b>Coverage Duration</b>	(Initial): 6 months (Reauth): 12 months
<b>Other Criteria</b>	(PAH)(Reauth): (1) Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# PRALUENT 2026

## Products Affected

- PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Primary Hyperlipidemia (HLA) including heterozygous familial hypercholesterolemia (HeFH) and prevention of cardiovascular (CV) events in members with increased risk of major adverse CV events (Initial): (1) Diagnosis of hyperlipidemia, (2) ONE of the following: (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</p> <p>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 55mg/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</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	(Initial): 6 months (Continuation): 2 years

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>Homozygous Familial Hypercholesterolemia (HoFH)(Initial): (1) Diagnosis of HoFH. (2) Untreated LDL-C greater than 400 mg/dL (3) Member is receiving other lipid-lowering therapy (e.g. statin, ezetimibe). (ASVCD)(Primary Hyperlipidemia (HLA) including heterozygous familial hypercholesterolemia (HeFH) and prevention of cardiovascular (CV) events in members with increased risk of major adverse CV events)(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).</p>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# PREFERRED DENOSUMAB (XGEVA PRODUCTS) 2026

## Products Affected

- WYOST

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Part D is medically necessary when: Prevention of Skeletal Related Events in Multiple Myeloma or Bone Metastases from Solid Tumors (MM-BMST) : (1) For prevention of skeletal related events in multiple myeloma or bone metastases from solid tumors. Giant Cell Tumor of the Bone (GCTB): (1) Diagnosis of GCTB. (2) Member is (a) adult or (b) adolescent that is skeletally mature. (3) Tumor is unresectable or surgical resection is likely to result in severe morbidity. Hypercalcemia of Malignancy Refractory to Bisphosphonates (HCMRB): (1) Diagnosis of HCMRB
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(GCTB, HCMRB): Prescribed by or in consultation with an urologist, oncologist or hematologist.
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	Subject to Part B vs Part D review. (All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# PREFERRED DENOSUMAB 2026

## Products Affected

- JUBBONTI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Part D is medically necessary when all of the following criteria are met:</p> <p>Osteoporosis (OS) (Initial): ALL of the following: (1) Diagnosis of osteoporosis confirmed by one of the following: (a) T-score less than or equal to -2.5 (b) history of osteoporotic fracture (e.g. vertebral, hip, non-vertebral) or multiple risk factors for fracture. (2) ONE of the following: (a) inadequate response or inability to tolerate at least one other osteoporosis medicine (e.g. oral bisphosphonates, calcitonin, estrogens, selective estrogen receptor modulator (SERMs)) or (b) severely deteriorated condition indicating that the osteoporosis is so significant that a trial of oral bisphosphonates is not medically warranted or documented moderate to severe renal insufficiency (glomerular filtration rate [GFR] 30 to 35 ml/min or less). Osteopenia (OPN) (Initial): BOTH of the following: (1) Diagnosis of osteopenia confirmed by a T-score less than -1.0, but greater than -2.5. (2) One of the following: (a) Member is receiving adjuvant aromatase inhibitor therapy for breast cancer (b) member is receiving androgen deprivation therapy for non-metastatic prostate cancer. Prophylaxis of Postmenopausal Osteoporosis (PO) (Initial): BOTH of the following: (1) BMD T score less than -1.0 and greater than -2.5. (2) ONE of the following: (a) Inadequate response or inability to tolerate an oral bisphosphonates or a selective estrogen receptor modulator (SERMs) or (b) documented moderate to severe renal insufficiency (glomerular filtration rate [GFR] 30 to 35 ml/min or less) not receiving dialysis or diagnosed with stage 5 kidney disease.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	Subject to Part B vs Part D review. Glucocorticoid Induced Osteoporosis (GCO)(Initial): ALL of the following: (1) Diagnosis of CGO in men or women. (2) Daily dose of prednisone is greater than or equal to 5mg for at least 3 months. (3) ONE of the following: (a)Inadequate response or inability to tolerate ONE of the following: (i) bisphosphonates, (ii) hormone replacement therapy, (iii) selective-estrogen receptor modulators (SERMs),. (b) severely deteriorated condition indicating that the osteoporosis is so significant that a trial of oral bisphosphonates is not medically warranted, documented moderate to severe renal insufficiency (glomerular filtration rate [GFR] 30 to 35 ml/min or less). (All Indications)(Reauth): (1) Member demonstrates positive clinical response to therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(DM2)(Reauth): Documentation of positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# PREFERRED HEPATITIS C AGENTS 2026

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## Products Affected

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

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

# PREFERRED TOCILIZUMAB SQ 2026

## Products Affected

- TYENNE SUBCUTANEOUS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with other biologic disease modifying antirheumatic drug (DMARD), e.g. tumor necrosis factor antagonists.
<b>Required Medical Information</b>	Part D is medically necessary when there is documentation of the following: Polyarticular Juvenile Idiopathic Arthritis (PJIA)(Initial): (1) Diagnosis of PJIA. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e., Adalimumab-AACF), (b) etanercept (Enbrel), Xeljanz, (d) Orencia, (e) Rinvoq/Rinvoq LQ OR documentation demonstrating that a trial may be inappropriate. Systemic Juvenile Idiopathic Arthritis (SJIA)(Initial): (1) Diagnosis of SJIA. Moderate to severe 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, Rinvoq, (d) Xeljanz/Xeljanz XR, (e) Orencia, OR documentation demonstrating that a trial may be inappropriate. Giant Cell Arteritis (GCA)(Initial): (1) Diagnosis of GCA. Systemic Sclerosis (SSc-ILD) (Initial): (1): Diagnosis of SSc-ILD (2) Documentation of inadequate response/inability to tolerate a 3-month trial of ONE of the following: (a) mycophenolate mofetil, (b) cyclophosphamide, OR azathioprine (3) Diagnosis of SSc-ILD confirmed by a high-resolution CT scan or biopsy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PJIA, SJIA, RA, GCA): Prescribed by or in consultation with a Rheumatologist (SSc-ILD) -Prescribed by or in consultation with a rheumatologist or pulmonologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(PJIA, SJIA, RA, GCA, SSc-ILD) (Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	

PA Criteria	Criteria Details
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# PREFERRED USTEKINUMAB SQ 2026

## Products Affected

- YESINTEK SUBCUTANEOUS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
<b>Required Medical Information</b>	Part D is medically necessary when: Plaque psoriasis (PsO)(Initial): (1) Diagnosis of moderate to severe PsO. Psoriatic arthritis (PsA)(Initial): (1) Diagnosis of PsA. Crohn's Disease (CD)(Initial): (1) Diagnosis of moderate to severe CD. Ulcerative Colitis (UC)(Initial): (1) Diagnosis of moderate to severe UC.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(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
<b>Coverage Duration</b>	(CD, UC, PsA, PsO): 12 months
<b>Other Criteria</b>	(CD, UC, PsA, PsO): (Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# PROMACTA 2026

## Products Affected

- *eltrombopag olamine*
- PROMACTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>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, 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, absolute reticulocyte count less than 60,000/mcL. (4) Used in combination with standard immunosuppressive therapy (e.g. Agam [antithymocyte globulin equine] and cyclosporine).</p> <p>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.</p> <p>Chronic Hepatitis C-Associated Thrombocytopenia (HEPC-TP)(initial): (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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(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.
<b>Coverage Duration</b>	(ITP).=12mo.(FLSAA)=6mo.(RSAA)Initial=6mo.(HEPC-TP)Initial=3mo.(RSAA,HEPC-TP)Cont.=12mo.

PA Criteria	Criteria Details
<b>Other Criteria</b>	(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.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# QBREXZA 2026

## Products Affected

- QBREXZA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a dermatologist, primary care physician, internist, or pediatrician.
<b>Coverage Duration</b>	(Initial, Reauth): 12 months
<b>Other Criteria</b>	(PAH)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# QUALAQUIN 2026

## Products Affected

- *quinine sulfate oral*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Use for treatment or prevention of nocturnal leg cramps
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Babesiosis: 10 days Uncomplicated Malaria: 14 Days
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# RADICAVA 2026

## Products Affected

- RADICAVA ORS STARTER KIT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(ALS): Prescribed by or in consultation with a neurologist with expertise in the diagnosis of ALS
<b>Coverage Duration</b>	6 months.
<b>Other Criteria</b>	(ALS)(Reauth): (1) Member shows benefit from therapy (e.g. slowing of decline of functional abilities).
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# RALDESY 2026

## Products Affected

- RALDESY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# REPATHA 2026

## Products Affected

- REPATHA
- REPATHA SURECLICK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Primary Hyperlipidemia (HLA) including heterozygous familial hypercholesterolemia (HeFH) and prevention of cardiovascular (CV) events in members with increased risk of major adverse CV events (CV death, myocardial infarction, stroke, unstable angina requiring hospitalization, or coronary revascularization)(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 55 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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	

PA Criteria	Criteria Details
<b>Coverage Duration</b>	(Initial): 6 months (Continuation): 2 years
<b>Other Criteria</b>	Homozygous Familial Hypercholesterolemia (HoFH) (Initial): (1) Diagnosis of HoFH. (2) Untreated LDL-C greater than 400 mg/dL, (3) Member is receiving other lipid-lowering therapy (e.g. statin, ezetimibe). (Primary Hyperlipidemia (HLA) including heterozygous familial hypercholesterolemia (HeFH) and prevention of cardiovascular (CV) events in members with increased risk of major adverse CV events)(ASCVD)(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).
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# RESPIRATORY ENZYMES 2026

## Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(ATT): (1) IgA deficiency with known anti-IgA antibody. (2) Member is a smoker
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	Subject to Part B vs Part D review.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# REXULTI 2026

## Products Affected

- REXULTI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# REZDIFFRA 2026

## Products Affected

- REZDIFFRA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(MASH) (Initial): (1) Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH) (2) Submission of medical records (e.g., chart notes) confirming diagnosis has been confirmed by ONE of the following: (a) FibroScan-aspartate aminotransferase (FAST) (b) MRI-aspartate aminotransferase (MAST) Liver biopsy (3) Submission of medical records (e.g., chart notes) documenting that disease is moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) as confirmed by ONE of the following: (a) FibroScan (b) Fibrosis-4 index (FIB-4) Magnetic Resonance Elastography (MRE), (d) liver biopsy. (4) Presence of greater than or equal to 1 metabolic risk factor (e.g. Type 2 diabetes, hypertension, obesity).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist or hepatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(MASH) (Reauth): (1) Member demonstrates positive response to therapy (e.g. MASH resolution, fibrosis stage improvement, etc.) (2) Member has not progressed to cirrhosis
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# REZUROCK 2026

## Products Affected

- REZUROCK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(cGVHD): Prescribed by or in consultation with one of the following (1) Hematologist, (2) Oncologist, (3) physician experienced in the management of transplant patients
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(cGVHD) (Reauth): (1) Member does not show evidence of progressive disease while on therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# RINVOQ 2026

## Products Affected

- RINVOQ

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with any other biologic disease modifying antirheumatic drug (DMARD), other JAK inhibitors, or potent immunosuppressants (e.g. azathioprine, cyclosporine).
<b>Required Medical Information</b>	<p>Rheumatoid Arthritis (RA)(Initial): (1) Diagnosis of moderate to severely active RA. (2) Member has inadequate response or inability to tolerate one DMARD: (e.g. methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine (3) Member had 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. 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. Atopic Dermatitis (AD)(Initial): (1) Diagnosis of moderate to severe atopic dermatitis, (2) Inadequate response of or inability to tolerate at least ONE of the following: (a) medium or higher potency topical corticosteroid, (b) pimecrolimus cream, Topical tacrolimus cream (3) Inadequate response or inability to tolerate at least one systemic drug product for the treatment of atopic dermatitis (examples include, but are not limited to Dupixent, Adbry or documentation that a trial may be inappropriate. Ulcerative Colitis (UC)(Initial): (1) Diagnosis of Ulcerative Colitis (2) One of the following: (a) Member had an inadequate response or inability to tolerate one or more TNF inhibitors (e.g. Adalimumab-AACF), (b) If TNF blockers are clinically inadvisable, an inadequate response or inability to tolerate at least one approved systemic therapy. Giant Cell Arteritis (GCA): (1) Diagnosis of GCA.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(RA, AS, nr-AxSPA, PJIA, GCA): Prescribed by or in consultation with a rheumatologist. (PsA): Prescribed by or in consultation with a rheumatologist or dermatologist. (AD): Prescribed by or in consultation with a dermatologist, allergist, immunologist. (UC, CD): Prescribed by or in consultation with a gastroenterologist.

PA Criteria	Criteria Details
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<p>Ankylosing Spondylitis (AS)(Initial): (1) Diagnosis of active ankylosing spondylitis. (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. Non-radiographic axial spondylarthritis (nr-AxSPA): (1) Diagnosis of nr-AxSPA (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 (3) Inadequate response or inability to tolerate one NSAID. Crohn's Disease (CD)(Initial): (1) Diagnosis of CD. (2) One of the following: (a) Member had an inadequate response or inability to tolerate one or more TNF inhibitors (e.g. Adalimumab-AACF) (b) If TNF blockers are clinically inadvisable, an inadequate response or inability to tolerate at least one approved systemic therapy. 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. (RA, PsA, AD, UC, AS, nr- AxSPA, CD, PJIA, GCA)(Reauth): (1) Member demonstrates positive clinical response to therapy</p>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# RINVOQ LQ 2026

## Products Affected

- RINVOQ LQ

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with any other biologic disease modifying antirheumatic drug (DMARD), other JAK inhibitors, or potent immunosuppressants (e.g. azathioprine, cyclosporine).
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PsA): Prescribed by or in consultation with a rheumatologist or dermatologist. (pJIA): Prescribed by or in consultation with a rheumatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(PsA, pJIA)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# SIGNIFOR 2026

## Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Cushing's disease (CD)(Initial): (1) Diagnosis of (pituitary) Cushing's disease. (2) Pituitary surgery is not an option or has not been curative
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(CD) Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(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)
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# SILDENAFIL 2026

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(PAH, RP): Documentation of concomitant nitrate use
<b>Required Medical Information</b>	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). 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PAH): Prescribed by or in consultation with a Cardiologist or Pulmonologist
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# SIMPONI 2026

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
<b>Required Medical Information</b>	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), 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, 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, 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, Ustekinumab (i.e. Yesintek), (d) Rinvoq, (e) Skyrizi OR documentation demonstrating that a trial may be inappropriate.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(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.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(AS, PsA, RA, UC)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Pulmonary Multi-Drug Resistant Tuberculosis (MDR-TB): (1) Diagnosis of MDR-TB due to Mycobacterium tuberculosis resistant to at least rifampin and isoniazid. (2) Member weighs at least 8 kg (2) Sirturo (bedaquiline) will be administered by directly observed therapy (DOT).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(MDR-TB): Prescribed by or in consultation with infectious disease specialist or pulmonologist
<b>Coverage Duration</b>	24 weeks
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# SKYRIZI SC 2026

## Products Affected

- SKYRIZI PEN
- SKYRIZI SUBCUTANEOUS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
<b>Required Medical Information</b>	Plaque psoriasis (PsO):Diagnosis of moderate to severe PsO. Psoriatic Arthritis (PsA)(Initial): (1) Diagnosis of PsA. Crohn's Disease (CD)(Initial): (1) Diagnosis of CD. (2) Used as a maintenance therapy following induction therapy with the IV formulation. Ulcerative Colitis (UC)(Initial): (1) Diagnosis of moderately to severely active UC (2) Used as a maintenance dose following the intravenous induction doses.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PsO): Prescribed by or in consultation a dermatologist (PsA): Prescribed by or consultation with a rheumatologist or dermatologist (CD, UC): Prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Part B drug applies only to beneficiaries enrolled in an MA-PD plan. (PsO, PsA, CD, UC)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# SOTATERCEPT 2026

## Products Affected

- WINREVAIR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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) IV prostacyclin therapy (treprostinil, epoprostenol) (3) Member continues to receive other PAH therapies (e.g. ambrisentan, tadalafil)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PAH): Prescribed by or in consultation with cardiologist or pulmonologist.
<b>Coverage Duration</b>	(Initial) 6 months (Reauth) 12 months
<b>Other Criteria</b>	(PAH)(Reauth): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# TADALAFIL (BPH) 2026

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## Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(BPH): Concurrent use of nitrates.
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# TALTZ 2026

## Products Affected

- TALTZ

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
<b>Required Medical Information</b>	<p>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, 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 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) 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), 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).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(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.
<b>Coverage Duration</b>	12 months

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

# TAVNEOS 2026

## Products Affected

- TAVNEOS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(ANCA-V(GPA)(MPA))Prescribed by or in consultation with a nephrologist, pulmonologist, or rheumatologist.
<b>Coverage Duration</b>	(Initial): 6 Months (Reauth): 1 year
<b>Other Criteria</b>	(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).
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Primary or Hypogonadal Osteoporosis (HGO)(Initial): (1) Diagnosis of HGO in men. (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 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 (a) bisphosphonates or (b) hormone replacement therapy. 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 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, selective-estrogen receptor modulators (SERMs), OR (d) denosumab (i.e. Jubbonti).</p>
<b>Age Restrictions</b>	(HGO, PMO, GCO) (Initial and Reauth): Member is 18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	(Initial and Reauth): Remainder of contract year

PA Criteria	Criteria Details
<b>Other Criteria</b>	Glucocorticoid Induced Osteoporosis (GCO)(Initial): (1) Diagnosis of CGO in men or women. (2) Daily dose of prednisone is greater than or equal to 5mg for at least 3 months. (3) Inadequate response or inability to tolerate ONE of the following: (a) bisphosphonates, (b) hormone replacement therapy, selective-estrogen receptor modulators (SERMs), or (d) denosumab (i.e. Jubbonti). (HGO, PMO, GCO) (Reauth): One of the following: (1) Cumulative lifetime therapy does not exceed 2 years, OR (2) member remains at or has returned to having a high risk for fracture despite a total of 24 months of use of parathyroid hormones.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# TESTOSTERONE PRODUCTS 2026

## Products Affected

- JATENZO 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 cypionate intramuscular solution 100 mg/ml, 200 mg/ml
- testosterone enanthate intramuscular solution
- testosterone transdermal gel 12.5 mg/act (1%),
- testosterone transdermal solution
- XYOSTED

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 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) documentation that the risk versus benefit has been assessed.
<b>Age Restrictions</b>	(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
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	(DP, BC): Indefinite (HG)(New Starts, Continuation): Indefinite
<b>Other Criteria</b>	(HG)(Continuation): ONE of the following (1) negative history of prostate and breast cancer OR (2) documentation that the risk versus benefit has been assessed
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	No

# TETRABENAZINE 2026

## Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(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.
<b>Coverage Duration</b>	(TD)(Initial): 3 months. (TD)(Reauth): Indefinite. (TS, CHD): Indefinite.
<b>Other Criteria</b>	(TD)(Reauth): Positive clinical response to therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# TOLVAPTAN 2026

## Products Affected

- *tolvaptan oral tablet*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(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)
<b>Required Medical Information</b>	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.).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Hyponatremia: Prescribed by or in consultation with a cardiologist, endocrinologist or nephrologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# TOPICAL CHEMO AGENTS 2026

## Products Affected

- *bexarotene*
- VALCHLOR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or dermatologist
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# TOPICAL RETINOID PRODUCTS 2026

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## 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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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). 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PAH): Prescribed by or in consultation with a Cardiologist or Pulmonologist
<b>Coverage Duration</b>	(Initial): 6 months. (Continuation):12 months.
<b>Other Criteria</b>	(PAH)(Continuation): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# TREMFYA SQ 2026

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
<b>Required Medical Information</b>	<p>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, 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 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), 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</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(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
<b>Coverage Duration</b>	12 months

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

# TRIKAFTA 2026

## Products Affected

- TRIKAFTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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. 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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(CF): Prescribed by or in consultation with a pulmonologist or Specialist affiliated with a CF care center
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(CF)(Reauth): Member has had a positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# TYMLOS 2026

## Products Affected

- TYMLOS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>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 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, selective-estrogen receptor modulators (SERMs), OR (d) denosumab (i.e. Jubbonti).</p> <p>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,denosumab [i.e. Jubbonti])</p>
<b>Age Restrictions</b>	(PMO, OSTm) Member is 18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Remainder of contract year
<b>Other Criteria</b>	(PMO, OSTm)(Reauth): Cumulative lifetime therapy does not exceed 2 years
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	Yes

# TYVASO DPI 2026

## Products Affected

- TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32MCG & 112 X64MCG, 112 X 48MCG & 112 X64MCG, 16 MCG, 32 MCG, 48 MCG, 64 MCG, 80 MCG
- TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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). 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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PAH)(PH-ILD): Prescribed by or in consultation with a Cardiologist or Pulmonologist
<b>Coverage Duration</b>	(Initial): 6 months. (Continuation): 12 months.
<b>Other Criteria</b>	(PAH)(PH-ILD)(CONTINUATION): Member demonstrates positive clinical response as evaluated by a cardiologist or pulmonologist.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# UBRELVY 2026

## Products Affected

- UBRELVY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Medication will be used in combination with another CGRP inhibitor for treatment of acute migraines.
<b>Required Medical Information</b>	Acute Treatment of Migraines (AM)(Initial): (1) Diagnosis of migraine with or without aura in adults. (2) Member has fewer than 15 headache days per month. (3) One of the following: (a) inadequate response or inability to tolerate ONE generic formulary triptan (e.g., eletriptan, rizatriptan, sumatriptan) or (b) member has a history of coronary artery disease, peripheral vascular disease, uncontrolled hypertension, or other vascular risk factors or disorder and is unable to tolerate triptans.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist, headache specialist certified by the United Council for Neurologic Subspecialties, or pain specialist
<b>Coverage Duration</b>	(AM)(Initial): 6 months. (AM)(Reauth): 12 months
<b>Other Criteria</b>	(AM)(Reauth): (1) Positive response to therapy (e.g. reduction in pain, photophobia, phonophobia, nausea)
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# VEOZAH 2026

## Products Affected

- VEOZAH

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	(VMS)(Initial): 6 months, (Reauth): 12 months
<b>Other Criteria</b>	(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.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# VERQUVO 2026

## Products Affected

- VERQUVO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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) 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]
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(CHF) (Initial): Prescribed by or in consultation with a Cardiologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(CHF) (Cont): Documentation of positive clinical response to therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# VIGAFYDE SOLUTION 2026

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## Products Affected

- VIGAFYDE

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

# VOQUEZNA TABLETS 2026

## Products Affected

- VOQUEZNA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	H. pylori: 1 month Healing of EE: 8 weeks. Maintenance of EE: 6 month GERD: 1 month
<b>Other Criteria</b>	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.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	

PA Criteria	Criteria Details
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# VOWST 2026

## Products Affected

- VOWST

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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) Difucid (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)
<b>Age Restrictions</b>	(PCDI): Member is 18 years of age or older
<b>Prescriber Restrictions</b>	(PCDI): Prescribed by or in consultation with gastroenterologist or infectious disease specialist
<b>Coverage Duration</b>	(PCDI): 14 days
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# VRAYLAR 2026

## Products Affected

- VRAYLAR ORAL CAPSULE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# WAINUA 2026

## Products Affected

- WAINUA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(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
<b>Required Medical Information</b>	(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 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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(hATTR amyloidosis): Prescribed by or in consultation with a neurologist, geneticist, or professional provider specializing in the treatment of amyloidosis
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(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 Member continues to have a baseline Karnofsky Performance Status score greater than 50 percent
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	No

# WILSONS DISEASE 2026

## Products Affected

- *trientine hcl oral capsule 500 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(WD): Prescribed by or in consultation with gastroenterologist, hepatologist, or liver transplant specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(WD) (Reauth): (1) Member demonstrates positive clinical response to therapy (e.g., reduction in 24-hour urinary copper excretion levels from baseline)
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# XDEMVIY 2026

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## Products Affected

- XDEMVIY

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
<b>Exclusion Criteria</b>	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), Janus kinase (JAK) inhibitors or potent immunosuppressants (e.g. azathioprine, cyclosporine)
<b>Required Medical Information</b>	Rheumatoid arthritis (RA) [applies to Xeljanz/Xeljanz XR tablets](Initial): (1) Diagnosis of moderate to severe RA. (2) Inadequate response or inability to tolerate one DMARD: (e.g. methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine), (3) Member had 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. Psoriatic Arthritis (PsA) [applies to Xeljanz/Xeljanz XR tablets](Initial): (1) Diagnosis of PsA. (2) 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. Ulcerative Colitis (UC) [applies to Xeljanz/Xeljanz XR tablets](Initial): (1) Diagnosis of moderate to severe UC. (2) Inadequate response or inability to tolerate one or more TNF inhibitors (e.g. Adalimumab-AACF) or documentation demonstrating that a trial may be inappropriate. Polyarticular Juvenile Idiopathic Arthritis (PJIA) [applies to Xeljanz tablets/oral solution](Initial): (1) Diagnosis of PJIA. (2) Inadequate response or inability to tolerate one or more TNF inhibitors (e.g. etanercept (Enbrel), Adalimumab-AACF) OR documentation demonstrating that a trial may be inappropriate. (3) Inadequate response or inability to tolerate ONE of the following: Methotrexate, Leflunomide, Sulfasalazine.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(RA, PJIA, AS): Prescribed by or in consultation with a rheumatologist. (PsA): Prescribed by or in consultation with a dermatologist or rheumatologist. (UC): Prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	Ankylosing Spondylitis (AS): (1) Diagnosis of ankylosing spondylitis. (2) Inadequate response or inability to tolerate one or more TNF inhibitors (e.g. adalimumab (adalimumab-AACF), etanercept (Enbrel)) OR documentation that a trial may be inappropriate. (RA, PsA, UC, AS, PJIA)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# XERMELO 2026

## Products Affected

- XERMELO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	(CSD): Member is 18 years of age or older
<b>Prescriber Restrictions</b>	(CSD): Prescribed by or in consultation with an Oncologist, Endocrinologist, or Gastroenterologist
<b>Coverage Duration</b>	(Initial): 12 months (Reauth): Indefinite
<b>Other Criteria</b>	(CSD)(Reauth): (1) Positive clinical response to Xermelo therapy, (2) Xermelo will continue to be used in combination with SSA therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# XIFAXAN 550MG 2026

## Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	:
<b>Coverage Duration</b>	(HE): Indefinite. (IBS): 2 weeks. (SBBO/SIBO): Initial and Reauth: 2 weeks.
<b>Other Criteria</b>	(SBBO/SIBO) (Reauth): (1) Documentation of Small Bowel Bacterial Overgrowth (SBBO)/Small Intestinal Bacterial Overgrowth (SIBO) recurrence following successful initial treatment
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	Yes

# XOLAIR 2026

## Products Affected

- XOLAIR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with any other biologic agents for asthma/allergic conditions (e.g., benralizumab [Fasenra], dupilumab [Dupixent], mepolizumab [Nucala])
<b>Required Medical Information</b>	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), 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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(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
<b>Coverage Duration</b>	12 months.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>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</p>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# XYREM 2026

## Products Affected

- XYREM

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	CN, EDSN: Concurrent use of sedative hypnotics and alcohol
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(CN, EDSN): Prescribed by or in consultation with a neurologist, psychiatrist, or sleep specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(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.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# XYWAV 2026

## Products Affected

- XYWAV

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	CN, EDSN: Concurrent use of sedative hypnotics and alcohol
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(CN, EDSN, IH): Prescribed by or in consultation with a neurologist, psychiatrist, or sleep specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(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.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# ZAVESCA 2026

## Products Affected

- *miglustat*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	(T1GD): Member is 18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(T1GD)(Reauth): Documentation of positive clinical response to therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# ZTALMY 2026

## Products Affected

- ZTALMY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder: (1) Diagnosis of cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (2) Documentation of mutation in the CDKL5 gene (3) member is experiencing motor seizures (e.g. bilateral tonic, generalized tonic-clonic, bilateral clonic, atonic, focal, or bilateral tonic-clonic).
<b>Age Restrictions</b>	(CDKL5): Member is 2 years of age or older
<b>Prescriber Restrictions</b>	(CDKL5): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	Approve if for continuation of therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# ZURZUVAE 2026

## Products Affected

- ZURZUVAE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Postpartum depression (PPD): (1) Diagnosis of postpartum depression (PPD) (2) Onset of symptoms in the third trimester or within 4 weeks of delivery (3) Prescriber attests that the patient has been counseled and has agreed to adhere to the following: Will follow instructions to not drive or operate machinery until at least 12 hours after taking each dose of Zurzuvae for the duration of the 14-day treatment course and that patients are informed that they may not be able to assess their own driving competence or the degree of driving impairment caused by Zurzuvae.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	14 days
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes



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