

2027 **Priority**Medicare® Dual Premier (HMO D-SNP)

Prior Authorization Criteria

An alphabetical index by drug name appears after the drug criteria listings.

Last updated: September 2026
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ACTHAR

Products Affected

- Acthar
- Acthar Gel

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of prior therapies and responses to treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 weeks
Other Criteria	Not covered for acute gouty arthritis, severe psoriasis, and atopic dermatitis. For all covered indications, except infantile spasms, must have a therapeutic trial of a parenteral glucocorticoid AND Cortrophin. Supporting documentation for all drug trials is required demonstrating inadequate response, intolerance, or FDA labeled contraindication to therapy. Reauthorization of previously authorized therapy requires demonstrated clinical benefit. Quantity limited to dosage as supported by the FDA-approved label.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

ACTIMMUNE

Products Affected

- Actimmune

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient's body surface area (BSA)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	FOR PULMONARY ARTERIAL HYPERTENSION (PAH): Documentation that the patient has pulmonary arterial hypertension (WHO Group 1) confirmed by right heart catheterization must be provided. FOR CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH): Documentation that the patient has CTEPH (WHO Group 4) - and - CTEPH is classified as inoperable or as persistent/recurrent after pulmonary endarterectomy must be provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

AIMOVIG

Products Affected

- Aimovig

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other CGRP antagonist therapy.
Required Medical Information	For migraine prevention initial requests: Must have at least four migraine days per month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 1 year. Reauth: 2 years. Dosing must align with FDA labeling.
Other Criteria	For migraine prevention reauthorization requests: Must provide documentation of a decrease in migraine days per month with use of Aimovig.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

AKEEGA

Products Affected

- Akeega

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ALPRAZOLAM

Products Affected

- alprazolam oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	End of plan year.
Other Criteria	For all indications, approve if: (1) The provider has determined that taking opioids and benzodiazepines together is medically necessary for the patient, OR (2) the patient is in hospice, palliative (end-of-life) care, has cancer and/or has sickle cell disease, OR (3) the patient will not be taking an opioid or benzodiazepine concurrently, OR (4) the patient is less than 18 years old. Note: The criteria only apply to patients 18 years of age or older with concurrent use of a benzodiazepine and opioid. The use of opioids concurrently with benzodiazepines is associated with an increased risk of opioid overdose.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

ALUNBRIG

Products Affected

- Alunbrig Oral Tablet 180 MG, 30 MG, 90 MG
- Alunbrig Oral Tablet Therapy Pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ambrisentan

Products Affected

- ambrisentan

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

AMITRIPTYLINE

Products Affected

- amitriptyline hcl oral

PA Criteria	Criteria Details
Exclusion Criteria	The criteria only apply to patients 65 years and older.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Coverage requires the following: (1) Prescriber acknowledges that the benefit of therapy outweighs the potential risks for this patient, and (2) Prescriber has considered therapy changes if the patient is using more than one anticholinergic drug in combination. Note: Due to safety concerns, this medication is considered potentially inappropriate in older adults, and is best avoided, prescribed at lower dose, or used with caution.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Antihistamines – 2nd Generation

Products Affected

- cetirizine hcl childrens oral solution 5 mg/5ml
- cetirizine hcl oral tablet chewable

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Allergy to the preferred medications, OR Contraindication or drug to drug interaction with the preferred medications, OR History of unacceptable side effects with the preferred medications, OR Trial and failure on one preferred second-generation antihistamine or clinical rationale why they cannot be tried
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	The preferred products (No Prior Authorization required) in this class are: cetirizine tablets, cetirizine 1mg/ml solution, fexofenadine tablets, levocetirizine, loratadine tablets/ODT/solution syrup.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Anti-Obesity/Weight Loss Agents - Non-Preferred Products

Products Affected

- | | |
|---|--|
| • liraglutide -weight management | 1 MG/0.5ML, 1.7 MG/0.75ML, 2.4 |
| • Saxenda | MG/0.75ML |
| • Wegovy HD | • Zepbound KwikPen |
| • Wegovy Subcutaneous Solution Auto-Injector 0.25 MG/0.5ML, 0.5 MG/0.5ML, | • Zepbound Subcutaneous Solution Auto-Injector |

PA Criteria	Criteria Details
Exclusion Criteria	Prescriber attests that the patient will not use more than one weight loss medication in this drug class concurrently, AND for patients with an eating disorder, prescriber attests that treatment has been optimized and confirms the safety and appropriateness of this anti-obesity treatment, AND prescriber attests that metabolic or other reason(s) for obesity/symptoms have been ruled out or diagnosed and treated (e.g., thyroid dysfunction, diabetes, sleep apnea, etc.), AND prescriber attests to patient's absence of any contraindications to use of the requested product, including pregnancy, lactation, a personal or family history of medullary thyroid cancer or multiple endocrine neoplasia type II, AND prescriber attests medication therapy is part of a total treatment plan including diet and exercise/activity as appropriate for the patient's ability, AND prescriber attests that patient has been informed weight may return with cessation of medication unless healthy lifestyle diet and activity changes, as appropriate for the patient's ability, are permanently adopted, AND prescriber attests there has been documented failure of all other clinically appropriate weight loss interventions, AND prescriber attests that use of this GLP-1 agent for weight loss is considered only as a measure to avert the need for higher-cost bariatric surgery, AND prescriber attests that the patient will not use an anti-obesity GLP-1 agonist (Wegovy, Saxenda/liraglutide or Zepbound) concurrently with a medication that contains a DPP-4 inhibitor (alogliptin, linagliptin, saxagliptin or sitagliptin).

PA Criteria	Criteria Details
Required Medical Information	Prescriber attests patient age 12 years to less than 18 years and has an initial BMI per CDC growth charts for age and sex and is classified as morbidly obese, OR prescriber attests patient age is 18 years or older and has an initial body mass index (BMI) classified as morbidly obese (e.g., baseline BMI greater than or equal to 40 kg/m ² or greater), AND allergy to all five types of preferred medications (e.g., at least 1 of each benzphetamine, diethylpropion, orlistat products, phendimetrazine, and phentermine products), OR contraindication or drug to drug interaction with all five types of preferred medications, OR history of unacceptable side effects of all five types of preferred medications, OR trial and failure with all five types of preferred agents (e.g., at least one orlistat agent and one phentermine product in addition to benzphetamine, diethylpropion and phendimetrazine).
Age Restrictions	Patient aged 12 years and older (Wegovy injectable, Saxenda/liraglutide), OR patient aged 18 years and older (Wegovy HD, Zepbound).
Prescriber Restrictions	
Coverage Duration	6 months, initial and reauthorization.

PA Criteria	Criteria Details
Other Criteria	The preferred products in this class are: benzphetamine (only available as generic), diethylpropion (only available as generic), orlistat products (orlistat, Xenical), phendimetrazine (only available as generic), phentermine products (Adipex-P, Lomaira, phentermine, phentermine/topiramate (only available as a generic)). RENEWAL CRITERIA: For adults aged greater than or equal to 18 years, prescriber provides clinical documentation showing that the patient has maintained a weight loss of greater than or equal to 5% from baseline weight at initiation of therapy, OR for patients aged 12 years to less than 18 years, prescriber provides clinical documentation showing that the patient has maintained or improved BMI percentile per CDC growth charts from baseline weight at initiation of therapy, AND for the first renewal request - for weight loss ONLY - in established members without an initial approval on or after 1/1/2026 criteria changes: Prescriber attests that the patient was classified as morbidly obese when they were initially started on the GLP-1 agent for weight loss, AND prescriber attests there was documented failure of all other clinically appropriate weight loss interventions prior to starting the GLP-1 agent for weight loss, AND prescriber attests that use of the GLP-1 agent for weight loss was considered only as a measure to avert the need for higher-cost bariatric surgery.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Anti-Obesity/Weight Loss Agents - Preferred Products

Products Affected

- Adipex-P Oral Tablet
- benzphetamine hcl oral tablet 50 mg
- diethylpropion hcl er
- diethylpropion hcl oral
- Lomaira
- orlistat oral
- phendimetrazine tartrate
- phendimetrazine tartrate er
- phentermine hcl oral capsule
- phentermine hcl oral tablet 37.5 mg
- phentermine-topiramate er
- Xenical

PA Criteria	Criteria Details
Exclusion Criteria	Prescriber attests that the patient will not use more than one weight loss medication in this drug class concurrently, AND for patients with an eating disorder, prescriber attests that treatment has been optimized and confirms the safety and appropriateness of this anti-obesity treatment, AND prescriber attests that metabolic or other reason(s) for obesity/symptoms have been ruled out or diagnosed and treated (e.g., thyroid dysfunction, diabetes, sleep apnea, etc.), AND prescriber attests to patient's absence of any contraindications to use of the requested product, including pregnancy, lactation, a personal or family history of medullary thyroid cancer or multiple endocrine neoplasia type II, AND prescriber attests medication therapy is part of a total treatment plan including diet and exercise/activity as appropriate for the patient's ability, AND prescriber attests that patient has been informed weight may return with cessation of medication unless healthy lifestyle diet and activity changes, as appropriate for the patient's ability, are permanently adopted.
Required Medical Information	Patient 12 years to less than 18 years of age must have an initial BMI per CDC growth charts at the 95th percentile or greater for age and sex (obesity), OR patient aged 12 years to less than 18 years with BMI in the 85th - 94th percentile (overweight) per CDC growth charts and has at least one of the following weight-related coexisting conditions: diabetes, sleep apnea, hypertension, or dyslipidemia, OR patient aged 18 years and older must have an initial body mass index (BMI) greater than or equal to 30 kg/m ² , OR patient aged 18 years and older must have an initial body mass index (BMI) greater than or equal to 27 kg/m ² but less than 30 kg/m ² and at least one of the following: hypertension, coronary artery disease, diabetes, dyslipidemia, or sleep apnea.

PA Criteria	Criteria Details
Age Restrictions	Patient aged 12 years and older (phentermine/topiramate, Xenical/Orlistat), OR patient aged 17 years and older (phentermine), OR patient aged 18 years and older (benzphetamine, diethylpropion, phendimetrazine).
Prescriber Restrictions	
Coverage Duration	6 months, initial and reauthorization.
Other Criteria	RENEWAL CRITERIA: For adults aged greater than or equal to 18 years, prescriber provides clinical documentation showing that the patient has maintained a weight loss of greater than or equal to 5% from baseline weight at initiation of therapy, OR for patients aged 12 years to less than 18 years, prescriber provides clinical documentation showing that the patient has maintained or improved BMI percentile per CDC growth charts from baseline weight at initiation of therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

aprepitant

Products Affected

- aprepitant

PA Criteria	Criteria Details
Exclusion Criteria	Aprepitant is not covered in the following situations: (1) treatment of established nausea and vomiting, and (2) for chronic continuous use.
Required Medical Information	For post-op nausea/vomiting: Provide date of surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year authorization with limit of one 30-day fill for post-op nausea/vomiting
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For the treatment of recurrent pericarditis: Must have documentation supporting a trial and failure (defined as inadequate response) with an NSAID in combination with colchicine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ARIKAYCE

Products Affected

- Arikayce

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial review, sputum culture supporting the diagnosis of Mycobacterium avium complex (MAC) lung disease must be submitted.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an infectious disease specialist or pulmonologist.
Coverage Duration	Initial approval for 6 months. Reauthorization for 12 months.
Other Criteria	For initial review, documentation of failure to obtain negative sputum cultures after a minimum of 6 months of a multidrug background regimen therapy for MAC lung disease must be provided. For reauthorization, documentation of a negative sputum culture obtained within the last 30 days must be provided. Criteria will be applied consistent with current ATS/IDSA guidelines.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

aripiprazole odt

Products Affected

- aripiprazole oral tablet dispersible

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation to support an inability to use generic aripiprazole tablet.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ARIPIRAZOLE ORAL SOLUTION

Products Affected

- aripiprazole oral solution

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have tried and have a documented intolerance or contraindication to aripiprazole TABLET and either olanzapine ODT or risperidone ODT.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

armodafinil

Products Affected

- armodafinil

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

asenapine

Products Affected

- asenapine maleate

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as an inadequate response) with two of the following generic drugs used for at least 28 days each: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, or lurasidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

AUGTYRO

Products Affected

- Augtyro Oral Capsule 160 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

AUSTEDO

Products Affected

- Austedo Oral Tablet 12 MG, 6 MG, 9 MG 18 & 24 & 30 MG
- Austedo XR
- Austedo XR Patient Titration Oral Tablet
Extended Release Therapy Pack 12 &

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with tetrabenazine or Ingrezza.
Required Medical Information	TARDIVE DYSKINESIA (TD) INITIAL REQUESTS: (1) Patient has tried and failed tetrabenazine, and (2) the TD is not associated with a dopamine receptor blocking drug, OR (3) the TD is associated with a dopamine receptor blocking drug and symptoms have persisted despite stopping or reducing the dose of the dopamine blocking drug, OR (4) stopping or reducing the dose of the dopamine blocking drug is not possible.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial and reauth: One year.
Other Criteria	REAUTHORIZATION OF TD OR CHOREA ASSOCIATED WITH HUNTINGTON'S DISEASE: Documentation supporting improvement or stabilization of the condition with the use of Austedo compared to baseline has been provided.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

AUVELITY

Products Affected

- Auvelity
- Auvelity Titration Pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of prior therapies and responses to treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years. Dosing must follow the FDA-approved labeling.
Other Criteria	Must try and fail (defined as an inability to improve depressive symptoms after at least 4 weeks of treatment) with an SSRI or SNRI and 1 atypical antidepressant (e.g., bupropion, mirtazapine).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

AVMAPKI-FAKZYNJA

Products Affected

- Avmapki Fakzynja Co-Pack

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

AVONEX

Products Affected

- Avonex Pen Intramuscular Auto-Injector Kit
- Avonex Prefilled Intramuscular Prefilled Syringe Kit

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

AVTOZMA

Products Affected

- Avtozma Subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, Janus Kinase Inhibitor (JAKis).
Required Medical Information	Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dose must align with FDA label or Part D compendia.
Other Criteria	FOR RHEUMATOID ARTHRITIS and JUVENILE IDIOPATHIC ARTHRITIS: Trial of two of the following with inadequate response: a preferred adalimumab product, Rinvoq, tofacitinib or Enbrel. FOR SScILD INITIAL COVERAGE: Confirmed diagnosis by HRCT. FOR SScILD REAUTHORIZATION: Documentation of improvement in condition.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

AYVAKIT

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

BALVERSA

Products Affected

- Balversa Oral Tablet 3 MG, 4 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

BENLYSTA

Products Affected

- Benlysta Subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used with another biologic drug or Lupkynis.
Required Medical Information	For SLE initial requests: Must have a SELENA-SLEDAI score of 6 or more before starting Benlysta AND either an anti-dsDNA antibody greater than 30 IU/ml or ANA greater than 1:80. For LN initial requests: Must have a confirmed diagnosis of SLE AND a kidney biopsy confirming class 3, 4, and/or 5 disease.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a specialist in treating the condition or have consulted with a specialist.
Coverage Duration	1 year initial. 2 years reauthorization.
Other Criteria	For SLE initial requests: Must be taking two of the following drugs together for at least 12 weeks each: a steroid, immunosuppressant, and/or hydroxychloroquine - AND - For SLE reauthorization: Must have evidence of clinical improvement with Benlysta. For lupus nephritis (LN) initial requests: Must be receiving standard therapy for LN (e.g., mycophenolate or azathioprine plus a steroid) - AND - For LN reauthorization: Must have evidence of clinical improvement with Benlysta, including improved or stable eGFR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

BESREMI

Products Affected

- Besremi
- Besremi Pen

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years. Dosing must follow the FDA-approved labeling.
Other Criteria	Must trial and fail hydroxyurea (defined as an intolerance and/or persistence or recurrence of disease).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

BETASERON

Products Affected

- Betaseron Subcutaneous Kit

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

bexarotene

Products Affected

- bexarotene oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

BEXAROTENE GEL

Products Affected

- bexarotene external

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must first try tazarotene.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

BILPREVDA

Products Affected

- Bilprevda

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

bosentan

Products Affected

- bosentan oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

BOSULIF

Products Affected

- Bosulif Oral Capsule 100 MG, 50 MG
- Bosulif Oral Tablet 100 MG, 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

BOSUTINIB

Products Affected

- bosutinib oral tablet 100 mg, 400 mg, 500 mg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

BRAFTOVI

Products Affected

- Braftovi Oral Capsule 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have documentation of BRAF V600 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

BRIVARACETAM

Products Affected

- brivaracetam oral solution
- brivaracetam oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate seizure control) with generic levetiracetam and at least 1 other generic anticonvulsant for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

BRUKINSA

Products Affected

- Brukinsa Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For CLL/SLL, marginal zone lymphoma, mantle cell lymphoma, and Waldenström Macroglobulinemia where NCCN Guidelines give the same category of recommendation: Your prescriber must provide rationale supporting why Calquence or Imbruvica cannot be used in place of Brukinsa.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

BYSANTI

Products Affected

- Bysanti
- Bysanti Titration Pack A
- Bysanti Titration Pack B
- Bysanti Titration Pack C

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must have documentation supporting a trial and failure (defined as an inadequate response) with two of the following generic drugs that have support for the requested condition and each used for at least 28 days: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, or lurasidone.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

calcipotriene/betamethasone suspension

Products Affected

- calcipotriene-betameth diprop external suspension

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure with a generic topical steroid for the scalp (such as fluocinonide solution, clobetasol solution, clobetasol shampoo) in combination with generic calcipotriene solution. Failure is defined as an inadequate response in treating the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

CALQUENCE

Products Affected

- Calquence Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

CAPLYTA

Products Affected

- Caplyta

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of prior therapies and responses to treatment must be provided.
Age Restrictions	Must be age 18 or older.
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	For schizophrenia: Patient must have tried and failed (defined as taking the medication as prescribed without an adequate response or with intolerance) two of the following generic atypical antipsychotics: aripiprazole, ziprasidone, olanzapine, risperidone, quetiapine. For depressive episodes associated with bipolar 1 disorder: Patient must have tried and failed (defined above) one of the following generic products: quetiapine or olanzapine (with fluoxetine) - AND - Patient must have tried and failed (defined above) generic lurasidone. For depressive episodes associated with bipolar 2 disorder: Patient must have tried and failed (defined above) quetiapine. For adjunctive therapy with antidepressants for major depressive disorder (MDD): Must have tried and failed (defined above) two generic atypical antipsychotics (such as aripiprazole and quetiapine ER).
Indications	All FDA-approved Indications.
Off Label Uses	

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

CAPRELSA

Products Affected

- Caprelsa Oral Tablet 100 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

CARGLUMIC ACID

Products Affected

- carglumic acid oral tablet soluble

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

CAVHANZA

Products Affected

- Cavhanza

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, prior therapies.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must have a documented inability to use generic nilotinib.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

CAYSTON

Products Affected

- Cayston

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

CHLORDIAZEPOXIDE

Products Affected

- chlordiazepoxide hcl

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	End of plan year.
Other Criteria	For all indications, approve if: (1) The provider has determined that taking opioids and benzodiazepines together is medically necessary for the patient, OR (2) the patient is in hospice, palliative (end-of-life) care, has cancer and/or has sickle cell disease, OR (3) the patient will not be taking an opioid or benzodiazepine concurrently, OR (4) the patient is less than 18 years old. Note: The criteria only apply to patients 18 years of age or older with concurrent use of a benzodiazepine and opioid. The use of opioids concurrently with benzodiazepines is associated with an increased risk of opioid overdose.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

clobazam

Products Affected

- clobazam oral suspension 2.5 mg/ml
- clobazam oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Patient must first try one generic anticonvulsant. Clobazam suspension may only be used in patients where tablets are contraindicated (e.g., dysphagia).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

CLONAZEPAM

Products Affected

- clonazepam oral tablet 0.5 mg, 1 mg, 2 mg
- clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	End of plan year.
Other Criteria	For all indications, approve if: (1) The provider has determined that taking opioids and benzodiazepines together is medically necessary for the patient, OR (2) the patient is in hospice, palliative (end-of-life) care, has cancer and/or has sickle cell disease, OR (3) the patient will not be taking an opioid or benzodiazepine concurrently, OR (4) the patient is less than 18 years old. Note: The criteria only apply to patients 18 years of age or older with concurrent use of a benzodiazepine and opioid. The use of opioids concurrently with benzodiazepines is associated with an increased risk of opioid overdose.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

CLORAZEPATE DIPOTASSIUM

Products Affected

- clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	End of plan year.
Other Criteria	For all indications, approve if: (1) The provider has determined that taking opioids and benzodiazepines together is medically necessary for the patient, OR (2) the patient is in hospice, palliative (end-of-life) care, has cancer and/or has sickle cell disease, OR (3) the patient will not be taking an opioid or benzodiazepine concurrently, OR (4) the patient is less than 18 years old. Note: The criteria only apply to patients 18 years of age or older with concurrent use of a benzodiazepine and opioid. The use of opioids concurrently with benzodiazepines is associated with an increased risk of opioid overdose.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

CLOZAPINE ODT

Products Affected

- clozapine oral tablet dispersible

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient has had prior trial AND a documented contraindication (e.g. dysphagia) to generic clozapine tablet.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

COBENFY

Products Affected

- Cobenfy
- Cobenfy Starter Pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as an inadequate response) with two generic atypical antipsychotics used for at least 28 days each.
Age Restrictions	Must be age 18 or older.
Prescriber Restrictions	Must be prescribed by, or in consultation with, a specialist for the condition being treated.
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

COMETRIQ

Products Affected

- 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)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

COPIKTRA

Products Affected

- Copiktra

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

CORTROPHIN

Products Affected

- Cortrophin

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial-in accordance with FDA label or max of 3 mos. if unspecified in label. Reauth-1 year.
Other Criteria	For acute exacerbations of multiple sclerosis: trial of a parenteral and an oral glucocorticoid. For nephrotic syndrome associated with lupus erythematosus, systemic lupus erythematosus, and inflammatory ocular disorders: trial of a parenteral glucocorticoid and an immunosuppressant (e.g. cyclophosphamide, tacrolimus, mycophenolate mofetil, methotrexate, azathioprine). For adjunctive therapy for short-term administration in rheumatic disease: trial of a parenteral glucocorticoid and a covered biologic drug. For systemic dermatomyositis (polymyositis): trial of a parenteral glucocorticoid and rituximab. For all other covered indications, except infantile spasms: trial of a parenteral glucocorticoid and one other medication for the condition. Infantile spasm does not require prerequisite drug trials. Supporting documentation for all drug trials is required demonstrating inadequate response, intolerance, or FDA labeled contraindication to therapy. Reauthorization of previously authorized therapy requires demonstrated clinical benefit. Quantity limited to dosage as supported by the FDA-approved label for all requests.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Infantile Spasms
Part B Prerequisite	Yes
Prerequisite Therapy Required	Yes

COSENTYX

Products Affected

- Cosentyx (300 MG Dose)
- Cosentyx Sensoready (300 MG)
- Cosentyx Subcutaneous Solution Prefilled Syringe 75 MG/0.5ML
- Cosentyx UnoReady

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dose must follow FDA-label or be supported in Part D compendia.
Other Criteria	FOR ANKYLOSING SPONDYLITIS and NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NRAS): Trial of an NSAID with inadequate response. FOR PSORIASIS: Trial of a traditional DMARD (e.g., methotrexate, cyclosporine, acitretin) with inadequate response. FOR ERA: Trial of one other drug (e.g., methotrexate, NSAIDs) with inadequate response - or - have aggressive disease that requires initial biologic therapy. FOR HIDRADENITIS SUPPURATIVA: Trial of one other therapy (e.g., prednisone, clindamycin) with inadequate response.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

CRESEMBA

Products Affected

- Cresemba Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For invasive aspergillosis, documentation to support an inability to use generic voriconazole for the condition must be provided.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

CYSTADROPS

Products Affected

- Cystadrops

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

CYSTARAN

Products Affected

- Cystaran

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DALFAMPRIDINE ER

Products Affected

- dalfampridine er

PA Criteria	Criteria Details
Exclusion Criteria	Not covered with any of the following: (1) History of seizure, (2) Creatinine clearance (CrCl) of 50 ml per min or less, and (3) Patient is wheel-chair bound.
Required Medical Information	INITIAL: CrCl, diagnosis, walking status, baseline T25FW. REAUTH: CrCl, walking status, T25FW or other objective measurement.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial and Reauthorization: 1 year
Other Criteria	INITIAL COVERAGE: Requires documentation of a baseline timed 25-foot walk (T25FW) test (prior to initiation of dalfampridine treatment). REAUTHORIZATION: Requires documentation of stability or improvement in the T25FW test or in another objective measure of walking ability compared to baseline (prior to treatment with dalfampridine).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DANZITEN

Products Affected

- Danziten

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DASATINIB

Products Affected

- dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DAURISMO

Products Affected

- Daurismo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Diabetic Supplies

Products Affected

- assure id insulin safety syr 29g x 1/2" 1 ml
- bd autoshield duo
- bd pen needle 29g x 12mm
- bd pen needle micro u/f
- bd pen needle micro ultrafine
- bd pen needle mini u/f
- bd pen needle mini ultrafine
- bd pen needle nano 2nd gen
- bd pen needle nano u/f
- bd pen needle nano ultrafine
- bd pen needle orig ultrafine
- bd pen needle original u/f
- bd pen needle short u/f
- bd pen needle short ultrafine
- comfort assist insulin syringe 29g x 1/2" 1 ml
- cvs gauze sterile pad 2"x2"
- embecta autoshield duo
- embecta pen needle nano
- embecta pen needle nano 2 gen
- embecta pen needle ultrafine
- global alcohol prep ease
- novofine pen needle
- novofine plus pen needle
- preferred plus insulin syringe 28g x 1/2" 0.5 ml
- reli-on insulin syringe 29g 0.3 ml

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Approve if the prescriber confirms that the medical supply is being requested for a use that is directly associated with delivering insulin to the body.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

DIACOMIT

Products Affected

- Diacomit

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(1) Patient has a diagnosis of seizures associated with Dravet syndrome AND (2) Patient is not currently controlled on current therapy (defined as experiencing generalized tonic clonic or clonic seizures within the past 28 days) AND (3) Patient taking concomitant clobazam therapy.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a specialist (i.e. neurologist, epileptologist).
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

DIAZEPAM

Products Affected

- diazePAM Intensol
- diazepam oral solution 5 mg/5ml
- diazepam oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	End of plan year.
Other Criteria	For all indications, approve if: (1) The provider has determined that taking opioids and benzodiazepines together is medically necessary for the patient, OR (2) the patient is in hospice, palliative (end-of-life) care, has cancer and/or has sickle cell disease, OR (3) the patient will not be taking an opioid or benzodiazepine concurrently, OR (4) the patient is less than 18 years old. Note: The criteria only apply to patients 18 years of age or older with concurrent use of a benzodiazepine and opioid. The use of opioids concurrently with benzodiazepines is associated with an increased risk of opioid overdose.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

DICHLORPHENAMIDE

Products Affected

- dichlorphenamide

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

dihydroergotamine nasal spray

Products Affected

- dihydroergotamine mesylate nasal

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation to support (1) a trial and failure (defined as inability to improve symptoms or condition) of one non-oral triptan drug (e.g., sumatriptan nasal spray or injection) AND (2) a trial and failure (defined above) of Nurtec ODT.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

dimethyl fumarate

Products Affected

- dimethyl fumarate oral
- dimethyl fumarate starter pack oral
capsule delayed release therapy pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DRIZALMA

Products Affected

- Drizalma Sprinkle Oral Capsule Delayed Release Sprinkle 20 MG, 30 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have current documentation to support the following: (1) an inability to use duloxetine (generic Cymbalta), and (2) trial and failure (defined as an inability to improve the condition) with one other generic antidepressant.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

droxidopa

Products Affected

- droxidopa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year initial and reauthorization.
Other Criteria	Patient must first try midodrine. For reauthorization: Must have documentation of a positive clinical response (e.g., sustained decrease in dizziness).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

DUPIXENT

Products Affected

- Dupixent Subcutaneous Solution Auto-Injector 200 MG/1.14ML, 300 MG/2ML
- Dupixent Subcutaneous Solution Pen-Injector 200 MG/1.14ML, 300 MG/2ML
- Dupixent Subcutaneous Solution Prefilled Syringe 200 MG/1.14ML, 300 MG/2ML

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Diagnosis, concurrent therapies (CRSwNP), and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	1 year initial, 2 years reauth. Dose must align with FDA label or Part D compendia.

PA Criteria	Criteria Details
Other Criteria	ASTHMA INITIAL COVERAGE: (1) Use of an ICS/LABA inhaler as prescribed in the past 6 months with inadequate control of condition, AND (2) Current dependence on oral steroids OR a blood eosinophil level at least 150 cells per microliter in the past 12 months. EOSINOPHILIC ESOPHAGITIS (EOE) INITIAL COVERAGE: (1) confirmed diagnosis by biopsy defined as 15 or more eosinophils per high power field (HPF), and (2) symptomatic disease, and (3) Current weight at least 15 kg, AND (4) trial of a proton pump inhibitor or a swallowed topical steroid (e.g., fluticasone, budesonide) for at least 2 months with inadequate response. PRURIGO NODULARIS (PN) INITIAL COVERAGE: Confirmed diagnosis. ATOPIC DERMATITIS (AD) INITIAL COVERAGE: (1) Moderate to severe disease, AND (2) Trial of a medium or higher potency topical steroid or topical calcineurin inhibitor with inadequate response. CHRONIC RHINOSINUSITIS WITH NASAL POLYP (CRSwNP) INITIAL COVERAGE: (1) Chronic disease defined as 2 or more of the following symptoms for at least 12 weeks despite management (e.g., intranasal steroids, etc.): nasal congestion, obstruction, or blockage, nasal drainage, facial pain/pressure, or reduction in smell, AND (2) trial of an intranasal steroid with inadequate response, AND (3) Concurrent use of Dupixent and an intranasal steroid. COPD INITIAL COVERAGE: (1) blood eosinophil level at least 300 cells per microliter within the past 12 months, AND (2) Trial and failure of a LAMA, LABA, and ICS inhaled regimen used together (also called triple therapy) and as prescribed with failure defined as 2 or more COPD exacerbations in the past 12 months or 1 COPD hospitalization in the past 12 months. CHRONIC URTICARIA (CU) INITIAL COVERAGE: (1) Urticaria occurring for more than 6 weeks, and (2) trial of an H1 antihistamine with inadequate response. BULLOUS PEMPHIGOID (BP) INITIAL COVERAGE: (1) Confirmed diagnosis, AND (2) trial of a generic steroid-sparing drug (such as doxycycline, methotrexate, etc.) with inadequate response. ALLERGIC FUNGAL RHINOSINUSITIS (AFRS) INITIAL
	COVERAGE: Confirmed diagnosis and history of sino-nasal surgery. REAUTHORIZATION FOR ALL INDICATIONS: Documentation of clinical benefit compared to baseline (prior to Dupixent) - and - for CRSwNP only - continued use of Dupixent with an intranasal steroid.
Indications	All FDA-approved Indications.

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

ELTROMBOPAG

Products Affected

- eltrombopag olamine oral packet 12.5 mg, 25 mg
- eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg

PA Criteria	Criteria Details
Exclusion Criteria	Use of eltrombopag to normalize platelet counts is not covered.
Required Medical Information	Documentation supporting the request including current platelet count must be provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months

PA Criteria	Criteria Details
Other Criteria	FOR ITP INITIAL REQUESTS: (1) Must have a platelet count less than 30,000/mcL - OR - less than 50,000/mcL with bleeding or risk factor(s) for bleeding (e.g., history of bleeding, conditions that increase bleeding risk like peptic ulcer disease, history of falling, anticoagulation therapy), AND (2) Must have an inadequate response or intolerance to steroids or immunoglobulins, AND (3) Must have an inadequate response or intolerance to rituximab or splenectomy, AND (4) must not be used in combination with other drugs used for maintenance treatment of ITP including other thrombopoietin receptor agonists (ex: Doptelet, Nplate), Wayrilz, or Tavalisse. FOR THROMBOCYTOPENIA FROM HEPATITIS C INITIAL REQUESTS: Degree of thrombocytopenia prevents the initiation OR maintenance of interferon-based therapy. FOR APLASTIC ANEMIA INITIAL REQUESTS: Must be used with standard immunosuppressive therapy (antithymocyte globulin and cyclosporine) for first-line treatment or must have had an insufficient response to cyclosporine for second-line or subsequent treatment. FOR REAUTHORIZATION OF ALL PREVIOUSLY APPROVED REQUESTS: (1) Documentation that current platelet count is less than 400 x 10 ⁹ /L, AND (2) Documentation that supports patient is positively responding to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	Yes
Prerequisite Therapy Required	Yes

EMGALITY

Products Affected

- Emgality
- Emgality (300 MG Dose)

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other CGRP antagonist therapy.
Required Medical Information	FOR MIGRAINE PREVENTION INITIAL REQUESTS: Must have at least four migraine days per month. FOR CLUSTER HEADACHE INITIAL REQUESTS: Must try verapamil and have an intolerance or inability to improve the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year. Cluster reauth: 1 year. Migraine reauth: 2 years. Dosing must align with FDA labeling.
Other Criteria	For migraine prevention reauthorization requests: Must provide documentation of a decrease in migraine days per month with use of Emgality. For cluster headache reauthorization requests: Must provide documentation of a decrease in the frequency or intensity of cluster headaches with Emgality.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

EMSAM

Products Affected

- Emsam

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation supporting the trial and failure (defined as an inadequate improvement in depressive symptoms) with two of the following generic antidepressants is required: SNRIs, SSRIs, mirtazapine, or bupropion.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ENBREL

Products Affected

- Enbrel Subcutaneous Solution 25 MG/0.5ML
- Enbrel Subcutaneous Solution Prefilled Syringe 25 MG/0.5ML, 50 MG/ML
- Enbrel SureClick Subcutaneous Solution Auto-Injector

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dose must follow FDA-label or be supported in Part D compendia.
Other Criteria	Must try and fail adalimumab. Fail is defined as an intolerance or inability to improve condition.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ENBREL MINI

Products Affected

- Enbrel Mini

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dose must follow FDA-label or be supported in Part D compendia.
Other Criteria	Must try and fail adalimumab. Fail is defined as an intolerance or inability to improve condition.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ENSACOVE

Products Affected

- Ensacove

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

ENTYVIO PEN

Products Affected

- Entyvio Pen

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dose must follow FDA-label or be supported in Part D compendia.
Other Criteria	FOR CROHN'S DISEASE: (1) Patient has tried two of the following: infliximab, adalimumab, ustekinumab, Skyrizi, and Rinvoq. FOR ULCERATIVE COLITIS: (1) Patient has tried two of the following: infliximab, adalimumab, ustekinumab, tofacitinib, Skyrizi, and Rinvoq.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

EPIDIOLEX

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure with at least 2 generic anticonvulsants for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ERLEADA

Products Affected

- Erleada Oral Tablet 240 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	FOR METASTATIC DISEASE: Patient must be unable to use (such as a failure, intolerance or contraindication to) abiraterone and Xtandi. FOR NON-METASTATIC DISEASE: Patient must be unable to use (such as a failure, intolerance or contraindication to) Xtandi.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

erlotinib

Products Affected

- erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ESLICARBAZEPINE

Products Affected

- eslicarbazepine acetate oral tablet 200 mg, 400 mg, 600 mg, 800 mg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate seizure control) with at least 2 generic anticonvulsants for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

EUCRISA

Products Affected

- Eucrisa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Approve in patients who have tried and failed a prescription strength topical steroid for the current condition being treated. If a topical steroid is not appropriate for the patient, approve in patients who have tried a generic topical calcineurin inhibitor for the current condition being treated.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

EULEXIN

Products Affected

- Eulexin

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Coverage requires a trial with generic flutamide or bicalutamide.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

everolimus

Products Affected

- everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg
- everolimus oral tablet soluble

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

EXXUA ER

Products Affected

- Exxua
- Exxua Titration Pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of prior therapies and responses to treatment must be provided.
Age Restrictions	Must be age 18 or older.
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	For the treatment of major depressive disorder (MDD), must try and fail (defined as an inability to improve depressive symptoms after at least 4 weeks of treatment) with two generic antidepressants from a different class, one of which must be either bupropion or mirtazapine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

FANAPT

Products Affected

- Fanapt
- Fanapt Titration Pack A
- Fanapt Titration Pack B Oral Tablet
- Fanapt Titration Pack C Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as an inadequate response) with two of the following generic drugs that have support for the requested condition and each used for at least 28 days: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, or lurasidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

FARXIGA

Products Affected

- Farxiga

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must have documentation that supports an inability to use generic dapagliflozin.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

FASENRA

Products Affected

- Fasenra Pen
- Fasenra Subcutaneous Solution Prefilled Syringe 10 MG/0.5ML, 30 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs.
Required Medical Information	Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	1 year initial, 2 years reauth. Dose must align with FDA label or Part D compendia.
Other Criteria	ASTHMA INITIAL COVERAGE: (1) Use of an ICS/LABA inhaler as prescribed in the past 6 months with inadequate control of condition, AND (2) blood eosinophil level at least 150 cells per microliter in the past 12 months. FOR EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA) INITIAL COVERAGE: (1) Non-severe EGPA (defined as absence of life or organ-threatening manifestations). REAUTHORIZATION FOR ALL INDICATIONS: Documentation of clinical benefit compared to baseline (prior to Fasenra).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

FILSPARI

Products Affected

- Filspari Oral Tablet 200 MG, 400 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, kidney biopsy report, proteinuria measure (g/day or g/24 hours), history of prior therapies, clinical benefit (for reauthorization)
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a specialist.
Coverage Duration	One year initial and reauthorization.

PA Criteria	Criteria Details
Other Criteria	FOR IgA NEPHROPATHY INITIAL COVERAGE: (1) Patient has primary IgA nephropathy confirmed by biopsy, AND (2) Patient has persistent proteinuria (defined as 0.5 grams/day or more) despite use of a maximally tolerated ACEI or ARB, AND (3) Patient is not receiving dialysis, AND (4) Patient has not undergone kidney transplant. FOR IgA NEPHROPATHY REAUTHORIZATION: Patient has experienced clinical benefit evidenced by a reduction in proteinuria. FOR FSGS INITIAL COVERAGE: (1) Patient has primary focal segmental glomerulosclerosis (FSGS) confirmed by biopsy, AND (2) Patient is not currently in nephrotic syndrome (defined as proteinuria greater than 3.5 grams per 24 hours in adults), AND (3) Patient has persistent proteinuria (defined as 0.5 grams/day or more) despite use of a maximally tolerated ACEI or ARB, AND (4) Patient is not receiving dialysis, AND (5) Patient has not undergone kidney transplant. FOR FSGS REAUTHORIZATION: (1) Patient has experienced clinical benefit evidenced by a reduction in proteinuria, and (2) Patient is not currently in NS (defined as proteinuria greater than 3.5 grams per 24 hours in adults).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

FINGOLIMOD

Products Affected

- fingolimod hcl

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

FINTEPLA

Products Affected

- Fintepla

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate seizure control) with two of the following: clobazam, valproic acid, topiramate.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

FOTIVDA

Products Affected

- Fotivda

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

FRUZAQLA

Products Affected

- Fruzaqla Oral Capsule 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

GAVRETO

Products Affected

- Gavreto

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

GEFITINIB

Products Affected

- gefitinib

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

glatiramer

Products Affected

- glatiramer acetate subcutaneous solution
prefilled syringe 20 mg/ml, 40 mg/ml

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

GLATOPA

Products Affected

- Glatopa Subcutaneous Solution Prefilled Syringe 20 MG/ML, 40 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

GOMEKLI

Products Affected

- Gomekli

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

GROWTH HORMONE

Products Affected

- Norditropin FlexPro Subcutaneous Solution Pen-Injector 10 MG/1.5ML, 15 MG/1.5ML, 5 MG/1.5ML
- Omnitrope Subcutaneous Solution
- Cartridge
- Omnitrope Subcutaneous Solution Reconstituted

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	FOR CHILDREN: must submit an untreated growth velocity curve with a minimum of 1 year of growth data showing a growth velocity of less than 10th % for bone age and gender, growth plates must be open, bone age must be a minimum of 1 year behind chronological age (unless GHD is related to pituitary surgery, radiation therapy, or with precocious puberty), must have a documented GH deficiency via 2 growth hormone stimulation tests below 10ng/ml or GH stimulation test level less than 15 ng/ml + IGF-1 and IGF-PB3 levels below normal for bone age and sex, decreased muscle tone by exam. FOR ADULTS with a diagnosis of GHD: Must have confirmation of GHD by meeting one of the following: (1) A suboptimal response using an appropriate GH-stimulation test, (2) Child-onset GHD with confirmed persistent GHD, or (3) patient has all the following: (a) documented pituitary or hypothalamic disease (e.g., brain tumor with previous brain irradiation), (b) greater than or equal to 3 pituitary hormone deficiencies (thyroid-stimulating hormone (TSH), corticotropin (ACTH), and gonadotropins), and (c) low insulin-like growth factor-1 (IGF-1). If IGF-1 value is indeterminate, a suboptimal response on an appropriate GH-stimulation test required.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by an endocrinologist, gastroenterologist, or nephrologist.
Coverage Duration	One year

PA Criteria	Criteria Details
Other Criteria	FOR CHILDREN: Diagnosis of Growth Hormone Deficiency-height must be less than the 5th% fir age/sex. Diagnosis of Turner's syndrome-height must be less than 10th%. Diagnosis of Pre-transplant chronic renal insufficiency-height must be less than 5th% for age/sex and patient must be receiving weekly dialysis or SCR less than 2 mg/dL. FOR CHILDREN: must not have constitutional growth delay, or acute or chronic catabolic illness. FOR ADULTS, the following conditions are not covered: treatment of reduced growth hormone related to aging, Turner's syndrome or cystinosis. For reauthorization in adults and children: Above normal IGF-1 level requires provider attestation that dose will be decreased and therapy will be managed to obtain a level within normal range.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HADLIMA

Products Affected

- Hadlima PushTouch Subcutaneous Syringe 40 MG/0.4ML, 40 MG/0.8ML
Solution Auto-Injector 40 MG/0.4ML, 40
MG/0.8ML
- Hadlima Subcutaneous Solution Prefilled

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dose must follow FDA-label or be supported in Part D compendia.
Other Criteria	FOR RHEUMATOID ARTHRITIS: Trial of a traditional DMARD (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) with inadequate response. FOR PSORIASIS: Trial of a traditional DMARD (e.g., methotrexate, cyclosporine, acitretin) with inadequate response. FOR ANKYLOSING SPONDYLITIS: Trial of an NSAID with inadequate response. FOR HIDRADENITIS SUPPURATIVA: Trial of one other therapy (e.g., prednisone, clindamycin) with inadequate response. FOR UVEITIS: Trial of one other therapy (e.g., intraocular or oral steroid) with inadequate response. FOR JUVENILE IDIOPATHIC ARTHRITIS: Trial of one other therapy (e.g., methotrexate, NSAIDs) with inadequate response - or - patient is starting the drug concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the physician.
Indications	All Medically-accepted Indications.
Off Label Uses	

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

Haegarda

Products Affected

- Haegarda

PA Criteria	Criteria Details
Exclusion Criteria	Haegarda is not covered if any of the following are met: (1) use in combination with an angiotensin-converting enzyme inhibitor (ACEI), (2) use in combination with other preventative therapies for HAE (e.g., Orladeyo, Takhyzro), and/or (3) used for the treatment of acute attacks.
Required Medical Information	Requires submission of C4, C1-INH protein, and C1-INH function lab results confirming diagnosis.
Age Restrictions	Must be age 6 or older.
Prescriber Restrictions	Prescriber is an allergist, immunologist, hematologist, or other specialist experienced in treating HAE.
Coverage Duration	1 year initial and reauth
Other Criteria	For reauthorization: Must also have documentation showing a decrease in the frequency of attacks.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

HERNEXEOS

Products Affected

- Hernexeos

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

HYRNUO

Products Affected

- Hyrnuo

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

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

IBTROZI

Products Affected

- Ibtrozi

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

icatibant acetate

Products Affected

- icatibant acetate subcutaneous solution prefilled syringe
- Sajazir Subcutaneous Solution Prefilled Syringe

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of an angiotensin-converting enzyme inhibitor (ACEI) is not covered.
Required Medical Information	Documentation of C4, C1-INH protein, and C1-INH function lab results confirming diagnosis.
Age Restrictions	Must be age 18 or older.
Prescriber Restrictions	Prescriber is an allergist, immunologist, hematologist, or other specialist experienced in treating HAE.
Coverage Duration	6 months, initial and reauthorization.
Other Criteria	For reauthorization: Must have documentation showing use of previously approved syringes AND a favorable clinical response (decrease in the duration of attacks, quick onset of symptom relief, resolution of symptoms, decrease in attack frequency or severity).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

IDHIFA

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of IDH2 (isocitrate dehydrogenase-2) mutation must be submitted.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

imatinib mesylate

Products Affected

- imatinib mesylate oral tablet 100 mg, 400 mg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

IMBRUVICA

Products Affected

- Imbruvica Oral Capsule
- Imbruvica Oral Suspension
- Imbruvica Oral Tablet 140 MG, 280 MG, 420 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years. Dosing must follow the FDA-approved labeling.
Other Criteria	Criteria will be applied consistent with current NCCN guidance. Reauthorization for GVHD: Must have documentation of clinical benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

IMKELDI

Products Affected

- imkeldi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Coverage requires that the patient is unable to swallow or appropriately use the generic imatinib tablet formulation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

IMPAVIDO

Products Affected

- Impavido

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One month
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

INCRELEX

Products Affected

- Increlex

PA Criteria	Criteria Details
Exclusion Criteria	Increlex is not covered in patients with closed epiphyses.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

INFLIXIMAB

Products Affected

- infliximab

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dose must follow FDA-approved labeling or be supported in approved compendia for Part D.
Other Criteria	FOR RHEUMATOID ARTHRITIS AND PSORIASIS: Trial of a traditional non-biologic DMARD (such as methotrexate) with inadequate response. FOR ANKYLOSING SPONDYLITIS: Trial of an NSAID with inadequate response. FOR HIDRADENITIS SUPPURATIVA AND UVEITIS: Trial of one other therapy for the condition (such as prednisone) with inadequate response. FOR JUVENILE IDIOPATHIC ARTHRITIS: Trial of one other therapy for the condition (such as methotrexate or NSAIDs) with inadequate response - or - patient is starting the drug concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the physician.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

INLURIYO

Products Affected

- Inluriyo

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

INLYTA

Products Affected

- Inlyta

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

INQOVI

Products Affected

- Inqovi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Patient must first try IV decitabine.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	Yes
Prerequisite Therapy Required	Yes

INREBIC

Products Affected

- Inrebic

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must have tried and failed (defined as an intolerance or inability to improve the condition) Jakafi.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ISTURISA

Products Affected

- Isturisa Oral Tablet 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation supporting an FDA-approved diagnosis of Cushing syndrome in an adult where surgery is not an option or has not been curative.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by an endocrinologist.
Coverage Duration	Two years
Other Criteria	Patient must have tried and failed two of the following: ketoconazole, Lysodren, and cabergoline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ITOVEBI

Products Affected

- Itovebi Oral Tablet 3 MG, 9 MG

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

IVIG

Products Affected

- Gamunex-C

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(1) A current weight and requested dose, AND (2) Dosing must follow FDA-approved labeling, or have documentation supporting that the requested dose follows accepted standards of medical practice, AND (3) Patient's dose has been weight-adjusted if the BMI is 30 or more or the actual body weight is 20% higher than the member's ideal body weight, AND (4) Medical records supporting the request, including support for the diagnosis and dose have been provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Diagnosis and administration information will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit. FOR MYASTHENIA GRAVIS: Patient must be experiencing acute myasthenic crisis with decompensation. Use of IVIG for chronic or routine use is not covered (there is a lack of evidence to support use of IVIG in stable MG).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

IWILFIN

Products Affected

- Iwilfin

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

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Criteria will be applied consistent with current NCCN guidance. Reauthorization for GVHD: Must have documentation of clinical benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

JARDIANCE

Products Affected

- Jardiance

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must have documentation that supports an inability to use generic dapagliflozin.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

JAYPIRCA

Products Affected

- Jaypirca

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, prior therapies, NCCN alignment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Coverage requires: (1) The use of Jaypirca follows current NCCN recommendations, and (2) Patient has been previously treated with Calquence or Imbruvica.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

JYLAMVO

Products Affected

- Jylamvo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must have current documentation to support an inability to use generic methotrexate. Diagnosis will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have laboratory confirmation of ivacaftor-responsive mutation in the CFTR gene.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

KERENDIA

Products Affected

- Kerendia

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial treatment in adults with heart failure and left ventricular ejection fraction (LVEF) greater than or equal to 40%: (1) Patient has New York Heart Association (NYHA) Class II through IV heart failure, AND (2) Patient has a documented ejection fraction of 40% or more in the previous 12 months, and (3) patient has a pre-treatment eGFR of 25ml/min/1.73m ² or more, and (4) Kerendia has been prescribed by, or in consultation with, a cardiologist, AND (5) Patient has been receiving standard heart failure treatment defined as taking at least 2 of the following medications together, each from a different class, and at appropriate doses for heart failure: ACEI, ARB, or Entresto, bisoprolol, carvedilol or metoprolol ER, and/or a diuretic such as spironolactone or furosemide.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	FOR CHRONIC KIDNEY DISEASE (CKD) ASSOCIATED WITH TYPE 2 DIABETES (T2DM) INITIAL REQUESTS: (1) Must try an SGLT2i or GLP-1 RA initially and provide support through medical records for adding or switching to Kerendia (such as having an intolerance, contraindication, or having regular assessments and monitoring following initial therapy that support additional risk-based therapy per ADA guidelines), and (2) must be on maximally tolerated ACEI or ARB, and (3) must have an eGFR greater than or equal to 25ml/min/1.73m ² .

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

KISQALI

Products Affected

- Kisqali (200 MG Dose)
- Kisqali (400 MG Dose)
- Kisqali (600 MG Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

KOMZIFTI

Products Affected

- Komzifti

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

KOSELUGO

Products Affected

- Koselugo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

KRAZATI

Products Affected

- krazati

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medical records supporting that the use of Krazati follows current NCCN recommendations must be provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Use of Krazati must follow current NCCN recommendations.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

lapatinib

Products Affected

- lapatinib ditosylate

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LAZCLUZE

Products Affected

- Lazcluze Oral Tablet 240 MG, 80 MG

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

LENALIDOMIDE

Products Affected

- lenalidomide

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LENVIMA

Products Affected

- 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)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LEVETIRACETAM ORAL TABLET DISINTEGRATING SOLUBLE

Products Affected

- levetiracetam oral tablet disintegrating soluble 250 mg, 500 mg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have current documentation to support the following: (1) an inability to use generic levetiracetam tablet, and (2) trial and failure (defined as an inability to improve the condition) with one other generic anticonvulsant.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

L-Glutamine

Products Affected

- l-glutamine oral packet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must try and fail hydroxyurea. Fail is defined as continuing to have pain episodes despite appropriately dosed hydroxyurea or having any intolerance to hydroxyurea.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

LIDOCAINE PATCH

Products Affected

- lidocaine external patch 5 %
- Lidocan
- Lidocan III
- Tridacaine III
- Tridacaine XL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Medically accepted indications for lidocaine 5% patch include relief of pain associated with postherpetic neuralgia (PHN), diabetic neuropathy, and cancer-related neuropathic pain.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LIFYORLI

Products Affected

- Lifyorli (125 MG DOSE)
- Lifyorli (150 MG DOSE)

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

LIVTENCITY

Products Affected

- Livtency

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Baseline CMV DNA level confirming diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	8 weeks
Other Criteria	Must not be used concomitantly with other CMV antivirals (e.g., ganciclovir, valganciclovir). Dosing must follow FDA-approved labeling. Must have documented trial and failure with ganciclovir, valganciclovir, cidofovir or foscarnet. For reauthorization, documentation of response (e.g., CMV DNA level) must be provided.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LORAZEPAM

Products Affected

- LORazepam Intensol
- lorazepam oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	End of plan year.
Other Criteria	For all indications, approve if: (1) The provider has determined that taking opioids and benzodiazepines together is medically necessary for the patient, OR (2) the patient is in hospice, palliative (end-of-life) care, has cancer and/or has sickle cell disease, OR (3) the patient will not be taking an opioid or benzodiazepine concurrently, OR (4) the patient is less than 18 years old. Note: The criteria only apply to patients 18 years of age or older with concurrent use of a benzodiazepine and opioid. The use of opioids concurrently with benzodiazepines is associated with an increased risk of opioid overdose.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

LORBRENA

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LUMAKRAS

Products Affected

- Lumakras Oral Tablet 120 MG, 240 MG, 320 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LUPRON DEPOT

Products Affected

- Lupron Depot (1-Month) Intramuscular Kit 3.75 MG
- Lupron Depot (3-Month) Intramuscular Kit 11.25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LYBALVI

Products Affected

- Lybalvi

PA Criteria	Criteria Details
Exclusion Criteria	Not covered for patients currently using opioids. Not covered for patients undergoing acute opioid withdrawal.
Required Medical Information	Documentation of diagnosis, baseline and current weight, and prior therapy trial and failure.
Age Restrictions	Must be 18 years of age or older
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	(1) Patient does not have a known opioid use disorder and is not dependent on opioids for a chronic health condition, and (2) Patient has tried and failed olanzapine, and (3) Patient has tried and failed another generic atypical antipsychotic associated with less weight gain such as aripiprazole or lurasidone. Failure is defined as demonstrating a positive clinical response to the required therapy, but with clinically significant weight gain defined as 7 percent of more weight gain compared to baseline (weight prior to Lybalvi).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

LYNPARZA

Products Affected

- Lynparza Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

LYTGOBI

Products Affected

- Lytgobi (12 MG Daily Dose)
- Lytgobi (16 MG Daily Dose)
- Lytgobi (20 MG Daily Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MACITENTAN

Products Affected

- macitentan

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, prior therapies.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	FOR PAH (WHO GROUP 1): Diagnosis confirmed by right heart catheterization.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MARPLAN

Products Affected

- Marplan

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation supporting the trial and failure (defined as an inadequate improvement in depressive symptoms) with two of the following generic antidepressants is required: SNRIs, SSRIs, mirtazapine, or bupropion.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

MATULANE

Products Affected

- Matulane

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MEKINIST

Products Affected

- Mekinist Oral Tablet 0.5 MG, 2 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MEKINIST ORAL SOLUTION

Products Affected

- Mekinist Oral Solution Reconstituted

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Coverage requires that the patient is unable to swallow the tablet formulation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MEKTOVI

Products Affected

- Mektovi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have documentation of BRAF V600 mutation status
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MERCAPTOPURINE

Products Affected

- mercaptopurine oral suspension

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have current documentation to support an inability to use generic mercaptopurine tablet.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

MIFEPRISTONE

Products Affected

- mifepristone oral tablet 300 mg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Must be prescribed by an endocrinologist.
Coverage Duration	One year.
Other Criteria	For reauthorization of previously approved requests: Must provide documentation of improvement in hyperglycemia control with mifepristone.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

modafinil

Products Affected

- modafinil oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

MODEYSO

Products Affected

- Modeyso

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

MOUNJARO

Products Affected

- Mounjaro Subcutaneous Solution Auto-Injector

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	FOR T2DM: Trial with two oral generic drugs (e.g., dapagliflozin, metformin, glimepiride, glimepiride, etc.).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

Nasal Corticosteroids

Products Affected

- allergy relief nasal
- budesonide nasal

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Allergy to the preferred medications, OR contraindication or drug to drug interaction with the preferred medications, OR history of unacceptable side effects with the preferred medications, OR therapeutic failure with a one-month trial with a preferred medication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	The preferred products (No Prior Authorization required) in this class are fluticasone (Rx) and mometasone (Rx).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NAYZILAM

Products Affected

- Nayzilam

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months total therapy
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NEXLETOL

Products Affected

- Nexletol

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used along with PCSK9 inhibitors (e.g., Repatha), Juxtapid.
Required Medical Information	Must submit most recent LDL-C level. Must submit documentation of prior therapies and responses to treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Patient must meet the following: (1) Patient has tried one high-intensity statin (or if a high-intensity strength statin is not tolerated, a maximally-tolerated statin is acceptable), along with ezetimibe for at least 4 weeks and LDL-C remains greater than or equal to 70mg/dL OR (2) Patient has tried ezetimibe for at least 4 weeks with LDL-C greater than or equal to 70mg/dL and is statin intolerant defined as trying at least two different statins and experiencing statin-related symptoms on both agents.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NEXLIZET

Products Affected

- Nexlizet

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used along with PCSK9 inhibitors (e.g., Repatha), Juxtapid.
Required Medical Information	Must submit most recent LDL-C level. Must submit documentation of prior therapies and responses to treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Patient must meet the following: (1) Patient has tried one high-intensity statin (or if a high-intensity strength statin is not tolerated, a maximally-tolerated statin is acceptable), along with ezetimibe for at least 4 weeks and LDL-C remains greater than or equal to 70mg/dL OR (2) Patient has tried ezetimibe for at least 4 weeks with LDL-C greater than or equal to 70mg/dL and is statin intolerant defined as trying at least two different statins and experiencing statin-related symptoms on both agents.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NILOTINIB

Products Affected

- nilotinib hcl

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NINTEDANIB ESYLATE

Products Affected

- nintedanib esylate

PA Criteria	Criteria Details
Exclusion Criteria	Not covered in combination with Jascayd or pirfenidone.
Required Medical Information	High Resolution Computed Tomography (HRCT).
Age Restrictions	
Prescriber Restrictions	Prescriber is or has consulted with a specialist in the condition being treated.
Coverage Duration	1 year initial. 2 years reauth. Dosing must follow FDA-approved labeling or Part D compendia.
Other Criteria	FOR IDIOPATHIC PULMONARY FIBROSIS (IPF) INITIAL REQUESTS: (1) Prescriber must rule out other known causes of interstitial lung disease - AND - (2) must have presence of a UIP pattern on HRCT in patients not subjected to surgical lung biopsy. FOR CHRONIC FIBROSING INTERSTITIAL LUNG DISEASE WITH PROGRESSIVE PHENOTYPE: (1) confirmed diagnosis by HRCT - AND - (2) Forced Vital Capacity (FVC) decline of at least 10% - OR - at least 5% with one of the following: worsening respiratory symptoms OR worsening fibrosis on imaging. FOR SScILD INITIAL COVERAGE: Confirmed diagnosis by HRCT. FOR REAUTHORIZATION OF ALL INDICATIONS: Must have documentation of improvement in condition.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

nitisinone

Products Affected

- nitisinone

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NIVESTYM

Products Affected

- Nivestym Injection Solution Prefilled Syringe

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NORTRIPTYLINE

Products Affected

- nortriptyline hcl oral

PA Criteria	Criteria Details
Exclusion Criteria	The criteria only apply to patients 65 years and older.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Coverage requires the following: (1) Prescriber acknowledges that the benefit of therapy outweighs the potential risks for this patient and (2) Prescriber has considered therapy changes if the patient is using more than one anticholinergic drug in combination. Note: Due to safety concerns, this medication is considered potentially inappropriate in older adults, and is best avoided, prescribed at lower dose, or used with caution.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NUBEQA

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	FOR METASTATIC DISEASE: Patient must be unable to use (such as a failure, intolerance or contraindication to) abiraterone or Xtandi. FOR NON-METASTATIC, CASTRATION RESISTANT DISEASE: Patient must be unable to use (such as a failure, intolerance or contraindication to) Xtandi.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NUCALA

Products Affected

- Nucala Subcutaneous Solution Auto-Injector
- Nucala Subcutaneous Solution Prefilled Syringe 100 MG/ML, 40 MG/0.4ML
- Nucala Subcutaneous Solution Reconstituted

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs.
Required Medical Information	Diagnosis, concurrent therapies (CRSwNP), and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	1 year initial, 2 years reauth. Dose must align with FDA label or Part D compendia.

PA Criteria	Criteria Details
Other Criteria	ASTHMA INITIAL COVERAGE: (1) Use of an ICS/LABA inhaler as prescribed in the past 6 months with inadequate control of condition, AND (2) Blood eosinophil level at least 150 cells per microliter in the past 12 months. CHRONIC RHINOSINUSITIS WITH NASAL POLYP (CRSwNP) INITIAL COVERAGE: (1) Chronic disease defined as 2 or more of the following symptoms for at least 12 weeks despite management (e.g., intranasal steroids, etc.): nasal congestion, obstruction, or blockage, nasal drainage, facial pain/pressure, or reduction in smell, AND (2) trial of an intranasal steroid with inadequate response, AND (3) Concurrent use of Nucala and an intranasal steroid. COPD INITIAL COVERAGE: (1) Blood eosinophil level at least 150 cells per microliter within the past 12 months, AND (2) Trial and failure of a LAMA, LABA, and ICS inhaled regimen used together (also called triple therapy) and as prescribed with failure defined as 2 or more COPD exacerbations in the past 12 months or 1 COPD hospitalization in the past 12 months. EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA) INITIAL COVERAGE: Clinically documented history of EGPA for at least 6 months. HYPEREOSINOPHILIC SYNDROME (HES) INITIAL COVERAGE: (1) Clinically documented history of HES for at least 6 months, AND (2) blood eosinophil count of at least 1,000 cells per microliter, AND (3) at least 2 HES flares in the past year defined as worsening HES symptoms or blood eosinophil counts requiring escalation in therapy. REAUTHORIZATION FOR ALL INDICATIONS: Documentation of clinical benefit compared to baseline (prior to Nucala) - and - for CRSwNP only - continued use of Nucala with an intranasal steroid.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NULIBRY

Products Affected

- Nulibry

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of MoCD Type A by genetic testing. Documentation of genetic testing results must be submitted.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with a physician who specializes in the treatment of inherited metabolic disorders.
Coverage Duration	Initial 1 year. Reauthorization 2 years
Other Criteria	For reauthorization requests, must also provide documentation demonstrating a beneficial response to therapy compared to pretreatment baseline in one or more of the following: neurological function, gross motor function, and/or developmental milestones.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NUPLAZID

Products Affected

- Nuplazid Oral Capsule
- Nuplazid Oral Tablet 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NURTEC

Products Affected

- Nurtec

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other CGRP antagonist therapy.
Required Medical Information	FOR EPISODIC MIGRAINE PREVENTION INITIAL REQUESTS: Must have at least 4 but less than 15 migraine headache days per month. FOR ACUTE MIGRAINE INITIAL REQUESTS: Unless contraindicated per the FDA label, must try and fail (defined as an intolerance or inability to improve symptoms) one generic triptan medication (e.g., sumatriptan, rizatriptan, etc.).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 1 year. Reauth: 1 year. Dosing must align with FDA labeling.
Other Criteria	FOR EPISODIC MIGRAINE PREVENTION REAUTHORIZATION: (1) Must have at least 4 but less than 15 migraine headache days per month, AND (2) Must provide documentation of a decrease in migraine days per month with use of Nurtec ODT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Exclusion Criteria	Not covered in combination with Jascayd or pirfenidone.
Required Medical Information	High Resolution Computed Tomography (HRCT) and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is or has consulted with a specialist in the condition being treated.
Coverage Duration	One year initial and reauth. Dosing must follow FDA-approved labeling.
Other Criteria	FOR IDIOPATHIC PULMONARY FIBROSIS (IPF) INITIAL REQUESTS: (1) Prescriber must rule out other known causes of interstitial lung disease - AND - (2) must have presence of a UIP pattern on HRCT in patients not subjected to surgical lung biopsy - AND - (3) documented inability to use generic nintedanib. FOR CHRONIC FIBROSING INTERSTITIAL LUNG DISEASE WITH PROGRESSIVE PHENOTYPE: (1) confirmed diagnosis by HRCT - AND - (2) Forced Vital Capacity (FVC) decline of at least 10% - OR - at least 5% with one of the following: worsening respiratory symptoms OR worsening fibrosis on imaging - AND - (3) documented inability to use generic nintedanib. FOR SScILD INITIAL COVERAGE: (1) Confirmed diagnosis by HRCT - AND - (2) documented inability to use generic nintedanib. FOR REAUTHORIZATION OF ALL INDICATIONS: Must have documentation of: (1) improvement in condition - AND - (2) documented inability to use generic nintedanib.
Indications	All Medically-accepted Indications.

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

OGSIVEO

Products Affected

- Ogsiveo Oral Tablet 100 MG, 150 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

OJEMDA

Products Affected

- Ojemda Oral Suspension Reconstituted
- Ojemda Oral Tablet 100 MG, 100 MG (16 pack), 100 MG (24 pack)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For oral suspension, coverage requires that patient is unable to swallow the tablet formulation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year. Limited to 1 box per 28 days, based on requested strength.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

OJJAARA

Products Affected

- ojjaara

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Criteria will be applied consistent with current NCCN guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ONUREG

Products Affected

- Onureg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Ophthalmic Antihistamines

Products Affected

- Zaditor Ophthalmic Solution 0.035 %

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Allergy to the preferred medications, OR contraindication or drug to drug interaction with the preferred medications, OR history of unacceptable side effects with the preferred medications, OR therapeutic failure with a one-month trial with one preferred medication
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	The preferred products (No Prior Authorization required) in this class are: azelastine, ketotifen fumarate (OTC Only)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

OPIPZA

Products Affected

- Opipza Oral Film 10 MG, 2 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must have documentation of the following: (1) a current inability to swallow oral tablets, AND (2) trial and failure of two of the following generic drugs (failure does not include difficulty swallowing since the alternatives include dosage forms that can be used for patients with difficulty swallowing): aripiprazole, aripiprazole ODT, olanzapine, olanzapine ODT, quetiapine, risperidone, risperidone ODT, ziprasidone, or lurasidone.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ORENITRAM

Products Affected

- Orenitram
- Orenitram Month 1
- Orenitram Month 2
- Orenitram Month 3

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	FOR PULMONARY ARTERIAL HYPERTENSION (PAH): Documentation that the patient has pulmonary arterial hypertension (WHO Group 1) confirmed by right heart catheterization must be provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ORGOVYX

Products Affected

- Orgovyx

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as an intolerance or inadequate response) with Firmagon (degarelix).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	Yes
Prerequisite Therapy Required	Yes

ORKAMBI

Products Affected

- Orkambi Oral Packet
- Orkambi Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have laboratory confirmation of homozygous F508del mutation in the cystic fibrosis transmembrane regulator (CFTR) gene
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ORSERDU

Products Affected

- Orserdu Oral Tablet 345 MG, 86 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medical records supporting that the use of Orserdu follows current NCCN recommendations must be provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Use of Orserdu must follow current NCCN recommendations.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

OTEZLA

Products Affected

- Otezla Oral Tablet
- Otezla Oral Tablet Therapy Pack
- Otezla XR
- Otezla/Otezla XR Initiation Pk

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dose must follow FDA-label or be supported in Part D compendia.
Other Criteria	FOR MODERATE TO SEVERE PSORIASIS: Trial of a traditional DMARD (e.g., methotrexate, cyclosporine, acitretin) with inadequate response. The step therapy does not apply for MILD psoriasis. FOR ORAL ULCERS ASSOCIATED WITH BEHCET'S DISEASE: Trial of colchicine with inadequate response.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

OTULFI

Products Affected

- Otulfi Subcutaneous Solution
- Otulfi Subcutaneous Solution Prefilled Syringe 45 MG/0.5ML, 90 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dose must follow FDA-label or be supported in Part D compendia.
Other Criteria	FOR PSORIASIS: Trial of a traditional DMARD (e.g., methotrexate, cyclosporine, acitretin) with inadequate response.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

OZEMPIC

Products Affected

- Ozempic
- 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)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	FOR T2DM: Trial with two oral generic drugs (e.g., dapagliflozin, metformin, glimepiride, glimepiride, etc.).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

PANRETIN

Products Affected

- Panretin

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must first try and fail (defined as an intolerance or inability to improve the condition) with imiquimod 5% cream.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

PAROXETINE

Products Affected

- paroxetine hcl

PA Criteria	Criteria Details
Exclusion Criteria	The criteria only apply to patients 65 years and older.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Coverage requires the following: (1) Prescriber acknowledges that the benefit of therapy outweighs the potential risks for this patient, and (2) Prescriber has considered therapy changes if the patient is using more than one anticholinergic drug in combination. Note: Due to safety concerns, this medication is considered potentially inappropriate in older adults, and is best avoided, prescribed at lower dose, or used with caution.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PAZOPANIB

Products Affected

- pazopanib hcl oral tablet 200 mg, 400 mg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PEMAZYRE

Products Affected

- Pemazyre

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

penicillamine

Products Affected

- penicillamine oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	For cystinuria, documentation that treatment with conservative measures (e.g. high fluid intake, sodium and protein restriction, urinary alkalization) were ineffective, not tolerated, or contraindicated. Quantity limited to dosage as supported by the FDA-approved label.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PERAMPANEL

Products Affected

- perampanel oral suspension
- perampanel oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate seizure control) with at least 2 generic anticonvulsants for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

PHENOBARBITAL

Products Affected

- phenobarbital oral elixir
- phenobarbital oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PIQRAY

Products Affected

- Piqray (200 MG Daily Dose)
- Piqray (250 MG Daily Dose)
- Piqray (300 MG Daily Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PIRFENIDONE

Products Affected

- pirfenidone oral capsule
- pirfenidone oral tablet 267 mg, 801 mg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For all indications, must have documentation of High Resolution Computed Tomography (HRCT) confirming diagnosis.
Age Restrictions	
Prescriber Restrictions	Prescriber is or has consulted with a pulmonologist.
Coverage Duration	Two years
Other Criteria	For idiopathic pulmonary fibrosis (IPF): (1) The patient's diagnosis must be confirmed by a surgical lung biopsy or by the presence of a UIP pattern on a HRCT, and (2) the prescriber must rule out other known causes of interstitial lung disease. For reauthorization requests: Documentation of improvement in condition with use of pirfenidone must be provided.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PLEGRIDY

Products Affected

- Plegridy
- Plegridy Starter Pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

POMALIDOMIDE

Products Affected

- pomalidomide

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation to support an inability to use generic pomalidomide.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

PREVYMIS

Products Affected

- Prevymis Oral Packet
- Prevymis Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	200 days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PROLASTIN-C

Products Affected

- Prolastin-C Intravenous Solution

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Documentation of (1) Alpha-1-antitrypsin deficiency with a phenotype of PiZZ, PiZ (null), or Pi (null, null), or phenotypes associated with reduced serum alpha-1 antitrypsin concentrations - AND - (2) Serum AAT level less than 11 micromoles per liter (80 milligrams per deciliter if measured by radial immunodiffusion or 50 milligrams per deciliter if measure by nephelometry) - AND - (3) Symptomatic emphysema.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Proton Pump Inhibitors

Products Affected

- omeprazole oral tablet delayed release
- Prevacid 24HR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Allergy to the preferred medications, OR contraindication or drug to drug interaction with the preferred medications, OR history of unacceptable side effects with the preferred medications, OR therapeutic failure after one-month trial with one preferred medication
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	The preferred products (No Prior Authorization required) in this class are: omeprazole (Rx) capsules, pantoprazole (Rx) tablets
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

protriptyline

Products Affected

- protriptyline hcl

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate response) with 2 of the following generic antidepressants: SSRIs, SNRIs, bupropion, mirtazapine, or trazodone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

QINLOCK

Products Affected

- Qinlock

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

RALDESY

Products Affected

- Raldesy

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Coverage requires that the patient meet the following: (1) the patient is unable to swallow the generic trazodone tablet - and - (2) the patient has tried and failed (defined as depression symptoms not improving) at least one generic oral solution for depression (such as escitalopram oral solution, sertraline oral concentrate, nortriptyline oral solution).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

REDEMPLO

Products Affected

- Redemplo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial requests, documentation of the following is required: (1) Dosing aligns with FDA labeling, and (2) Confirmation of a diagnosis of familial chylomicronemia syndrome (FCS) by the following: (a) Fasting triglyceride level greater than 10 mmol/L or 880 mg/dL, AND either (b) genetic testing, or (c) a clinical diagnosis following current clinical practice guidance such as the Delphi Consensus (e.g., recurrent unexplained abdominal pain, history of pancreatitis).
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	Must be prescribed by or in conjunction with a specialist for the condition.
Coverage Duration	One year initial. Two years reauth.
Other Criteria	For reauthorization, documentation of the following is required: (1) Dosing aligns with FDA labeling, AND (2) Patient has had benefit from Redemplo compared to baseline (such as reduction in symptoms).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

RELISTOR

Products Affected

- Relistor Oral
- Relistor Subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	Patient must not have mechanical gastrointestinal obstruction.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Must try and fail (defined as an inadequate response or intolerance) to lactulose.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

REPATHA

Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha SureClick

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Patient must meet one of the following: (1) Patient has tried a high intensity statin (i.e., atorvastatin 40 mg to 80 mg daily or rosuvastatin 20 mg to 40 mg daily) and LDL-C remains above goal, OR (2) if a high-intensity strength statin is not tolerated, the patient has tried a the maximally tolerated statin dose and LDL-C remains above goal, OR (3) Patient has tried two different statins and experienced statin-related symptoms on both agents.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

RETEVMO

Products Affected

- Retevmo Oral Tablet 120 MG, 160 MG, 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

REVCovi

Products Affected

- Revcovi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must provide trough plasma ADA activity and trough dAXP levels. Must provide patient's current weight and requested dose.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year initial and reauthorization.
Other Criteria	Provider attestation that treatment will follow FDA-approved labeling with dose adjusted to maintain trough ADA activity over 30 mmol/hr/L, trough dAXP level under 0.02 mmol/L, and/or to maintain adequate immune reconstitution based on clinical assessment of the patient.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

REVUFORJ

Products Affected

- Revuforj Oral Tablet 110 MG, 160 MG, 25 MG

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

REXULTI

Products Affected

- Rexulti

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For agitation in Alzheimer's disease requests: (1) Must have documentation supporting a trial and failure (defined as an inadequate response) with one generic atypical antipsychotic used for at least 28 days. For all other medically-accepted indications: (1) Must have documentation supporting a trial and failure (defined above) with two generic atypical antipsychotic drugs, used for at least 28 days each.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

REZDIFFRA

Products Affected

- Rezdiffra

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial requests, documentation supporting the following is required: (1) A diagnosis of metabolic dysfunction-associated steatohepatitis (MASH), AND (2) moderate to advanced liver fibrosis that is consistent with a fibrosis stage of F2 or F3 confirmed by biopsy or non-invasive tests (NITs), AND (3) current weight, AND (4) the patient is using Rezdiffra at a dose aligned with the FDA-approved labeling (i.e., 80 mg/day if weight is less than 100 kg, and 100 mg/day if weight is 100 kg or more), AND (5) Rezdiffra will be used in conjunction with diet and exercise as per its FDA labeling, AND (6) trial and failure with semaglutide.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation, with a specialist
Coverage Duration	One year initial and reauthorization.
Other Criteria	For reauthorization, documentation supporting the following is required: (1) current ALT and/or fibrosis score supporting that the patient's liver disease has not worsened (worsening of liver disease is defined as a consistent increase in ALT or fibrosis progression assessed by biopsy or NITs), AND (2) current weight, AND (3) the patient is using Rezdiffra at a dose aligned with the FDA-approved labeling (i.e., 80 mg/day if weight is less than 100 kg, and 100 mg/day if weight is 100 kg or more), AND (4) Rezdiffra will be used in conjunction with diet and exercise as per its FDA labeling.
Indications	All FDA-approved Indications.

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

REZLIDHIA

Products Affected

- Rezlidhia

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

REZUROCK

Products Affected

- Rezurock

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year initial and continuation.
Other Criteria	Other criteria will be applied consistent with current NCCN guidance. Reauthorization for GVHD: Must have documentation of clinical benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

RINVOQ

Products Affected

- Rinvoq LQ
- Rinvoq Oral Tablet Extended Release 24 Hour 15 MG, 30 MG, 45 MG

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dose must follow FDA-label or be supported in Part D compendia.
Other Criteria	FOR RHEUMATOID ARTHRITIS: Trial of a traditional DMARD (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) with inadequate response. FOR PSORIASIS: Trial of a traditional DMARD (e.g., methotrexate, cyclosporine, acitretin) with inadequate response. FOR ANKYLOSING SPONDYLITIS: Trial of an NSAID with inadequate response. FOR HIDRADENITIS SUPPURATIVA: Trial of one other therapy (e.g., prednisone, clindamycin) with inadequate response. FOR UVEITIS: Trial of one other therapy (e.g., intraocular or oral steroid) with inadequate response. FOR JUVENILE IDIOPATHIC ARTHRITIS: Trial of one other therapy (e.g., methotrexate, NSAIDs) with inadequate response - or - patient is starting the drug concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the physician.
Indications	All Medically-accepted Indications.
Off Label Uses	

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

ROMVIMZA

Products Affected

- Romvimza

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

ROZLYTREK

Products Affected

- Rozlytrek Oral Capsule 100 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ROZLYTREK PELLET PACK

Products Affected

- Rozlytrek Oral Packet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient has had prior trial with AND is unable to use Rozlytrek oral capsule formulation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as an intolerance or inadequate response) with Lynparza.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

RUFINAMIDE

Products Affected

- rufinamide oral suspension 40 mg/ml
- rufinamide oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For diagnosis of acute myeloid leukemia (AML), patient must have FLT3 mutation-positive disease as detected by an FDA-approved test.
Age Restrictions	Must be age 18 or older
Prescriber Restrictions	
Coverage Duration	One year.
Other Criteria	For diagnosis of AML, patient must be using Rydapt in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SCEMBLIX

Products Affected

- Scemblix Oral Tablet 100 MG, 20 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For PH+ CML-CP with T315I mutation, documentation confirming mutation must be provided.
Age Restrictions	Must be 18 years of age or older.
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	1 year. 20mg limit to 60 tabs per 30 days. 40mg limit to 240 tabs per 30 days.
Other Criteria	For PH+ CML-CP with T315I mutation, your prescriber must provide rationale supporting why Iclusig cannot be used in place of Scemblix.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SECUADO

Products Affected

- Secuado

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as an inadequate response) with two of the following generic drugs used for at least 28 days each: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, or lurasidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

SIGNIFOR

Products Affected

- Signifor

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Patient must be too ill for pituitary surgery or patient must have had surgery that failed to completely removed the tumor. Patient must have a documented trial with ketoconazole to reduce cortisol secretion.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

SILDENAFIL CITRATE

Products Affected

- sildenafil citrate oral tablet 20 mg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SIMLANDI

Products Affected

- Simlandi (1 Pen) Subcutaneous Auto-Injector Kit 80 MG/0.8ML
 - Simlandi (2 Pen)
 - Simlandi (2 Syringe) Subcutaneous
- Prefilled Syringe Kit 20 MG/0.2ML, 40 MG/0.4ML

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dose must follow FDA-label or be supported in Part D compendia.
Other Criteria	FOR RHEUMATOID ARTHRITIS: Trial of a traditional DMARD (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) with inadequate response. FOR PSORIASIS: Trial of a traditional DMARD (e.g., methotrexate, cyclosporine, acitretin) with inadequate response. FOR ANKYLOSING SPONDYLITIS: Trial of an NSAID with inadequate response. FOR HIDRADENITIS SUPPURATIVA: Trial of one other therapy (e.g., prednisone, clindamycin) with inadequate response. FOR UVEITIS: Trial of one other therapy (e.g., intraocular or oral steroid) with inadequate response. FOR JUVENILE IDIOPATHIC ARTHRITIS: Trial of one other therapy (e.g., methotrexate, NSAIDs) with inadequate response - or - patient is starting the drug concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the physician.
Indications	All Medically-accepted Indications.
Off Label Uses	

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

SIRTURO

Products Affected

- Sirturo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SKYRIZI

Products Affected

- Skyrizi Pen Syringe 150 MG/ML, 55 MG/0.37ML
- Skyrizi Subcutaneous Solution Cartridge
180 MG/1.2ML, 360 MG/2.4ML
- Skyrizi Subcutaneous Solution Prefilled

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dose must follow FDA-label or be supported in Part D compendia.
Other Criteria	FOR PSORIASIS: Trial of a traditional DMARD (e.g., methotrexate, cyclosporine, acitretin) with inadequate response.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

SODIUM OXYBATE

Products Affected

- Sodium Oxybate

PA Criteria	Criteria Details
Exclusion Criteria	Patient must not be receiving sedative hypnotics with sodium oxybate. Patient must not suffer from succinic semialdehyde dehydrogenase deficiency.
Required Medical Information	Documentation of prior therapies and responses to treatment. Documentation of MSLT and polysomnography confirming diagnosis of narcolepsy.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a sleep specialist or neurologist.
Coverage Duration	Two years
Other Criteria	For narcolepsy with excessive daytime sleepiness in adults: Must first try and fail (defined as an intolerance or inability to improve the condition) amphetamine salts, dextroamphetamine or methylphenidate - AND - either modafinil or armodafinil. For reauthorization requests, must provide documentation demonstrating a decrease in excessive daytime sleepiness with narcolepsy or a decrease in cataplexy episodes.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

SOFOSBUVIR-VELPATASVIR

Products Affected

- sofosbuvir-velpatasvir

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have chronic hepatitis C infection.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Duration of therapy will be applied consistent with current AASLD/IDSA.
Other Criteria	Must have documentation to support that the use of the drug is consistent with current AASLD/IDSA guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SOMAVERT

Products Affected

- Somavert

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

SORAFENIB

Products Affected

- sorafenib tosylate

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SUBVENITE

Products Affected

- Subvenite Oral Suspension

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have documentation supporting an inability to use generic lamotrigine tablet or chewable tablet AND lamotrigine orally disintegrating tablet.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SUNITINIB MALATE

Products Affected

- sunitinib malate

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SYMDEKO

Products Affected

- Symdeko

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have laboratory confirmation of homozygous F508del mutation or have at least one tezacaftor/ivacaftor-responsive mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
Age Restrictions	Must be age 6 or older.
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SYMPAZAN

Products Affected

- Sympazan

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient has had prior trial with AND has a documented contraindication (e.g. dysphagia) to BOTH generic clobazam tablet AND clobazam oral suspension.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year initial and reauthorization.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

SYNJARDY

Products Affected

- Synjardy
- Synjardy XR Oral Tablet Extended Release 24 Hour 10-1000 MG, 12.5-1000 MG, 25-1000 MG, 5-1000 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must have documentation that supports an inability to use (1) generic dapagliflozin (with metformin) and (2) Jardiance (with metformin) in place of Synjardy (a combination of empagliflozin and metformin).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TABRECTA

Products Affected

- Tabrecta

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

tadalafil 2.5mg and 5mg (Cialis)

Products Affected

- tadalafil oral tablet 2.5 mg, 5 mg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Patient must have tried and failed either 6 months of finasteride or 3 months of dutasteride and must have tried and failed 28 days of alfuzosin, doxazosin, tamsulosin, or terazosin.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

tadalafil 20mg (Adcirca)

Products Affected

- tadalafil (pah)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TAFINLAR

Products Affected

- Tafinlar Oral Capsule

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TAFINLAR TABLET FOR ORAL SUPENSION

Products Affected

- Tafinlar Oral Tablet Soluble

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Coverage requires that the patient is unable to swallow the tablet formulation.
Age Restrictions	Must be less than 18 years old.
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TAGRISSE

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TALZENNA

Products Affected

- Talzenna

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TARPEYO

Products Affected

- Tarpeyo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	Must be prescribed or in consultation with a specialist for the condition.
Coverage Duration	Nine months
Other Criteria	Before the drug is covered, the patient must meet all of the following requirements: (1) Diagnosis of biopsy-verified primary immunoglobulin A nephropathy, AND (2) Patient is on ACE inhibitor or ARB therapy unless there is documentation of intolerance or contraindication, AND (3) Patient is on SGLT2 inhibitor therapy unless there is documentation of intolerance or contraindication (such as an eGFR less than 25 mL/min), AND (4) Patient has tried systemic steroids such as low-dose methylprednisolone unless there is documentation of intolerance or contraindication, AND (5) Tarpeyo is not being used beyond the initial 9-month course, as per current KDIGO guidelines, AND (6) Patient is not currently receiving dialysis and has not undergone kidney transplant.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

TASIMELTEON

Products Affected

- tasimelteon

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Must be prescribed by a sleep specialist or a neurologist.
Coverage Duration	Two years
Other Criteria	Patient must be totally blind. For reauthorization: must have documented benefit from use of tasimelteon.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TAVNEOS

Products Affected

- Tavneos

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation to support the diagnosis.
Age Restrictions	Must be 18 years of age or older.
Prescriber Restrictions	Must be prescribed by or in consultation with a specialist for the condition.
Coverage Duration	Initial 6 months. Reauthorization 12 months.
Other Criteria	Tavneos must be used as an add-on to standard therapy including cyclophosphamide, rituximab, and steroids (such as methylprednisolone or prednisone) - AND - patient does not currently require dialysis. For reauthorization: Must have a reduction in the Birmingham Vasculitis Activity Score (BVAS) - AND - steroid dose.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

tazarotene cream

Products Affected

- tazarotene external cream 0.1 %

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TEMAZEPAM

Products Affected

- temazepam oral capsule 15 mg, 30 mg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	End of plan year.
Other Criteria	For all indications, approve if: (1) The provider has determined that taking opioids and benzodiazepines together is medically necessary for the patient, OR (2) the patient is in hospice, palliative (end-of-life) care, has cancer and/or has sickle cell disease, OR (3) the patient will not be taking an opioid or benzodiazepine concurrently, OR (4) the patient is less than 18 years old. Note: The criteria only apply to patients 18 years of age or older with concurrent use of a benzodiazepine and opioid. The use of opioids concurrently with benzodiazepines is associated with an increased risk of opioid overdose.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

TEPMETKO

Products Affected

- Tepmetko

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TERIFLUNOMIDE

Products Affected

- teriflunomide

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TERIPARATIDE

Products Affected

- Teriparatide Subcutaneous Solution
Pen-Injector 560 MCG/2.24ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation supporting one of the following: (1) Trial and failure, intolerance, or contraindication to alendronate, risedronate, or ibandronate - AND - zoledronic acid, OR (2) a very high risk of fracture defined as a T-score of -3.0 or less, a T-score of -2.5 or less with a fragility fracture, or a history of severe or multiple fragility fractures regardless of T-score.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by endocrinologist.
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	Yes
Prerequisite Therapy Required	Yes

testosterone gel

Products Affected

- testosterone transdermal gel 1.62 %, 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	FOR HYPOGONADISM: Documentation of the following is required: (1) Two pre-treatment serum total testosterone levels, each taken in the morning on separate days, that are less than 300 ng/dL or that are low as defined by the laboratory reference values, AND (2) Pre-treatment clinical signs or symptoms of low testosterone other than erectile dysfunction and decreased libido (such as depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

testosterone solution

Products Affected

- testosterone transdermal solution

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	FOR HYPOGONADISM: Documentation of the following is required: (1) Two pre-treatment serum total testosterone levels, each taken in the morning on separate days, that are less than 300 ng/dL or that are low as defined by the laboratory reference values, AND (2) Pre-treatment clinical signs or symptoms of low testosterone other than erectile dysfunction and decreased libido (such as depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

tetrabenazine

Products Affected

- tetrabenazine oral tablet 12.5 mg, 25 mg

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with Austedo or Ingrezza.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	CYP2D6 genotype must be provided for doses greater than 50mg/day.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

THALOMID

Products Affected

- Thalomid Oral Capsule 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TIBSOVO

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have documentation of IDH1 mutation status
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TOFACITINIB

Products Affected

- tofacitinib citrate er
- tofacitinib citrate oral solution
- tofacitinib citrate oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dose must follow FDA-label or be supported in Part D compendia.
Other Criteria	FOR RHEUMATOID ARTHRITIS: Trial of a traditional DMARD (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) with inadequate response. FOR ANKYLOSING SPONDYLITIS: Trial of an NSAID with inadequate response. FOR JUVENILE IDIOPATHIC ARTHRITIS: Trial of one other therapy (e.g., methotrexate, NSAIDs) with inadequate response - or - patient is starting the drug concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the physician.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

tolvaptan

Products Affected

- tolvaptan (hyponatremia)
- tolvaptan oral tablet
- tolvaptan oral tablet therapy pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	FOR HYPONATREMIA: (1) Documentation that confirms the patient has hypervolemic or euvolemic hyponatremia defined as a serum sodium less than 125 mEq/L or less-marked hyponatremia that is symptomatic and nonresponsive to fluid restriction (including patients with SIADH or heart failure), and (2) tolvaptan is being used at a quantity of up to 60 mg per day in line with the FDA-approved labeling. FOR AUTOSOMAL DOMINANT POLYCYSTIC KIDNEY DISEASE (ADPKD): (1) Patient is at risk of rapidly progressing, and (2) tolvaptan is being used at a quantity of up to 120 mg per day in line with the FDA-approved labeling.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Hyponatremia: 30 days, ADPKD: 2 years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TOPIRAMATE SOLUTION

Products Affected

- topiramate oral solution 25 mg/ml

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation to support the following: (1) an inability to use generic topiramate sprinkles, and (2) trial and failure (defined as an inability to improve the condition) with one other generic anticonvulsant.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TRETINOIN CAPSULES

Products Affected

- tretinoin oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TRIKAFTA

Products Affected

- Trikafta Oral Tablet Therapy Pack
- Trikafta Oral Therapy Pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation confirming an FDA-Approved diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

trimipramine maleate

Products Affected

- trimipramine maleate oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate response) with 2 of the following generic antidepressants: SSRIs, SNRIs, bupropion, mirtazapine, or trazodone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TRULICITY

Products Affected

- Trulicity Subcutaneous Solution Auto-Injector

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	FOR T2DM: Trial with two oral generic drugs (e.g., dapagliflozin, metformin, glimepiride, glimepiride, etc.).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TRUQAP

Products Affected

- Truqap Oral Tablet 200 MG
- Truqap Oral Tablet Therapy Pack 160 MG

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

TUKYSA

Products Affected

- Tukysa Oral Tablet 150 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TURALIO

Products Affected

- Turalio Oral Capsule 125 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TYENNE

Products Affected

- Tyenne Subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, Janus Kinase Inhibitor (JAKis).
Required Medical Information	For systemic sclerosis- related interstitial lung disease (SScILD): High Resolution Computed Tomography (HRCT). FOR ALL OTHER INDICATIONS: Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Initial-1 yr (SScILD), 2 yr (other). Reauth-2 yr. Dose must align with FDA label or Part D compendia
Other Criteria	FOR RHEUMATOID ARTHRITIS and JUVENILE IDIOPATHIC ARTHRITIS: Trial of two of the following with inadequate response: a preferred adalimumab product, Rinvoq, or Enbrel. FOR SScILD INITIAL COVERAGE: Confirmed diagnosis by HRCT. FOR SScILD REAUTHORIZATION: Documentation of improvement in condition.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TYMLOS

Products Affected

- Tymlos

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation supporting one of the following: (1) Trial and failure, intolerance, or contraindication to alendronate, risedronate, or ibandronate - AND - zoledronic acid, OR (2) a very high risk of fracture defined as a T-score of -3.0 or less, a T-score of -2.5 or less with a fragility fracture, or a history of severe or multiple fragility fractures regardless of T-score.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by endocrinologist
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	Yes
Prerequisite Therapy Required	Yes

VALCHLOR

Products Affected

- Valchlor

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For limited/localized skin involvement, must have tried topical steroids and either topical tazarotene or topical imiquimod. For generalized skin involvement, must have tried topical steroids.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

VALTOCO

Products Affected

- Valtoco 10 MG Dose
- Valtoco 15 MG Dose Nasal Liquid
- Valtoco 20 MG Dose Nasal Liquid
- Valtoco 5 MG Dose
- Therapy Pack 2 x 10 MG/0.1ML
- Therapy Pack 2 x 7.5 MG/0.1ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

VANFLYTA

Products Affected

- Vanflyta

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

VELSIPITY

Products Affected

- Velsipity

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dose must follow FDA-label or be supported in Part D compendia.
Other Criteria	FOR ULCERATIVE COLITIS: (1) Patient has tried and failed two of the following: infliximab, adalimumab, ustekinumab, tofacitinib, Skyrizi, and Rinvoq. Failed is defined as an inability to improve the condition.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

VEPPANU

Products Affected

- Veppanu

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

VERQUVO

Products Affected

- Verquvo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of prior therapies and responses to treatment must be provided. Documentation of an ejection fraction less than 45% assessed within the past 12 months must be provided.
Age Restrictions	Must be at least 18 years old.
Prescriber Restrictions	Must be prescribed by, or in consultation with, a cardiologist.
Coverage Duration	Two years
Other Criteria	Patient has symptomatic worsening chronic heart failure (NYHA class 2 to 4) - AND - has been hospitalized for heart failure in the past 6 months or treated with outpatient IV diuretic therapy for heart failure in the past 3 months AND - has tried and failed (defined as an intolerance or inability to improve symptoms) maximally tolerated doses of the following medications in combination: an ACEI, ARB, or ARNi (such as enalapril or Entresto) - AND - bisoprolol, carvedilol or metoprolol ER - AND - spironolactone or other diuretic.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

VERSACLOZ

Products Affected

- Versacloz

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient has had prior trial with AND has a documented contraindication (e.g. dysphagia) to BOTH generic clozapine tablet AND generic clozapine orally disintegrating tablet (ODT).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

VERZENIO

Products Affected

- Verzenio

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

vigabatrin

Products Affected

- vigabatrin

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For refractory complex partial seizures: Must have documentation supporting a trial and failure (defined as inadequate seizure control) with at least 2 other generic anticonvulsants for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

vigadrone

Products Affected

- vigadrone

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For refractory complex partial seizures: Must have documentation supporting a trial and failure (defined as inadequate seizure control) with at least 2 other generic anticonvulsants for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

VIGAFYDE

Products Affected

- Vigafyde

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Must be 2 years of age or younger (max age 2 years).
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

VITRAKVI

Products Affected

- Vitrakvi Oral Capsule 100 MG, 25 MG
- Vitrakvi Oral Solution

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

VONJO

Products Affected

- Vonjo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Criteria will be applied consistent with current NCCN guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

VORANIGO

Products Affected

- Voranigo Oral Tablet 10 MG, 40 MG

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

voriconazole

Products Affected

- voriconazole intravenous solution reconstituted

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

VOSEVI

Products Affected

- Vosevi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have chronic hepatitis C infection.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	(1) Must be using for retreatment of hepatitis C, AND (2) must be unable to use sofosbuvir/velpatasvir, and (3) must have documentation to support that the use of the drug is consistent with current AASLD/IDSA guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

VOWST

Products Affected

- Vowst

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of at least 2 recurrent episodes of CDI (3 or more total CDI episodes) after failure of appropriate antibiotic treatments.
Age Restrictions	Patient must be 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year. Limited to 1 treatment course (12 capsules over 3 days).
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

VRAYLAR

Products Affected

- Vraylar Oral Capsule

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as an inadequate response) with two of the following generic drugs that have support for the requested condition and each used for at least 28 days: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, or lurasidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

VYNDAMAX

Products Affected

- Vyndamax

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with TTR-lowering agents (e.g., Amvuttra, Onpattro).
Required Medical Information	INITIAL COVERAGE OF ATTR-CM: Documentation of the following: (1) New York Heart Association (NYHA) class 1 , 2, or 3 heart failure, AND (2) an echocardiogram (ECHO) or cardiac magnetic resonance (CMR) imaging demonstrating cardiac involvement (i.e., increased left ventricular wall thickness), AND (3) diagnosis confirmed by tissue biopsy, genetic testing, or radionuclide imaging (99mTc-PYP, 99mTc-DPD, or 99mTc-HMDP scan), AND (4) if the diagnosis was confirmed by radionuclide imaging, coverage also requires documentation of Grade 2 or 3 cardiac uptake.
Age Restrictions	Must be age 18 or older.
Prescriber Restrictions	
Coverage Duration	One year initial and reauthorization.
Other Criteria	Vyndamax will not be approved if the patient has primary (light-chain) amyloidosis. FOR REAUTHORIZATION OF ATTR-CM: Coverage requires documentation of a positive clinical response to Vyndamax compared to baseline (e.g., reduced cardiovascular-related hospitalizations, improved function, improved quality of life).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

WEGOVY

Products Affected

- Wegovy Oral

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other GLP-1 agonists or GLP-1/GIP receptor agonists.
Required Medical Information	Diagnosis, including BMI and diet and exercise plan, fibrosis stage (for MASH).
Age Restrictions	Must be 18 years or older.
Prescriber Restrictions	Must be Prescribed by or in consultation with a specialist for the condition.
Coverage Duration	One year

PA Criteria	Criteria Details
Other Criteria	MACE INITIAL COVERAGE: Approval requires: (1) Prior myocardial infarction, prior stroke, or symptomatic peripheral artery disease evidenced by intermittent claudication, peripheral arterial revascularization procedure, or amputation from atherosclerotic disease, AND (2) Baseline (prior to Wegovy) BMI is 27 kg/m² or more, AND (3) Use of Wegovy in conjunction with active participation in a reduced calorie diet AND increased physical activity, in line with the FDA-approved labeling. MACE REAUTHORIZATION: Approval requires: (1) Documented clinical benefit compared to baseline (prior to Wegovy) such as sustained weight loss, AND (2) Use of Wegovy in conjunction with active participation in a reduced calorie diet AND increased physical activity, in line with the FDA-approved labeling. MASH INITIAL COVERAGE: Approval requires: (1) No cirrhosis, AND (2) stage F2 or F3 fibrosis identified by biopsy or NIT, AND (3) Use of Wegovy in conjunction with active participation in a reduced calorie diet AND increased physical activity, in line with the FDA-approved labeling. MASH REAUTHORIZATION: Approval requires: (1) No cirrhosis, and (2) Use of Wegovy in conjunction with active participation in a reduced calorie diet AND increased physical activity, in line with the FDA-approved labeling.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

WELIREG

Products Affected

- Welireg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

WINREVAIR

Products Affected

- Winrevair

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial requests, documentation of the following is required: (1) Must have a confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1, by right heart catheterization, AND (2) Must have WHO functional class II or III symptoms, AND (3) Must have tried and failed (defined as an inability to improve the condition) of dual therapy with a phosphodiesterase inhibitor (e.g., sildenafil or tadalafil) AND an endothelin receptor antagonist (e.g., ambrisentan or bosentan), AND (4) Winrevair will be initiated as add on therapy to at least 2 other PAH agents (e.g. ERA, PDE5i, Prostaglandins).
Age Restrictions	Must be 18 years of age or older.
Prescriber Restrictions	Must be prescribed by or in consultation with a specialist for the condition.
Coverage Duration	One year initial. Two years reauthorization.
Other Criteria	For reauthorization requests: Documentation must be provided demonstrating that the patient has had a beneficial response to Winrevair compared to pretreatment baseline in one or more of the following: improvement in WHO functional class, risk status, or 6MWD.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

WYOST

Products Affected

- Wyost

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

XALKORI

Products Affected

- Xalkori Oral Capsule
- Xalkori Oral Capsule Sprinkle 150 MG, 20 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

XATMEP

Products Affected

- Xatmep

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must try and fail (defined as an intolerance or inability to improve the condition) generic methotrexate.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

XCOPRI

Products Affected

- Xcopri (250 MG Daily Dose) Oral Tablet MG, 25 MG, 50 MG
Therapy Pack 100 & 150 MG • Xcopri Oral Tablet Therapy Pack
- Xcopri (350 MG Daily Dose)
- Xcopri Oral Tablet 100 MG, 150 MG, 200

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate seizure control) with at least 2 generic anticonvulsants for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

XDEMZY

Products Affected

- Xdemzy

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have a diagnosis of Demodex blepharitis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

XERMELO

Products Affected

- Xermelo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must be experiencing 4 or more bowel movements per day.
Age Restrictions	Must be 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Patient must have been receiving stable doses of somatostatin analog (SSA) therapy for at least 3 months and its use has been inadequate on its own.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

XIFAXAN

Products Affected

- Xifaxan Oral Tablet 200 MG, 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	End of plan year (all). IBS-D limited to three, 14-day treatment courses. TD limited to three days.
Other Criteria	For travelers diarrhea (TD): Coverage requires a trial and failure (defined as an intolerance or inability to improve the condition) with azithromycin. For hepatic encephalopathy: Coverage requires a trial and failure (defined above) with lactulose.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs.
Required Medical Information	Diagnosis, baseline IgE level, current weight, concurrent therapies (nasal polyps), prior therapies. Administration information to determine coverage under Part B vs Part D.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	1 year initial, 2 years reauth. Dose must align with FDA label or Part D compendia.

PA Criteria	Criteria Details
Other Criteria	ASTHMA INITIAL COVERAGE: (1) Baseline (prior to Xolair) IgE level of at least 30 IU/mL, AND (2) current weight, AND (3) baseline positive skin test or in vitro reactivity to a perennial aeroallergen, AND (4) Use of an ICS/LABA inhaler as prescribed in the past 6 months with inadequate control of condition. ASTHMA REAUTHORIZATION: (1) Documentation of clinical benefit compared to baseline, AND (2) current weight, AND (3) Baseline IgE level. FOOD ALLERGY INITIAL COVERAGE: (1) Confirmed IgE-mediated food allergy by positive in vitro test for IgE to the specified foods AND a positive skin prick test to the specified foods, AND (2) Clinical history of a significant allergic reaction to the specified foods, AND (3) Baseline (prior to Xolair) IgE level of at least 30 IU/mL, AND (4) Xolair will be used along with a food allergen-avoidant diet, AND (5) Current weight, AND (6) Patient is at least 1 year of age. FOOD ALLERGY REAUTHORIZATION: (1) Xolair will be used along with a food allergen-avoidant diet, AND (2) current weight, AND (3) baseline IgE level. CHRONIC URTICARIA (CU) INITIAL COVERAGE: (1) Urticaria occurring for more than 6 weeks, and (2) trial of an H1 antihistamine with inadequate response. CU REAUTHORIZATION: (1) Documentation of clinical benefit compared to baseline (prior to Xolair). NASAL POLYP INITIAL COVERAGE: (1) Baseline (prior to Xolair) IgE level of at least 30 IU/mL, AND (2) Current weight, AND (3) trial of an intranasal steroid with inadequate response, AND (4) Concurrent use of Xolair and an intranasal steroid. NASAL POLYP REAUTHORIZATION: (1) Documentation of clinical benefit compared to baseline, AND (2) continued use of Xolair with an intranasal steroid, AND (3) current weight, AND (4) baseline IgE level.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

XOSPATA

Products Affected

- Xospata

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

XPOVIO

Products Affected

- 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, 80 MG
- Xpovio (80 MG Twice Weekly)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

XTANDI

Products Affected

- Xtandi Oral Capsule
- Xtandi Oral Tablet 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Coverage of Xtandi requires documentation supporting a trial of abiraterone acetate (generic Zytiga) with inadequate response, disease progression, or intolerance OR contraindication to the use of abiraterone acetate. Exception: For members with non-metastatic castration-resistant prostate cancer (nmCRPC), abiraterone trial does not apply.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

XTRENBO

Products Affected

- Xtrenbo

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

YESINTEK

Products Affected

- Yesintek Subcutaneous Solution
- Yesintek Subcutaneous Solution
Prefilled Syringe 45 MG/0.5ML, 90
MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dose must follow FDA-label or be supported in Part D compendia.
Other Criteria	FOR PSORIASIS: Trial of a traditional DMARD (e.g., methotrexate, cyclosporine, acitretin) with inadequate response.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

YUTREPIA

Products Affected

- Yutrepia

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, chest CT (for WHO Group 3), prior therapies (for WHO Group 1), and clinical response (for reauth).
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a specialist for the condition.
Coverage Duration	One year initial. Two years reauth.
Other Criteria	FOR PAH (WHO GROUP 1) INITIAL COVERAGE: Diagnosis confirmed by right heart catheterization, and (2) WHO/NYHA Functional Class 3 or 4 symptoms, AND (3) trial of an endothelin receptor antagonist (such as ambrisentan, bosentan) or a PDE5 inhibitor (such as tadalafil, sildenafil). FOR PH-ILD (WHO GROUP 3) INITIAL COVERAGE: Diagnosis confirmed by right heart catheterization AND (2) evidence of diffuse parenchymal lung disease (i.e., interstitial lung disease) on chest CT. FOR REAUTHORIZATION FOR ALL INDICATIONS: Documented clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

ZEJULA

Products Affected

- Zejula Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ZOLINZA

Products Affected

- Zolinza

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ZONISADE

Products Affected

- Zonisade

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For doses above 400 mg per day, documentation confirming need for further seizure reduction is required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must have tried generic zonisamide capsules with inability to swallow capsule - AND - must have tried and failed (defined as an inability to improve the condition) one other generic antiseizure medication.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ZTALMY

Products Affected

- Ztalmy

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(1) Must provide confirmation of CDKL5 deficiency based on genetic testing, (2) Must provide patient's current weight.
Age Restrictions	Must be 2 years of age or older.
Prescriber Restrictions	Must be prescribed by a neurologist.
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ZURZUVAE

Products Affected

- Zurzuvae Oral Capsule 20 MG, 25 MG, 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmation of diagnosis of postpartum depression.
Age Restrictions	Must be 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	One year. Limited to one treatment course per year.
Other Criteria	Must follow current ACOG recommendations which require the patient to be in the postpartum period (ie, within 12 months postpartum) for depression that has onset in the third trimester or within 4 weeks postpartum.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ZYKADIA

Products Affected

- Zykadia Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ZYMFENTRA

Products Affected

- Zymfentra (2 Pen)
- Zymfentra (2 Syringe)

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Diagnosis and prior therapies.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dose must follow FDA-label or be supported in Part D compendia.
Other Criteria	FOR CROHN'S DISEASE: (1) Patient has tried and failed two of the following: infliximab (the use of the intravenous induction doses alone do not constitute a trial with failure), adalimumab, ustekinumab, Skyrizi, and Rinvoq. FOR ULCERATIVE COLITIS: (1) Patient has tried and failed two of the following: infliximab (the use of the intravenous induction doses alone do not constitute a trial with failure), adalimumab, ustekinumab, tofacitinib, Skyrizi, and Rinvoq. Failed is defined as an inability to improve the condition.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

D. Index of Covered Drugs

In this section, you can find a drug by searching for its name alphabetically. This will tell you the page number where you can find additional coverage information for your drug.

Acthar.....	2	Balversa Oral Tablet 3 MG, 4 MG, 5	
Acthar Gel.....	2	MG.....	34
Actimmune.....	4	bd autoshield duo.....	81
Adempas.....	5	bd pen needle 29g x 12mm.....	81
Adipex-P Oral Tablet.....	18	bd pen needle micro u/f.....	81
Aimovig.....	6	bd pen needle micro ultrafine.....	81
Akeega.....	7	bd pen needle mini u/f.....	81
Alecensa.....	8	bd pen needle mini ultrafine.....	81
allergy relief nasal.....	195	bd pen needle nano 2nd gen.....	81
alprazolam oral tablet.....	9	bd pen needle nano u/f.....	81
Alunbrig Oral Tablet 180 MG, 30 MG,		bd pen needle nano ultrafine.....	81
90 MG.....	11	bd pen needle orig ultrafine.....	81
Alunbrig Oral Tablet Therapy Pack.....	11	bd pen needle original u/f.....	81
ambrisentan.....	12	bd pen needle short u/f.....	81
amitriptyline hcl oral.....	13	bd pen needle short ultrafine.....	81
aprepitant.....	20	Benlysta Subcutaneous.....	35
Arcalyst.....	21	benzphetamine hcl oral tablet 50 mg.....	18
Arikayce.....	22	Besremi.....	37
aripiprazole oral solution.....	24	Besremi Pen.....	37
aripiprazole oral tablet dispersible.....	23	Betaseron Subcutaneous Kit.....	38
armodafinil.....	25	bexarotene external.....	40
asenapine maleate.....	26	bexarotene oral.....	39
assure id insulin safety syr 29g x 1/2" 1		Bilprevda.....	41
ml.....	81	bosentan oral tablet.....	42
Augtyro Oral Capsule 160 MG, 40 MG.....	27	Bosulif Oral Capsule 100 MG, 50 MG...	43
Austedo Oral Tablet 12 MG, 6 MG, 9		Bosulif Oral Tablet 100 MG, 500 MG....	43
MG.....	28	bosutinib oral tablet 100 mg, 400 mg,	
Austedo XR.....	28	500 mg.....	44
Austedo XR Patient Titration Oral		Braftovi Oral Capsule 75 MG.....	45
Tablet Extended Release Therapy		brivaracetam oral solution.....	46
Pack 12 & 18 & 24 & 30 MG.....	28	brivaracetam oral tablet.....	46
Auvelity.....	29	Brukisa Oral Tablet.....	47
Auvelity Titration Pack.....	29	budesonide nasal.....	195
Avmapki Fakzynja Co-Pack.....	30	Bysanti.....	48
Avonex Pen Intramuscular Auto-		Bysanti Titration Pack A.....	48
Injector Kit.....	31	Bysanti Titration Pack B.....	48
Avonex Prefilled Intramuscular		Bysanti Titration Pack C.....	48
Prefilled Syringe Kit.....	31	Cabometyx.....	49
Avtozma Subcutaneous.....	32	calcipotriene-betameth diprop external	
Ayvakit.....	33	suspension.....	50
		Calquence Oral Tablet.....	51

Caplyta.....	52	Diacomit.....	83
Caprelsa Oral Tablet 100 MG, 300 MG.....	54	diazePAM Intensol.....	84
carglumic acid oral tablet soluble.....	55	diazepam oral solution 5 mg/5ml.....	84
Cavhanza.....	56	diazepam oral tablet.....	84
Cayston.....	57	dichlorphenamide.....	86
cetirizine hcl childrens oral solution 5 mg/5ml.....	14	diethylpropion hcl er.....	18
cetirizine hcl oral tablet chewable.....	14	diethylpropion hcl oral.....	18
chlordiazepoxide hcl.....	58	dihydroergotamine mesylate nasal.....	87
clobazam oral suspension 2.5 mg/ml....	60	dimethyl fumarate oral.....	88
clobazam oral tablet.....	60	dimethyl fumarate starter pack oral capsule delayed release therapy pack..	88
clonazepam oral tablet 0.5 mg, 1 mg, 2 mg.....	61	Drizalma Sprinkle Oral Capsule Delayed Release Sprinkle 20 MG, 30 MG, 60 MG.....	89
clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg.....	61	droxidopa.....	90
clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg.....	63	Dupixent Subcutaneous Solution Auto-Injector 200 MG/1.14ML, 300 MG/2ML.....	91
clozapine oral tablet dispersible.....	65	Dupixent Subcutaneous Solution Pen-Injector 200 MG/1.14ML, 300 MG/2ML.....	91
Cobenfy.....	66	Dupixent Subcutaneous Solution Prefilled Syringe 200 MG/1.14ML, 300 MG/2ML.....	91
Cobenfy Starter Pack.....	66	eltrombopag olamine oral packet 12.5 mg, 25 mg.....	94
Cometriq (100 MG Daily Dose) Oral Kit 80 & 20 MG.....	67	eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg.....	94
Cometriq (140 MG Daily Dose) Oral Kit 3 x 20 MG & 80 MG.....	67	embecta autoshield duo.....	81
Cometriq (60 MG Daily Dose).....	67	embecta pen needle nano.....	81
comfort assist insulin syringe 29g x 1/2" 1 ml.....	81	embecta pen needle nano 2 gen.....	81
Copiktra.....	68	embecta pen needle ultrafine.....	81
Cortrophin.....	69	Emgality.....	96
Cosentyx (300 MG Dose).....	71	Emgality (300 MG Dose).....	96
Cosentyx Sensoready (300 MG).....	71	Emsam.....	97
Cosentyx Subcutaneous Solution Prefilled Syringe 75 MG/0.5ML.....	71	Enbrel Mini.....	99
Cosentyx UnoReady.....	71	Enbrel Subcutaneous Solution 25 MG/0.5ML.....	98
Cotellic.....	73	Enbrel Subcutaneous Solution Prefilled Syringe 25 MG/0.5ML, 50 MG/ML.....	98
Cresemba Oral.....	74	Enbrel SureClick Subcutaneous Solution Auto-Injector.....	98
cvs gauze sterile pad 2"x2".....	81	Ensacove.....	100
Cystadrops.....	75	Entyvio Pen.....	101
Cystaran.....	76	Epidiolex.....	102
dalfampridine er.....	77	Erivedge.....	103
Danziten.....	78		
dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg.....	79		
Daurismo.....	80		

Erleada Oral Tablet 240 MG, 60 MG...	104	Hernexeos.....	132
erlotinib hcl oral tablet 100 mg, 150		Hyrnuo.....	133
mg, 25 mg.....	105	Ibrance.....	134
eslicarbazepine acetate oral tablet 200		Ibuprofen.....	135
mg, 400 mg, 600 mg, 800 mg.....	106	icatibant acetate subcutaneous	
Eucrisa.....	107	solution prefilled syringe.....	136
Eulexin.....	108	Iclusig.....	137
everolimus oral tablet 10 mg, 2.5 mg, 5		IDHIFA.....	138
mg, 7.5 mg.....	109	imatinib mesylate oral tablet 100 mg,	
everolimus oral tablet soluble.....	109	400 mg.....	139
Exxua.....	110	Imbruvica Oral Capsule.....	140
Exxua Titration Pack.....	110	Imbruvica Oral Suspension.....	140
Fanapt.....	111	Imbruvica Oral Tablet 140 MG, 280	
Fanapt Titration Pack A.....	111	MG, 420 MG.....	140
Fanapt Titration Pack B Oral Tablet....	111	imkeldi.....	141
Fanapt Titration Pack C Oral Tablet....	111	Impavido.....	142
Farxiga.....	112	Increlex.....	143
Fasenra Pen.....	113	infliximab.....	144
Fasenra Subcutaneous Solution		Inluriyo.....	146
Prefilled Syringe 10 MG/0.5ML, 30		Inlyta.....	147
MG/ML.....	113	Inqovi.....	148
Filspari Oral Tablet 200 MG, 400 MG..	115	Inrebic.....	149
fingolimod hcl.....	117	Isturisa Oral Tablet 1 MG, 5 MG.....	150
Fintepla.....	118	Itovebi Oral Tablet 3 MG, 9 MG.....	151
Fotivda.....	119	Iwifin.....	154
Fruzaqla Oral Capsule 1 MG, 5 MG....	120	Jakafi.....	155
Gamunex-C.....	152	Jardiance.....	156
Gavreto.....	121	Jaypirca.....	157
gefitinib.....	122	Jylamvo.....	158
Gilotrif.....	123	Kalydeco.....	159
glatiramer acetate subcutaneous		Kerendia.....	160
solution prefilled syringe 20 mg/ml, 40		Kisqali (200 MG Dose).....	162
mg/ml.....	124	Kisqali (400 MG Dose).....	162
Glatopa Subcutaneous Solution		Kisqali (600 MG Dose).....	162
Prefilled Syringe 20 MG/ML, 40		Komzifti.....	163
MG/ML.....	125	Koselugo.....	164
global alcohol prep ease.....	81	krazati.....	165
Gomekli.....	126	lapatinib ditosylate.....	166
Hadlima PushTouch Subcutaneous		Lazcluze Oral Tablet 240 MG, 80 MG..	167
Solution Auto-Injector 40 MG/0.4ML,		lenalidomide.....	168
40 MG/0.8ML.....	129	Lenvima (10 MG Daily Dose).....	169
Hadlima Subcutaneous Solution		Lenvima (12 MG Daily Dose).....	169
Prefilled Syringe 40 MG/0.4ML, 40		Lenvima (14 MG Daily Dose).....	169
MG/0.8ML.....	129	Lenvima (18 MG Daily Dose).....	169
Haegarda.....	131	Lenvima (20 MG Daily Dose).....	169

Lenvima (24 MG Daily Dose).....	169	nilotinib hcl.....	200
Lenvima (4 MG Daily Dose).....	169	Ninlaro.....	201
Lenvima (8 MG Daily Dose).....	169	nintedanib esylate.....	202
levetiracetam oral tablet disintegrating soluble 250 mg, 500 mg.....	170	nitisinone.....	204
l-glutamine oral packet.....	171	Nivestym Injection Solution Prefilled Syringe.....	205
lidocaine external patch 5 %.....	172	Norditropin FlexPro Subcutaneous Solution Pen-Injector 10 MG/1.5ML, 15 MG/1.5ML, 5 MG/1.5ML.....	127
Lidocan.....	172	nortriptyline hcl oral.....	206
Lidocan III.....	172	novofine pen needle.....	81
Lifyorli (125 MG DOSE).....	173	novofine plus pen needle.....	81
Lifyorli (150 MG DOSE).....	173	Nubega.....	207
liraglutide -weight management.....	15	Nucala Subcutaneous Solution Auto- Injector.....	208
Livtency.....	174	Nucala Subcutaneous Solution Prefilled Syringe 100 MG/ML, 40 MG/0.4ML.....	208
Lomaira.....	18	Nucala Subcutaneous Solution Reconstituted.....	208
Lonsurf.....	175	Nulibry.....	210
LORazepam Intensol.....	176	Nuplazid Oral Capsule.....	211
lorazepam oral tablet.....	176	Nuplazid Oral Tablet 10 MG.....	211
Lorbrena.....	178	Nurtec.....	212
Lumakras Oral Tablet 120 MG, 240 MG, 320 MG.....	179	Odomzo.....	213
Lupron Depot (1-Month) Intramuscular Kit 3.75 MG.....	180	Ofev.....	214
Lupron Depot (3-Month) Intramuscular Kit 11.25 MG.....	180	Ogsiveo Oral Tablet 100 MG, 150 MG.....	216
Lybalvi.....	181	Ojemda Oral Suspension Reconstituted.....	217
Lynparza Oral Tablet.....	182	Ojemda Oral Tablet 100 MG, 100 MG (16 pack), 100 MG (24 pack).....	217
Lytgobi (12 MG Daily Dose).....	183	oijaara.....	218
Lytgobi (16 MG Daily Dose).....	183	omeprazole oral tablet delayed release	243
Lytgobi (20 MG Daily Dose).....	183	Omnitrope Subcutaneous Solution Cartridge.....	127
macitentan.....	184	Omnitrope Subcutaneous Solution Reconstituted.....	127
Marplan.....	185	Onureg.....	219
Matulane.....	186	Opipza Oral Film 10 MG, 2 MG, 5 MG.....	221
Mekinist Oral Solution Reconstituted... ..	188	Orenitram.....	222
Mekinist Oral Tablet 0.5 MG, 2 MG.....	187	Orenitram Month 1.....	222
Mektovi.....	189	Orenitram Month 2.....	222
mercaptopurine oral suspension.....	190	Orenitram Month 3.....	222
mifepristone oral tablet 300 mg.....	191	Orgovyx.....	223
modafinil oral.....	192		
Modeyso.....	193		
Mounjaro Subcutaneous Solution Auto-Injector.....	194		
Nayzilam.....	196		
Nerlynx.....	197		
Nexletol.....	198		
Nexlizet.....	199		

Orkambi Oral Packet.....	224	Prevacid 24HR.....	243
Orkambi Oral Tablet.....	224	Prevymis Oral Packet.....	241
orlistat oral.....	18	Prevymis Oral Tablet.....	241
Orserdu Oral Tablet 345 MG, 86 MG..	225	Prolastin-C Intravenous Solution.....	242
Otezla Oral Tablet.....	226	protriptyline hcl.....	244
Otezla Oral Tablet Therapy Pack.....	226	Qinlock.....	245
Otezla XR.....	226	Raldesy.....	246
Otezla/Otezla XR Initiation Pk.....	226	Redemplo.....	247
Otulfi Subcutaneous Solution.....	227	reli-on insulin syringe 29g 0.3 ml.....	81
Otulfi Subcutaneous Solution Prefilled		Relistor Oral.....	249
Syringe 45 MG/0.5ML, 90 MG/ML.....	227	Relistor Subcutaneous.....	249
Ozempic.....	228	Repatha.....	250
Ozempic (0.25 or 0.5 MG/DOSE)		Repatha Pushtronex System.....	250
Subcutaneous Solution Pen-Injector 2		Repatha SureClick.....	250
MG/3ML.....	228	Retevmo Oral Tablet 120 MG, 160	
Ozempic (1 MG/DOSE) Subcutaneous		MG, 40 MG, 80 MG.....	251
Solution Pen-Injector 4 MG/3ML.....	228	Revcovi.....	252
Ozempic (2 MG/DOSE).....	228	Revuforj Oral Tablet 110 MG, 160 MG,	
Panretin.....	229	25 MG.....	253
paroxetine hcl.....	230	Rexulti.....	254
pazopanib hcl oral tablet 200 mg, 400		Rezdiffra.....	255
mg.....	231	Rezlidhia.....	257
Pemazyre.....	232	Rezurock.....	258
penicillamine oral tablet.....	233	Rinvoq LQ.....	259
perampanel oral suspension.....	234	Rinvoq Oral Tablet Extended Release	
perampanel oral tablet.....	234	24 Hour 15 MG, 30 MG, 45 MG.....	259
phendimetrazine tartrate.....	18	Romvimza.....	261
phendimetrazine tartrate er.....	18	Rozlytrek Oral Capsule 100 MG, 200	
phenobarbital oral elixir.....	235	MG.....	262
phenobarbital oral tablet.....	235	Rozlytrek Oral Packet.....	263
phentermine hcl oral capsule.....	18	Rubraca.....	264
phentermine hcl oral tablet 37.5 mg.....	18	rufinamide oral suspension 40 mg/ml..	265
phentermine-topiramate er.....	18	rufinamide oral tablet.....	265
Piqray (200 MG Daily Dose).....	236	Rydapt.....	266
Piqray (250 MG Daily Dose).....	236	Sajazir Subcutaneous Solution	
Piqray (300 MG Daily Dose).....	236	Prefilled Syringe.....	136
pirfenidone oral capsule.....	237	Saxenda.....	15
pirfenidone oral tablet 267 mg, 801 mg		Scemblix Oral Tablet 100 MG, 20 MG,	
.....	237	40 MG.....	267
Plegridy.....	238	Secuado.....	268
Plegridy Starter Pack.....	238	Signifor.....	269
pomalidomide.....	239	sildenafil citrate oral tablet 20 mg.....	270
Pomalyst.....	240	Simlandi (1 Pen) Subcutaneous Auto-	
preferred plus insulin syringe 28g x		Injector Kit 80 MG/0.8ML.....	271
1/2" 0.5 ml.....	81	Simlandi (2 Pen).....	271

Simlandi (2 Syringe) Subcutaneous Prefilled Syringe Kit 20 MG/0.2ML, 40 MG/0.4ML.....	271	testosterone transdermal gel 1.62 %, 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%).....	302
Sirturo.....	273	testosterone transdermal solution.....	303
Skyrizi Pen.....	274	tetrabenazine oral tablet 12.5 mg, 25 mg.....	304
Skyrizi Subcutaneous Solution Cartridge 180 MG/1.2ML, 360 MG/2.4ML.....	274	Thalomid Oral Capsule 100 MG, 50 MG.....	305
Skyrizi Subcutaneous Solution Prefilled Syringe 150 MG/ML, 55 MG/0.37ML.....	274	Tibsovo.....	306
Sodium Oxybate.....	275	tofacitinib citrate er.....	307
sofosbuvir-velpatasvir.....	276	tofacitinib citrate oral solution.....	307
Somavert.....	277	tofacitinib citrate oral tablet.....	307
sorafenib tosylate.....	278	tolvaptan (hyponatremia).....	309
Stivarga.....	279	tolvaptan oral tablet.....	309
Subvenite Oral Suspension.....	280	tolvaptan oral tablet therapy pack.....	309
sunitinib malate.....	281	topiramate oral solution 25 mg/ml.....	310
Symdeko.....	282	tretinoin oral.....	311
Sympazan.....	283	Tridacaine III.....	172
Synjardy.....	284	Tridacaine XL.....	172
Synjardy XR Oral Tablet Extended Release 24 Hour 10-1000 MG, 12.5- 1000 MG, 25-1000 MG, 5-1000 MG....	284	Trikafta Oral Tablet Therapy Pack.....	312
Tabrecta.....	285	Trikafta Oral Therapy Pack.....	312
tadalafil (pah).....	287	trimipramine maleate oral.....	313
tadalafil oral tablet 2.5 mg, 5 mg.....	286	Trulicity Subcutaneous Solution Auto- Injector.....	314
Tafinlar Oral Capsule.....	288	Truqap Oral Tablet 200 MG.....	315
Tafinlar Oral Tablet Soluble.....	289	Truqap Oral Tablet Therapy Pack 160 MG.....	315
Tagrisso.....	290	Tukysa Oral Tablet 150 MG, 50 MG....	316
Talzenna.....	291	Turalio Oral Capsule 125 MG.....	317
Tarpeyo.....	292	Tyenne Subcutaneous.....	318
tasimelteon.....	294	Tymlos.....	319
Tavneos.....	295	Valchlor.....	320
tazarotene external cream 0.1 %.....	296	Valtoco 10 MG Dose.....	321
temazepam oral capsule 15 mg, 30 mg	297	Valtoco 15 MG Dose Nasal Liquid Therapy Pack 2 x 7.5 MG/0.1ML.....	321
Tepmetko.....	299	Valtoco 20 MG Dose Nasal Liquid Therapy Pack 2 x 10 MG/0.1ML.....	321
teriflunomide.....	300	Valtoco 5 MG Dose.....	321
Teriparatide Subcutaneous Solution Pen-Injector 560 MCG/2.24ML.....	301	Vanflyta.....	322
		Velsipity.....	323
		Venclexta.....	324
		Venclexta Starting Pack.....	324
		Veppanu.....	325

Verquvo.....	326	Xpovio (40 MG Twice Weekly) Oral Tablet Therapy Pack 40 MG.....	357
Versacloz.....	328	Xpovio (60 MG Once Weekly) Oral Tablet Therapy Pack 60 MG.....	357
Verzenio.....	329	Xpovio (60 MG Twice Weekly).....	357
vigabatrin.....	330	Xpovio (80 MG Once Weekly) Oral Tablet Therapy Pack 40 MG, 80 MG...	357
vigadrone.....	331	Xpovio (80 MG Twice Weekly).....	357
Vigafyde.....	332	Xtandi Oral Capsule.....	358
Vitrakvi Oral Capsule 100 MG, 25 MG	333	Xtandi Oral Tablet 40 MG, 80 MG.....	358
Vitrakvi Oral Solution.....	333	Xtrenbo.....	359
Vonjo.....	334	Yesintek Subcutaneous Solution.....	360
Voranigo Oral Tablet 10 MG, 40 MG...	335	Yesintek Subcutaneous Solution Prefilled Syringe 45 MG/0.5ML, 90 MG/ML.....	360
voriconazole intravenous solution reconstituted.....	336	Yutrepia.....	361
Vosevi.....	337	Zaditor Ophthalmic Solution 0.035 %..	220
Vowst.....	338	Zejula Oral Tablet.....	363
Vraylar Oral Capsule.....	339	Zelboraf.....	364
Vyndamax.....	340	Zepbound KwikPen.....	15
Wegovy HD.....	15	Zepbound Subcutaneous Solution Auto-Injector.....	15
Wegovy Oral.....	342	Zolinza.....	365
Wegovy Subcutaneous Solution Auto- Injector 0.25 MG/0.5ML, 0.5 MG/0.5ML, 1 MG/0.5ML, 1.7 MG/0.75ML, 2.4 MG/0.75ML.....	15	Zonisade.....	366
Welireg.....	344	Ztalmy.....	367
Winrevair.....	345	Zurzuva Oral Capsule 20 MG, 25 MG, 30 MG.....	368
Wyost.....	347	Zykadia Oral Tablet.....	369
Xalkori Oral Capsule.....	348	Zymfentra (2 Pen).....	370
Xalkori Oral Capsule Sprinkle 150 MG, 20 MG, 50 MG.....	348	Zymfentra (2 Syringe).....	370
Xatmep.....	349		
Xcopri (250 MG Daily Dose) Oral Tablet Therapy Pack 100 & 150 MG...	350		
Xcopri (350 MG Daily Dose).....	350		
Xcopri Oral Tablet 100 MG, 150 MG, 200 MG, 25 MG, 50 MG.....	350		
Xcopri Oral Tablet Therapy Pack.....	350		
Xdemvy.....	351		
Xenical.....	18		
Xermelo.....	352		
Xifaxan Oral Tablet 200 MG, 550 MG.	353		
Xolair.....	354		
Xospata.....	356		
Xpovio (100 MG Once Weekly) Oral Tablet Therapy Pack 50 MG.....	357		
Xpovio (40 MG Once Weekly) Oral Tablet Therapy Pack 10 MG.....	357		