

Medicare Part D: 5 Tier Closed Venture Formulary 2024

Please click here.

For Medicare Part D: Prior Authorization Criteria

Please click here.

For Medicare Part D: Step Therapy Criteria

Please click here.

For more recent information or other questions, please contact:

Freedom Blue PPO (PA) Pharmacy Service at 1-800-550-8722

Security Blue HMO-POS Pharmacy Service at 1-800-935-2583

Community Blue Medicare HMO Pharmacy Service at 1-888-234-5397

Community Blue Medicare PPO Pharmacy Service at 1-888-757-2946

Complete Blue PPO Pharmacy Service at 1-833-227-9375

Community Blue Medicare Plus PPO Pharmacy Service at 1-888-757-2946

Blue Rx PDP Pharmacy Service at 1-800-290-3914

For TTY users, *711 National Relay Service*, Monday through Sunday, 8:00 a.m. to 8:00 p.m.
Visit medicare.highmark.com.

Notice: Oral Antivirals for COVID-19 Coverage

Paxlovid is covered with \$0 copay when dispensed at a preferred or non-preferred pharmacy.

Formulary ID: 24016 Version: 20

Updated: 11/2024

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this drug list (formulary) refers to “we,” “us,” or “our,” it means Highmark Senior Health Company, Highmark Choice Company, Highmark Senior Solutions Company, or HM Health Insurance Company.

When it refers to “plan” or “our plan,” it means Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Complete Blue PPO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, or Blue Rx PDP.

This document includes a list of the drugs (formulary) for our plan which is current as of January 1, 2024. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2025, and from time to time during the year.

What is the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Complete Blue PPO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, or Blue Rx PDP Formulary?

A formulary is a list of covered drugs selected by our Plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Our Plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at one of our plan’s network pharmacies, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Complete Blue PPO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, or Blue Rx PDP Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow Medicare rules in making these changes.

Changes that can affect you this year: In the below cases, you will be affected by coverage changes during the year:

- **New generic drugs.** We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking

that brand name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.

- o If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Complete Blue PPO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, or Blue Rx PDP Formulary?”
- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand name drug currently on the formulary or add new restrictions to the brand name drug or move it to different cost sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 31-day supply of the drug.
 - o If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Complete Blue PPO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, or Blue Rx PDP Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2024 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2024 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of January 1, 2024. To get updated information about the drugs covered by our Plan, please contact us. Our contact information appears on the front and back cover pages. In the event of mid-year non-maintenance formulary changes, members will be notified by mail and prospective members will receive an update with this formulary. The most up-to-date formulary is available on our website, [medicare.highmark.com](https://www.medicare.highmark.com).

How do I use the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Complete Blue PPO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, or Blue Rx PDP Formulary?

There are two ways to find your drug within the formulary:

Medical Condition

The formulary begins on page 9. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular – Hypertension & Lipids.” If you know what your drug is used for, look for the category name in the list that begins on page 9. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins at the end of this document. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Our Plan cover both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Our plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our Plan before you fill your prescriptions. If you don't get approval, our Plan may not cover the drug.
- **Quantity Limits:** For certain drugs, our Plan limits the amount of the drug we will cover. For example, our Plan provide 31 tablets, per 31 days per prescription for 100mg losartan. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy:** In some cases, our Plan require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, our Plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, our Plan will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 9. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online document(s) that explain(s) our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask our Plan to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, “How do I request an exception to the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Complete Blue PPO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, or Blue Rx PDP Formulary?” on page 5 for information about how to request an exception.

What if my drug is not on the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Complete Blue PPO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, or Blue Rx PDP Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Pharmacy Service and ask if your drug is covered.

If you learn that our plan does not cover your drug, you have two options:

- You can ask Pharmacy Service for a list of similar drugs that are covered by our Plan. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by our plan.
- You can ask our plan to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Complete Blue PPO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, or Blue Rx PDP Formulary?

You can ask our plan to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a formulary drug at a lower cost-sharing level unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, our Plan limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, our plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions, would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, or utilization restriction exception. **When you request a formulary or utilization restriction exception, you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan, you may be taking drugs that are not on our formulary. Or you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 31-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 31-day supply of medication. After your first 31-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

The above transition process will be implemented to accommodate you if you have an immediate need for a non-formulary drug or a drug that requires prior authorization due to a change in your level of care while you are waiting for an exception request to be processed.

For more information

For more detailed information about your plan's prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about your plan, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day / 7 days a week. TTY users should call 1-877-486-2048. Or visit <http://www.medicare.gov>.

Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Complete Blue PPO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, or Blue Rx PDP Formulary

The formulary that begins on the next page provides coverage information about the drugs covered by your plan. If you have trouble finding your drug in the list, turn to the Index that begins at the end of this document.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., ABELCET) and generic drugs are listed in lowercase italics (e.g., *abacavir*).

The information in the Requirements/Limits column tells you if Freedom Blue PPO, Security Blue HMO-POS, Community Blue Medicare HMO, Complete Blue PPO, Community Blue Medicare PPO, Community Blue Medicare Plus PPO, or Blue Rx PDP has any special requirements for coverage of your drug.

The following is a Formulary Format Example Only:

Drug Name	Venture Drug Tier	Requirements/ Limits
Anti - Infectives		
XYZ DRUG	T5	QL- 28

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Requirements/Limits**LA** = Limited access**PA** = Prior authorization required**PA-BvD** = This drug may be covered under Medicare part B or D depending on the circumstance.

Information may need to be submitted describing the use and setting of the drug to make the determination.

PA-NS = Prior authorization required for new starts only**QL** = Quantity limit applies. The quantity limit is noted for each drug. For example, if the quantity limit is QL (90 EA per 180 days), the quantity limit would be 90 units per 180-day supply.**ST** = Step therapy applies**ST-NS** = Step therapy applies to new starts only**Drug Tier****T1** = Cost-Sharing Tier 1 includes preferred generic drugs. This is the lowest cost-sharing tier.**T2** = Cost-Sharing Tier 2 includes generic drugs.**T3** = Cost-Sharing Tier 3 includes preferred brand name drugs and may include some single-sourced drugs (those generic drugs made by a single manufacturer).**T4** = Cost-Sharing Tier 4 includes non-preferred brand name drugs and may include some single-sourced generic drugs (those generic drugs made by a single manufacturer).**T5** = Cost-Sharing Tier 5 includes specialty drugs. This is the highest cost-sharing tier.**lowercase italics** = Generic drugs**UPPERCASE BOLD** = Brand name drugs

Drug Name	Drug Tier	Requirements/Limits
Anti - Infectives		
<i>abacavir oral solution</i>	T4	
<i>abacavir oral tablet</i>	T3	
<i>abacavir-lamivudine</i>	T4	
ABELCET	T4	PA-BvD
<i>acyclovir oral capsule</i>	T2	
<i>acyclovir oral suspension 200 mg/5 ml</i>	T2	
<i>acyclovir oral tablet</i>	T2	
<i>acyclovir sodium intravenous solution</i>	T2	PA-BvD
<i>adefovir</i>	T4	
<i>albendazole</i>	T4	
<i>amantadine hcl oral capsule</i>	T2	QL (124 EA per 31 days)
<i>amantadine hcl oral solution</i>	T2	
<i>amantadine hcl oral tablet</i>	T2	
<i>amikacin injection solution 500 mg/2 ml</i>	T2	
<i>amoxicillin oral capsule</i>	T1	
<i>amoxicillin oral suspension for reconstitution</i>	T1	
<i>amoxicillin oral tablet</i>	T1	
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	T1	
<i>amoxicillin-pot clavulanate oral suspension for reconstitution</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>amoxicillin-pot clavulanate oral tablet</i>	T2	
<i>amoxicillin-pot clavulanate oral tablet, chewable 400-57 mg</i>	T2	
<i>amphotericin b</i>	T4	PA-BvD
<i>amphotericin b liposome</i>	T5	PA-BvD
<i>ampicillin oral capsule 500 mg</i>	T2	
<i>ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg</i>	T2	
<i>ampicillin-sulbactam injection</i>	T2	
APTIVUS	T5	
ARIKAYCE	T5	PA
<i>atazanavir</i>	T4	
<i>atovaquone</i>	T4	
<i>atovaquone-proguanil</i>	T2	
AVYCAZ	T5	
<i>azithromycin intravenous</i>	T2	
<i>azithromycin oral packet</i>	T2	
<i>azithromycin oral tablet</i>	T2	
<i>aztreonam</i>	T4	
BICILLIN C-R	T3	
BICILLIN L-A INTRAMUSCULAR SYRINGE 600,000 UNIT/ML	T3	
BIKTARVY	T5	QL (31 EA per 31 days)
<i>casprofungin intravenous recon soln 50 mg</i>	T5	
<i>casprofungin intravenous recon soln 70 mg</i>	T4	
CAYSTON	T5	PA
<i>cefaclor oral capsule 500 mg</i>	T2	
<i>cefadroxil oral capsule</i>	T2	
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml</i>	T2	
<i>cefadroxil oral suspension for reconstitution 500 mg/5 ml</i>	T3	
<i>cefadroxil oral tablet</i>	T3	
<i>cefazolin injection recon soln 1 gram, 10 gram, 500 mg</i>	T2	
<i>cefdinir oral capsule</i>	T2	
<i>cefepime injection</i>	T4	
<i>cefixime</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>cefotetan injection</i>	T2	
<i>cefoxitin</i>	T2	
<i>cefpodoxime</i>	T2	
<i>cefprozil</i>	T2	
<i>ceftazidime</i>	T4	
<i>ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg</i>	T2	
<i>cefuroxime axetil oral tablet</i>	T2	
<i>cefuroxime sodium injection recon soln 750 mg</i>	T2	
<i>cefuroxime sodium intravenous recon soln 1.5 gram</i>	T2	
<i>cephalexin</i>	T2	
<i>chloroquine phosphate oral tablet 250 mg</i>	T2	QL (50 EA per 30 days)
<i>chloroquine phosphate oral tablet 500 mg</i>	T2	QL (25 EA per 30 days)
CIMDUO	T5	QL (31 EA per 31 days)
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	T1	
<i>ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml</i>	T2	
<i>clarithromycin</i>	T2	
<i>clindamycin hcl</i>	T2	
<i>clindamycin in 5 % dextrose</i>	T2	
CLINDAMYCIN PEDIATRIC	T2	
<i>clindamycin phosphate injection</i>	T2	
<i>clotrimazole mucous membrane</i>	T2	
COARTEM	T4	
<i>colistin (colistimethate na)</i>	T4	
COMPLERA	T5	
<i>cycloserine</i>	T4	
DALVANCE	T5	
<i>dapsone oral</i>	T3	
<i>daptomycin intravenous recon soln 350 mg</i>	T5	
<i>daptomycin intravenous recon soln 500 mg</i>	T4	
<i>darunavir</i>	T5	
DELSTRIGO	T5	QL (31 EA per 31 days)
<i>demeclocycline oral tablet 150 mg</i>	T2	
<i>demeclocycline oral tablet 300 mg</i>	T4	
DESCOVY	T5	QL (31 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>dicloxacillin</i>	T2	
DIFICID ORAL SUSPENSION FOR RECONSTITUTION	T5	QL (136 ML per 12 days)
DIFICID ORAL TABLET	T5	QL (20 EA per 10 days)
DOVATO	T5	QL (31 EA per 31 days)
DOXY-100	T2	
<i>doxycycline hyclate oral capsule</i>	T2	
<i>doxycycline hyclate oral tablet 100 mg</i>	T2	
<i>doxycycline hyclate oral tablet 150 mg, 50 mg, 75 mg</i>	T4	
<i>doxycycline hyclate oral tablet 20 mg</i>	T1	
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 100 mg, 200 mg, 50 mg</i>	T2	
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 150 mg, 75 mg</i>	T1	
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 80 mg</i>	T4	
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	T2	
<i>doxycycline monohydrate oral capsule 150 mg, 75 mg</i>	T4	
<i>doxycycline monohydrate oral suspension for reconstitution</i>	T2	
<i>doxycycline monohydrate oral tablet</i>	T2	
E.E.S. 400 ORAL TABLET	T4	
EDURANT	T5	
<i>efavirenz</i>	T3	
<i>efavirenz-emtricitabin-tenofovir</i>	T5	
<i>efavirenz-lamivudine-tenofovir disoproxil fumarate</i>	T5	QL (31 EA per 31 days)
<i>emtricitabine</i>	T3	
<i>emtricitabine-tenofovir (tdf) oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	T5	
<i>emtricitabine-tenofovir (tdf) oral tablet 200-300 mg</i>	T4	
EMTRIVA ORAL SOLUTION	T3	
EMVERM	T5	
<i>entecavir</i>	T4	
EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG	T5	PA; QL (28 EA per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
EPCLUSA ORAL PELLETS IN PACKET 200-50 MG	T5	PA; QL (56 EA per 28 days)
EPCLUSA ORAL TABLET	T5	PA; QL (28 EA per 28 days)
ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN 100 MG	T5	
ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN 50 MG	T4	
<i>ertapenem</i>	T4	
ERY-TAB ORAL TABLET,DELAYED RELEASE (DR/EC) 250 MG, 333 MG	T2	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml</i>	T4	
<i>erythromycin ethylsuccinate oral tablet</i>	T4	
<i>erythromycin oral tablet</i>	T2	
<i>ethambutol</i>	T2	
<i>etravirine</i>	T5	
EVOTAZ	T5	
<i>famciclovir</i>	T2	
FIRVANQ	T4	
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml</i>	T2	
<i>fluconazole in nacl (iso-osm) intravenous piggyback 400 mg/200 ml</i>	T3	
<i>fluconazole oral suspension for reconstitution</i>	T3	
<i>fluconazole oral tablet</i>	T2	
<i>flucytosine</i>	T5	
<i>fosamprenavir</i>	T5	
<i>fosfomycin tromethamine</i>	T4	
FUZEON SUBCUTANEOUS RECON SOLN	T5	
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml</i>	T2	
<i>gentamicin injection solution 40 mg/ml</i>	T1	
GENVOYA	T5	
<i>griseofulvin microsize oral suspension</i>	T2	
<i>griseofulvin microsize oral tablet</i>	T4	
<i>griseofulvin ultramicrosize</i>	T4	
HARVONI ORAL PELLETS IN PACKET	T5	PA; QL (28 EA per 28 days)
HARVONI ORAL TABLET 90-400 MG	T5	PA; QL (28 EA per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>hydroxychloroquine oral tablet 100 mg</i>	T4	QL (93 EA per 31 days)
<i>hydroxychloroquine oral tablet 200 mg</i>	T2	QL (93 EA per 31 days)
<i>hydroxychloroquine oral tablet 300 mg</i>	T4	QL (62 EA per 31 days)
<i>hydroxychloroquine oral tablet 400 mg</i>	T4	QL (31 EA per 31 days)
<i>imipenem-cilastatin</i>	T2	
IMPAVIDO	T5	
INTELENCE ORAL TABLET 25 MG	T4	
ISENTRESS HD	T5	
ISENTRESS ORAL POWDER IN PACKET	T5	
ISENTRESS ORAL TABLET	T5	
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	T5	
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	T3	
<i>isoniazid oral solution</i>	T2	
<i>isoniazid oral tablet</i>	T1	
<i>itraconazole oral capsule</i>	T2	PA
<i>itraconazole oral solution</i>	T4	PA
<i>ivermectin oral</i>	T2	PA
JULUCA	T5	
<i>ketoconazole oral</i>	T2	
KITABIS PAK	T4	PA
LAGEVRIO (EUA)	T3	QL (360 EA per 365 days)
<i>lamivudine</i>	T2	
<i>lamivudine-zidovudine</i>	T2	
<i>ledipasvir-sofosbuvir</i>	T5	PA; QL (28 EA per 28 days)
<i>levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml</i>	T2	
<i>levofloxacin oral solution</i>	T3	
<i>levofloxacin oral tablet</i>	T2	
<i>linezolid</i>	T4	
<i>linezolid in dextrose 5%</i>	T4	
LIVTENCITY	T5	PA; QL (372 EA per 31 days)
<i>lopinavir-ritonavir oral solution</i>	T4	
<i>lopinavir-ritonavir oral tablet 100-25 mg</i>	T3	
<i>lopinavir-ritonavir oral tablet 200-50 mg</i>	T4	
<i>maraviroc oral tablet 150 mg</i>	T5	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>maraviroc oral tablet 300 mg</i>	T4	
MAVYRET ORAL PELLETS IN PACKET	T5	PA; QL (140 EA per 28 days)
MAVYRET ORAL TABLET	T5	PA; QL (84 EA per 28 days)
<i>mefloquine</i>	T2	
<i>meropenem intravenous recon soln 1 gram, 500 mg</i>	T4	
<i>methenamine hippurate</i>	T2	
<i>metronidazole in nacl (iso-os)</i>	T2	
<i>metronidazole oral tablet</i>	T1	
<i>micafungin intravenous recon soln 100 mg</i>	T4	
<i>micafungin intravenous recon soln 50 mg</i>	T5	
<i>minocycline oral capsule</i>	T2	
<i>minocycline oral tablet</i>	T2	
<i>moxifloxacin oral</i>	T3	
<i>moxifloxacin-sod.chloride(iso)</i>	T4	
<i>nafcillin injection recon soln 1 gram</i>	T2	
<i>nafcillin injection recon soln 10 gram</i>	T5	
<i>nafcillin injection recon soln 2 gram</i>	T4	
<i>neomycin</i>	T2	
<i>nevirapine oral suspension</i>	T2	
<i>nevirapine oral tablet</i>	T2	
<i>nevirapine oral tablet extended release 24 hr 400 mg</i>	T4	
<i>nitazoxanide</i>	T4	
<i>nitrofurantoin macrocrystal oral capsule 100 mg</i>	T2	QL (90 EA per 365 days)
<i>nitrofurantoin macrocrystal oral capsule 25 mg</i>	T2	QL (360 EA per 365 days)
<i>nitrofurantoin macrocrystal oral capsule 50 mg</i>	T2	QL (180 EA per 365 days)
<i>nitrofurantoin monohyd/m-cryst</i>	T2	QL (90 EA per 365 days)
NORVIR ORAL POWDER IN PACKET	T4	
NUZYRA	T5	
<i>nystatin oral</i>	T2	
ODEFSEY	T5	QL (31 EA per 31 days)
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	T2	
<i>oseltamivir oral capsule 30 mg</i>	T2	QL (170 EA per 365 days)
<i>oseltamivir oral capsule 45 mg, 75 mg</i>	T2	QL (90 EA per 365 days)
<i>oseltamivir oral suspension for reconstitution</i>	T3	QL (1080 ML per 365 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>oxacillin in dextrose(iso-osm) intravenous piggyback 1 gram/50 ml</i>	T2	
<i>oxacillin injection recon soln 1 gram, 2 gram</i>	T2	
<i>oxacillin injection recon soln 10 gram</i>	T4	
PAXLOVID ORAL TABLETS,DOSE PACK 150-100 MG	T3	QL (180 EA per 365 days)
PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG	T3	QL (270 EA per 365 days)
<i>penicillin g pot in dextrose intravenous piggyback 2 million unit/50 ml, 3 million unit/50 ml</i>	T4	
<i>penicillin g potassium injection recon soln 20 million unit</i>	T2	
<i>penicillin g sodium</i>	T5	
<i>penicillin v potassium</i>	T1	
<i>pentamidine inhalation</i>	T4	PA-BvD
<i>pentamidine injection</i>	T4	
PIFELTRO	T5	QL (62 EA per 31 days)
<i>piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram</i>	T4	
<i>polymyxin b sulfate</i>	T2	
<i>posaconazole oral tablet,delayed release (dr/ec)</i>	T5	PA
<i>praziquantel</i>	T4	
PREVYMIS ORAL	T5	QL (31 EA per 31 days)
PREZCOBIX	T5	
PREZISTA ORAL SUSPENSION	T5	
PREZISTA ORAL TABLET 150 MG, 75 MG	T5	
PRIFTIN	T4	
<i>primaquine</i>	T3	
<i>pyrazinamide</i>	T4	
<i>pyrimethamine</i>	T5	PA
<i>quinine sulfate</i>	T3	PA; QL (42 EA per 28 days)
RELENZA DISKHALER	T3	
REYATAZ ORAL POWDER IN PACKET	T5	
<i>ribavirin oral capsule</i>	T2	
<i>ribavirin oral tablet 200 mg</i>	T2	
<i>rifabutin</i>	T4	
<i>rifampin intravenous</i>	T5	
<i>rifampin oral</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>rimantadine</i>	T2	
<i>ritonavir</i>	T3	
RUKOBIA	T5	QL (62 EA per 31 days)
SELZENTRY ORAL SOLUTION	T5	
SELZENTRY ORAL TABLET 25 MG	T4	
SELZENTRY ORAL TABLET 75 MG	T5	
SIRTURO	T5	PA
SIVEXTRO INTRAVENOUS	T5	
<i>sofosbuvir-velpatasvir</i>	T5	PA; QL (28 EA per 28 days)
<i>streptomycin</i>	T5	
STRIBILD	T5	
<i>sulfadiazine</i>	T2	
<i>sulfamethoxazole-trimethoprim oral</i>	T1	
SUNLENCA ORAL	T5	
SYMTUZA	T5	QL (31 EA per 31 days)
TEFLARO INTRAVENOUS RECON SOLN 400 MG	T4	
TEFLARO INTRAVENOUS RECON SOLN 600 MG	T5	
<i>tenofovir disoproxil fumarate</i>	T3	
<i>terbinafine hcl oral</i>	T1	QL (90 EA per 180 days)
<i>tetracycline oral capsule</i>	T2	
<i>tigecycline</i>	T5	
TIVICAY ORAL TABLET 10 MG	T4	
TIVICAY ORAL TABLET 25 MG, 50 MG	T5	
TIVICAY PD	T5	
TOBI PODHALER	T5	PA; QL (224 EA per 56 days)
<i>tobramycin in 0.225 % nacl</i>	T5	PA
<i>tobramycin inhalation</i>	T5	PA
<i>tobramycin sulfate injection solution</i>	T1	
TOLSURA	T5	PA; QL (130 EA per 31 days)
TRECTOR	T4	
<i>trimethoprim</i>	T2	
TRIUMEQ	T5	
TRIUMEQ PD	T5	QL (186 EA per 31 days)
TRIZIVIR	T5	
TYBOST	T3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>valacyclovir</i>	T2	
<i>valganciclovir oral recon soln</i>	T5	
<i>valganciclovir oral tablet</i>	T3	
<i>vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg, 750 mg</i>	T4	
<i>vancomycin oral capsule 125 mg</i>	T4	PA; QL (124 EA per 31 days)
<i>vancomycin oral capsule 250 mg</i>	T4	PA; QL (248 EA per 31 days)
<i>vancomycin oral recon soln</i>	T4	
VEMLIDY	T5	QL (31 EA per 31 days)
VIRACEPT ORAL TABLET	T5	
VIREAD ORAL POWDER	T5	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	T5	
VIVJOA	T4	PA; QL (18 EA per 84 days)
<i>voriconazole intravenous</i>	T5	PA
<i>voriconazole oral suspension for reconstitution</i>	T5	
<i>voriconazole oral tablet</i>	T4	
VOSEVI	T5	PA; QL (28 EA per 28 days)
XIFAXAN ORAL TABLET 200 MG	T4	QL (27 EA per 365 days)
XIFAXAN ORAL TABLET 550 MG	T5	PA; QL (62 EA per 31 days)
XOFLUZA ORAL TABLET 40 MG, 80 MG	T3	QL (9 EA per 365 days)
ZEMDRI	T5	
ZEPATIER	T5	PA; QL (28 EA per 28 days)
<i>zidovudine</i>	T2	
ZOSYN IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 2.25 GRAM/50 ML	T4	
Antineoplastic / Immunosuppressant Drugs		
<i>abiraterone oral tablet 250 mg</i>	T5	PA-NS; QL (124 EA per 31 days)
<i>abiraterone oral tablet 500 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
AKEEGA	T5	PA-NS; QL (62 EA per 31 days)
ALECENSA	T5	PA-NS; QL (248 EA per 31 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	T5	PA-NS; QL (31 EA per 31 days)
ALUNBRIG ORAL TABLET 30 MG	T5	PA-NS; QL (186 EA per 31 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	T5	PA-NS; QL (60 EA per 365 days)
<i>anastrozole</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR 0.5 MG, 1 MG	T3	PA-BvD
ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR 5 MG	T5	PA-BvD
AUGTYRO	T5	PA-NS; QL (248 EA per 31 days)
AYVAKIT	T5	PA-NS; QL (31 EA per 31 days)
<i>azathioprine oral tablet 100 mg, 75 mg</i>	T4	PA-BvD
<i>azathioprine oral tablet 50 mg</i>	T2	PA-BvD
BALVERSA	T5	PA-NS
<i>bexarotene oral</i>	T5	PA-NS
<i>bexarotene topical</i>	T5	PA-NS; QL (60 GM per 28 days)
<i>bicalutamide</i>	T2	
BOSULIF ORAL CAPSULE 100 MG	T5	PA-NS; QL (186 EA per 31 days)
BOSULIF ORAL CAPSULE 50 MG	T5	PA-NS; QL (341 EA per 31 days)
BOSULIF ORAL TABLET 100 MG	T5	PA-NS; QL (93 EA per 31 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	T5	PA-NS; QL (31 EA per 31 days)
BRAFTOVI	T5	PA-NS; QL (186 EA per 31 days)
BRUKINSA	T5	PA-NS; QL (124 EA per 31 days)
CABOMETYX	T5	PA-NS; QL (31 EA per 31 days)
CALQUENCE	T5	PA-NS; QL (62 EA per 31 days)
CALQUENCE (ACALABRUTINIB MAL)	T5	PA-NS; QL (62 EA per 31 days)
CAPRELSA ORAL TABLET 100 MG	T5	PA-NS; QL (62 EA per 31 days)
CAPRELSA ORAL TABLET 300 MG	T5	PA-NS; QL (31 EA per 31 days)
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)	T5	PA-NS; QL (56 EA per 28 days)
COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)	T5	PA-NS; QL (112 EA per 28 days)
COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)	T5	PA-NS; QL (84 EA per 28 days)
COPIKTRA	T5	PA-NS; QL (62 EA per 31 days)
COTELLIC	T5	PA-NS; LA; QL (63 EA per 28 days)
<i>cyclophosphamide oral</i>	T3	PA-BvD
<i>cyclosporine modified oral capsule</i>	T2	PA-BvD
<i>cyclosporine modified oral solution</i>	T4	PA-BvD
<i>cyclosporine oral capsule</i>	T2	PA-BvD
DAURISMO ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
DAURISMO ORAL TABLET 25 MG	T5	PA-NS; QL (62 EA per 31 days)
DROXIA	T4	
ELIGARD	T4	
ELIGARD (3 MONTH)	T4	
ELIGARD (4 MONTH)	T4	
ELIGARD (6 MONTH)	T4	
ENSPRYNG	T5	PA; QL (1 ML per 28 days)
ENVARBUS XR	T4	PA-BvD
ERIVEDGE	T5	PA-NS; QL (31 EA per 31 days)
ERLEADA ORAL TABLET 240 MG	T5	PA-NS; QL (31 EA per 31 days)
ERLEADA ORAL TABLET 60 MG	T5	PA-NS; QL (93 EA per 31 days)
<i>erlotinib</i>	T5	PA-NS; QL (31 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 7.5 mg</i>	T5	PA-NS; QL (31 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet 5 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet for suspension 2 mg, 5 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
<i>everolimus (antineoplastic) oral tablet for suspension 3 mg</i>	T5	PA-NS; QL (93 EA per 31 days)
<i>everolimus (immunosuppressive)</i>	T5	PA-BvD
<i>exemestane</i>	T2	
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	T5	
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	T4	
FOTIVDA	T5	PA-NS; QL (21 EA per 28 days)
FRUZAQLA ORAL CAPSULE 1 MG	T5	PA-NS; QL (84 EA per 28 days)
FRUZAQLA ORAL CAPSULE 5 MG	T5	PA-NS; QL (21 EA per 28 days)
GAVRETO	T5	PA-NS; QL (124 EA per 31 days)
<i>gefitinib</i>	T5	PA-NS; QL (31 EA per 31 days)
GENGRAF	T2	PA-BvD
GILOTRIF	T5	PA-NS; QL (31 EA per 31 days)
GLEOSTINE ORAL CAPSULE 10 MG, 40 MG	T4	PA-NS
GLEOSTINE ORAL CAPSULE 100 MG	T5	PA-NS
<i>hydroxyurea</i>	T2	
IBRANCE	T5	PA-NS; QL (21 EA per 28 days)
ICLUSIG	T5	PA-NS; QL (31 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
IDHIFA ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
IDHIFA ORAL TABLET 50 MG	T5	PA-NS; QL (62 EA per 31 days)
<i>imatinib oral tablet 100 mg</i>	T5	PA-NS; QL (93 EA per 31 days)
<i>imatinib oral tablet 400 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
IMBRUVICA ORAL CAPSULE 140 MG	T5	PA-NS; QL (124 EA per 31 days)
IMBRUVICA ORAL CAPSULE 70 MG	T5	PA-NS; QL (31 EA per 31 days)
IMBRUVICA ORAL SUSPENSION	T5	PA-NS; QL (216 ML per 25 days)
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG	T5	PA-NS; QL (31 EA per 31 days)
INLYTA	T5	PA-NS; QL (124 EA per 31 days)
INQOVI	T5	PA-NS; QL (5 EA per 28 days)
INREBIC	T5	PA-NS; QL (124 EA per 31 days)
IWILFIN	T5	PA-NS; QL (248 EA per 31 days)
JAKAFI	T5	PA-NS; QL (62 EA per 31 days)
JAYPIRCA ORAL TABLET 100 MG	T5	PA-NS; QL (62 EA per 31 days)
JAYPIRCA ORAL TABLET 50 MG	T5	PA-NS; QL (31 EA per 31 days)
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG	T5	PA-NS; QL (49 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG	T5	PA-NS; QL (70 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG	T5	PA-NS; QL (91 EA per 28 days)
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	T5	PA-NS; QL (21 EA per 28 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	T5	PA-NS; QL (42 EA per 28 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	T5	PA-NS; QL (63 EA per 28 days)
KLISYRI	T5	PA
KOSELUGO ORAL CAPSULE 10 MG	T5	PA; QL (279 EA per 31 days)
KOSELUGO ORAL CAPSULE 25 MG	T5	PA; QL (124 EA per 31 days)
KRAZATI	T5	PA-NS; QL (186 EA per 31 days)
<i>lapatinib</i>	T5	PA-NS; QL (186 EA per 31 days)
<i>lenalidomide</i>	T5	PA-NS; QL (21 EA per 28 days)
LENVIMA	T5	PA-NS
<i>letrozole</i>	T2	
<i>leucovorin calcium oral</i>	T2	
LEUKERAN	T5	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>leuprolide (3 month)</i>	T4	ST
<i>leuprolide subcutaneous kit</i>	T2	
LONSURF	T5	PA-NS
LORBRENA ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
LORBRENA ORAL TABLET 25 MG	T5	PA-NS; QL (93 EA per 31 days)
LUMAKRAS ORAL TABLET 120 MG	T5	PA-NS; QL (124 EA per 31 days)
LUMAKRAS ORAL TABLET 320 MG	T5	PA-NS; QL (93 EA per 31 days)
LUPRON DEPOT	T5	ST
LUPRON DEPOT (3 MONTH)	T5	ST
LUPRON DEPOT (4 MONTH)	T5	ST
LUPRON DEPOT (6 MONTH)	T5	ST
LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG	T5	PA
LUPRON DEPOT-PED INTRAMUSCULAR KIT 7.5 MG (PED)	T5	PA
LUPRON DEPOT-PED INTRAMUSCULAR SYRINGE KIT	T5	PA
LYNPARZA	T5	PA-NS; QL (124 EA per 31 days)
LYSODREN	T5	
LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3)	T5	PA-NS; QL (93 EA per 31 days)
LYTGOBI ORAL TABLET 16 MG/DAY (4 MG X 4)	T5	PA-NS; QL (124 EA per 31 days)
LYTGOBI ORAL TABLET 20 MG/DAY (4 MG X 5)	T5	PA-NS; QL (155 EA per 31 days)
MATULANE	T5	
<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml)</i>	T2	PA
<i>megestrol oral suspension 625 mg/5 ml (125 mg/ml)</i>	T4	PA
<i>megestrol oral tablet</i>	T2	PA-NS
MEKINIST ORAL RECON SOLN	T5	PA-NS; QL (1260 ML per 31 days)
MEKINIST ORAL TABLET 0.5 MG	T5	PA-NS; QL (93 EA per 31 days)
MEKINIST ORAL TABLET 2 MG	T5	PA-NS; QL (31 EA per 31 days)
MEKTOVI	T5	PA-NS; QL (186 EA per 31 days)
<i>mercaptopurine</i>	T2	
MESNEX ORAL	T3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>methotrexate sodium (pf) injection solution</i>	T2	PA-BvD
<i>methotrexate sodium injection</i>	T2	PA-BvD
<i>methotrexate sodium oral</i>	T1	PA-BvD
MYCAPSSA	T5	PA; QL (124 EA per 31 days)
<i>mycophenolate mofetil oral capsule</i>	T2	PA-BvD
<i>mycophenolate mofetil oral suspension for reconstitution</i>	T5	PA-BvD
<i>mycophenolate mofetil oral tablet</i>	T2	PA-BvD
<i>mycophenolate sodium</i>	T2	PA-BvD
NEORAL ORAL CAPSULE	T3	PA-BvD
NERLYNX	T5	PA-NS; QL (186 EA per 31 days)
<i>nilutamide</i>	T5	
NINLARO	T5	PA-NS; QL (3 EA per 28 days)
NUBEQA	T5	PA-NS; QL (124 EA per 31 days)
<i>octreotide acetate injection solution 1,000 mcg/ml</i>	T3	PA
<i>octreotide acetate injection solution 100 mcg/ml, 50 mcg/ml</i>	T2	PA
<i>octreotide acetate injection solution 200 mcg/ml</i>	T4	PA
<i>octreotide acetate injection solution 500 mcg/ml</i>	T5	PA
ODOMZO	T5	PA-NS; LA; QL (31 EA per 31 days)
OGSIVEO ORAL TABLET 100 MG, 150 MG	T5	PA-NS; QL (62 EA per 31 days)
OGSIVEO ORAL TABLET 50 MG	T5	PA-NS; QL (186 EA per 31 days)
OJEMDA ORAL SUSPENSION FOR RECONSTITUTION	T5	PA-NS; QL (96 ML per 28 days)
OJEMDA ORAL TABLET 500 MG/WEEK (100 MG X 5)	T5	PA-NS; QL (20 EA per 28 days)
OJJAARA	T5	PA-NS; QL (31 EA per 31 days)
ONUREG	T5	PA-NS; QL (14 EA per 28 days)
ORGOVYX	T5	PA-NS; QL (31 EA per 31 days)
ORSERDU ORAL TABLET 345 MG	T5	PA-NS; QL (31 EA per 31 days)
ORSERDU ORAL TABLET 86 MG	T5	PA-NS; QL (93 EA per 31 days)
<i>pazopanib</i>	T5	PA-NS; QL (124 EA per 31 days)
PEMAZYRE	T5	PA-NS; QL (14 EA per 21 days)
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1)	T5	PA-NS; QL (28 EA per 28 days)
PIQRAY ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)	T5	PA-NS; QL (56 EA per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
POMALYST	T5	PA-NS; QL (21 EA per 28 days)
PROGRAF ORAL GRANULES IN PACKET	T4	PA-BvD
PURIXAN	T5	
QINLOCK	T5	PA-NS; QL (93 EA per 31 days)
RETEVMO ORAL CAPSULE 40 MG	T5	PA-NS; QL (186 EA per 31 days)
RETEVMO ORAL CAPSULE 80 MG	T5	PA-NS; QL (124 EA per 31 days)
REZLIDHIA	T5	PA-NS; QL (62 EA per 31 days)
ROZLYTREK ORAL CAPSULE 100 MG	T5	PA-NS; QL (155 EA per 31 days)
ROZLYTREK ORAL CAPSULE 200 MG	T5	PA-NS; QL (93 EA per 31 days)
ROZLYTREK ORAL PELLETS IN PACKET	T5	PA-NS; QL (372 EA per 31 days)
RUBRACA	T5	PA-NS; QL (124 EA per 31 days)
RYDAPT	T5	PA-NS; QL (248 EA per 31 days)
SANDIMMUNE ORAL SOLUTION	T3	PA-BvD
SCEMBLIX ORAL TABLET 100 MG	T5	PA-NS; QL (124 EA per 31 days)
SCEMBLIX ORAL TABLET 20 MG	T5	PA-NS; QL (62 EA per 31 days)
SCEMBLIX ORAL TABLET 40 MG	T5	PA-NS; QL (310 EA per 31 days)
SIGNIFOR	T5	PA
<i>sirolimus oral solution</i>	T5	PA-BvD
<i>sirolimus oral tablet</i>	T2	PA-BvD
SOLTAMOX	T5	
<i>sorafenib</i>	T5	PA-NS; QL (124 EA per 31 days)
SPRYCEL	T5	PA-NS; QL (31 EA per 31 days)
STIVARGA	T5	PA-NS; QL (84 EA per 28 days)
<i>sunitinib malate</i>	T5	PA-NS; QL (31 EA per 31 days)
TABLOID	T3	
TABRECTA	T5	PA-NS; QL (124 EA per 31 days)
<i>tacrolimus oral capsule</i>	T2	PA-BvD
TAFINLAR ORAL CAPSULE	T5	PA-NS; QL (124 EA per 31 days)
TAFINLAR ORAL TABLET FOR SUSPENSION	T5	PA-NS; QL (930 EA per 31 days)
TAGRISSE	T5	PA-NS; LA; QL (31 EA per 31 days)
TALZENNA	T5	PA-NS; QL (31 EA per 31 days)
<i>tamoxifen</i>	T1	
TASIGNA	T5	PA-NS; QL (124 EA per 31 days)
TAZVERIK	T5	PA-NS; QL (248 EA per 31 days)
TEPMETKO	T5	PA-NS; QL (62 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
THALOMID ORAL CAPSULE 100 MG, 150 MG, 50 MG	T5	PA-NS; QL (28 EA per 28 days)
THALOMID ORAL CAPSULE 200 MG	T5	PA-NS; QL (56 EA per 28 days)
TIBSOVO	T5	PA-NS; QL (62 EA per 31 days)
<i>toremifene</i>	T4	
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	T4	ST
<i>tretinoin (antineoplastic)</i>	T5	
TREXALL	T3	PA-BvD
TRUQAP	T5	PA-NS; QL (64 EA per 28 days)
TUKYSA ORAL TABLET 150 MG	T5	PA-NS; QL (124 EA per 31 days)
TUKYSA ORAL TABLET 50 MG	T5	PA-NS; QL (248 EA per 31 days)
TURALIO ORAL CAPSULE 125 MG	T5	PA-NS; QL (124 EA per 31 days)
VANFLYTA	T5	PA-NS; QL (62 EA per 31 days)
VENCLEXTA ORAL TABLET 10 MG	T4	PA-NS; QL (62 EA per 31 days)
VENCLEXTA ORAL TABLET 100 MG	T5	PA-NS; QL (186 EA per 31 days)
VENCLEXTA ORAL TABLET 50 MG	T5	PA-NS; QL (31 EA per 31 days)
VENCLEXTA STARTING PACK	T5	PA-NS; QL (84 EA per 365 days)
VERZENIO	T5	PA-NS; QL (62 EA per 31 days)
VIJOICE ORAL GRANULES IN PACKET	T5	PA-NS; QL (31 EA per 31 days)
VIJOICE ORAL TABLET 125 MG, 50 MG	T5	PA-NS; QL (28 EA per 28 days)
VIJOICE ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1)	T5	PA-NS; QL (56 EA per 28 days)
VITRAKVI ORAL CAPSULE 100 MG	T5	PA-NS; QL (62 EA per 31 days)
VITRAKVI ORAL CAPSULE 25 MG	T5	PA-NS; QL (186 EA per 31 days)
VITRAKVI ORAL SOLUTION	T5	PA-NS; QL (310 ML per 31 days)
VIZIMPRO	T5	PA-NS; QL (31 EA per 31 days)
VONJO	T5	PA-NS; QL (124 EA per 31 days)
WELIREG	T5	PA-NS; QL (93 EA per 31 days)
XALKORI ORAL CAPSULE	T5	PA-NS; QL (124 EA per 31 days)
XALKORI ORAL PELLETT 150 MG	T5	PA-NS; QL (186 EA per 31 days)
XALKORI ORAL PELLETT 20 MG, 50 MG	T5	PA-NS; QL (124 EA per 31 days)
XATMEP	T4	PA-BvD
XERMELO	T5	PA; QL (93 EA per 31 days)
XGEVA	T5	PA-NS
XOSPATA	T5	PA-NS; QL (124 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40MG TWICE WEEK (40 MG X 2), 80 MG/WEEK (40 MG X 2)	T5	PA-NS; QL (8 EA per 28 days)
XPOVIO ORAL TABLET 40 MG/WEEK (40 MG X 1), 60 MG/WEEK (60 MG X 1)	T5	PA-NS; QL (4 EA per 28 days)
XPOVIO ORAL TABLET 60MG TWICE WEEK (120 MG/WEEK)	T5	PA-NS; QL (24 EA per 28 days)
XPOVIO ORAL TABLET 80MG TWICE WEEK (160 MG/WEEK)	T5	PA-NS; QL (32 EA per 28 days)
XTANDI ORAL CAPSULE	T5	PA-NS; QL (124 EA per 31 days)
XTANDI ORAL TABLET 40 MG	T5	PA-NS; QL (124 EA per 31 days)
XTANDI ORAL TABLET 80 MG	T5	PA-NS; QL (62 EA per 31 days)
YONSA	T5	PA-NS; QL (124 EA per 31 days)
ZEJULA ORAL TABLET	T5	PA-NS; QL (31 EA per 31 days)
ZELBORAF	T5	PA-NS; QL (248 EA per 31 days)
ZOLINZA	T5	PA-NS
ZYDELIG	T5	PA-NS; QL (62 EA per 31 days)
ZYKADIA	T5	PA-NS; QL (93 EA per 31 days)
Autonomic / Cns Drugs, Neurology / Psych		
ABILIFY MAINTENA	T5	QL (1 EA per 28 days)
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	T2	PA; QL (5167 ML per 31 days)
<i>acetaminophen-codeine oral tablet</i>	T2	PA; QL (403 EA per 31 days)
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 140 MG/ML	T3	PA; QL (1 ML per 28 days)
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 70 MG/ML	T3	PA; QL (2 ML per 28 days)
AJOVY AUTOINJECTOR	T3	PA; QL (1.5 ML per 28 days)
AJOVY SYRINGE	T3	PA; QL (1.5 ML per 28 days)
<i>almotriptan malate oral tablet 12.5 mg</i>	T2	QL (8 EA per 28 days)
<i>almotriptan malate oral tablet 6.25 mg</i>	T2	QL (16 EA per 28 days)
ALPRAZOLAM INTENSOL	T4	PA
<i>alprazolam oral tablet 0.25 mg, 0.5 mg</i>	T2	PA; QL (93 EA per 31 days)
<i>alprazolam oral tablet 1 mg, 2 mg</i>	T2	PA; QL (155 EA per 31 days)
<i>alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg</i>	T2	PA; QL (31 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>alprazolam oral tablet extended release 24 hr 2 mg</i>	T2	PA; QL (155 EA per 31 days)
<i>alprazolam oral tablet extended release 24 hr 3 mg</i>	T2	PA; QL (93 EA per 31 days)
<i>amitriptyline</i>	T2	PA-NS
<i>amitriptyline-chlordiazepoxide</i>	T4	PA-NS
<i>amoxapine</i>	T1	
<i>apomorphine</i>	T5	PA; QL (60 ML per 30 days)
APTIOM ORAL TABLET 200 MG	T5	QL (186 EA per 31 days)
APTIOM ORAL TABLET 400 MG	T5	QL (93 EA per 31 days)
APTIOM ORAL TABLET 600 MG, 800 MG	T5	QL (62 EA per 31 days)
<i>aripiprazole oral solution</i>	T4	PA-NS
<i>aripiprazole oral tablet</i>	T3	PA-NS
<i>aripiprazole oral tablet, disintegrating</i>	T4	PA-NS
ARISTADA INITIO	T5	QL (4.8 ML per 365 days)
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 1,064 MG/3.9 ML	T5	QL (3.9 ML per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 441 MG/1.6 ML	T5	QL (1.6 ML per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 662 MG/2.4 ML	T5	QL (2.4 ML per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 882 MG/3.2 ML	T5	QL (3.2 ML per 28 days)
<i>armodafinil</i>	T4	PA; QL (31 EA per 31 days)
<i>asenapine maleate</i>	T4	PA-NS; QL (62 EA per 31 days)
<i>atomoxetine oral capsule 10 mg, 25 mg, 40 mg</i>	T4	QL (62 EA per 31 days)
<i>atomoxetine oral capsule 100 mg, 60 mg, 80 mg</i>	T4	QL (31 EA per 31 days)
<i>atomoxetine oral capsule 18 mg</i>	T4	QL (124 EA per 31 days)
AUVELITY	T4	PA-NS; QL (62 EA per 31 days)
<i>baclofen oral tablet 10 mg</i>	T1	
<i>baclofen oral tablet 20 mg</i>	T2	
BAFIERTAM	T5	PA; QL (124 EA per 31 days)
<i>benztropine oral</i>	T2	PA
BRIVIACT ORAL SOLUTION	T5	QL (620 ML per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 75 MG	T5	QL (62 EA per 31 days)
BRIVIACT ORAL TABLET 50 MG	T4	QL (62 EA per 31 days)
<i>bromocriptine</i>	T4	
<i>buprenorphine</i>	T4	PA; QL (4 EA per 28 days)
<i>buprenorphine hcl sublingual tablet 2 mg</i>	T3	QL (93 EA per 31 days)
<i>buprenorphine hcl sublingual tablet 8 mg</i>	T3	QL (62 EA per 31 days)
<i>buprenorphine-naloxone sublingual film 12-3 mg, 4-1 mg, 8-2 mg</i>	T2	QL (62 EA per 31 days)
<i>buprenorphine-naloxone sublingual film 2-0.5 mg</i>	T2	QL (93 EA per 31 days)
<i>buprenorphine-naloxone sublingual tablet</i>	T4	QL (93 EA per 31 days)
<i>bupropion hcl oral tablet</i>	T2	
<i>bupropion hcl oral tablet extended release 24 hr 150 mg</i>	T2	QL (93 EA per 31 days)
<i>bupropion hcl oral tablet extended release 24 hr 300 mg</i>	T2	QL (31 EA per 31 days)
<i>bupropion hcl oral tablet extended release 24 hr 450 mg</i>	T4	QL (31 EA per 31 days)
<i>bupropion hcl oral tablet sustained-release 12 hr</i>	T2	QL (62 EA per 31 days)
<i>buspirone</i>	T2	
<i>butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg</i>	T4	PA; QL (403 EA per 31 days)
<i>butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg</i>	T4	PA; QL (372 EA per 31 days)
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	T2	QL (372 EA per 31 days)
<i>butalbital-acetaminophen-caff oral capsule 50-300-40 mg</i>	T4	QL (403 EA per 31 days)
<i>butalbital-acetaminophen-caff oral capsule 50-325-40 mg</i>	T4	QL (372 EA per 31 days)
<i>butalbital-acetaminophen-caff oral tablet</i>	T4	QL (372 EA per 31 days)
<i>butalbital-aspirin-caffeine oral capsule</i>	T2	
<i>butorphanol nasal</i>	T2	QL (5 ML per 28 days)
CAPLYTA	T5	PA-NS; QL (31 EA per 31 days)
<i>carbamazepine oral capsule, er multiphase 12 hr</i>	T2	
<i>carbamazepine oral suspension 100 mg/5 ml</i>	T1	
<i>carbamazepine oral tablet</i>	T1	
<i>carbamazepine oral tablet extended release 12 hr</i>	T2	
<i>carbamazepine oral tablet, chewable</i>	T1	
<i>carbidopa-levodopa</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>carbidopa-levodopa-entacapone</i>	T2	
<i>celecoxib</i>	T2	ST; QL (62 EA per 31 days)
<i>chlorpromazine oral</i>	T4	
<i>citalopram oral solution</i>	T3	
<i>citalopram oral tablet</i>	T1	
<i>clobazam oral suspension</i>	T4	PA-NS; QL (496 ML per 31 days)
<i>clobazam oral tablet</i>	T3	PA-NS; QL (62 EA per 31 days)
<i>clomipramine</i>	T4	PA-NS
<i>clonazepam oral tablet 0.5 mg</i>	T2	PA-NS; QL (93 EA per 31 days)
<i>clonazepam oral tablet 1 mg</i>	T2	PA-NS; QL (124 EA per 31 days)
<i>clonazepam oral tablet 2 mg</i>	T2	PA-NS; QL (310 EA per 31 days)
<i>clonazepam oral tablet, disintegrating 0.125 mg, 0.25 mg, 0.5 mg</i>	T2	PA-NS; QL (93 EA per 31 days)
<i>clonazepam oral tablet, disintegrating 1 mg</i>	T2	PA-NS; QL (124 EA per 31 days)
<i>clonazepam oral tablet, disintegrating 2 mg</i>	T2	PA-NS; QL (310 EA per 31 days)
<i>clonidine hcl oral tablet extended release 12 hr</i>	T4	PA
<i>clorazepate dipotassium oral tablet 15 mg</i>	T2	PA-NS; QL (186 EA per 31 days)
<i>clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg</i>	T2	PA-NS; QL (93 EA per 31 days)
<i>clozapine oral tablet 100 mg, 25 mg</i>	T2	QL (279 EA per 31 days)
<i>clozapine oral tablet 200 mg</i>	T2	QL (124 EA per 31 days)
<i>clozapine oral tablet 50 mg</i>	T2	QL (93 EA per 31 days)
<i>clozapine oral tablet, disintegrating 100 mg, 25 mg</i>	T2	QL (279 EA per 31 days)
<i>clozapine oral tablet, disintegrating 12.5 mg</i>	T2	QL (93 EA per 31 days)
<i>clozapine oral tablet, disintegrating 150 mg</i>	T4	QL (186 EA per 31 days)
<i>clozapine oral tablet, disintegrating 200 mg</i>	T4	QL (124 EA per 31 days)
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML	T5	PA; QL (31 ML per 31 days)
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	T5	PA; QL (12 ML per 28 days)
<i>cyclobenzaprine oral tablet 10 mg, 7.5 mg</i>	T2	QL (93 EA per 31 days)
<i>cyclobenzaprine oral tablet 5 mg</i>	T2	QL (155 EA per 31 days)
<i>dalfampridine</i>	T5	PA; QL (62 EA per 31 days)
<i>dantrolene oral</i>	T4	
DAYBUE	T5	PA; QL (3600 ML per 30 days)
<i>desipramine oral tablet 10 mg, 25 mg, 50 mg</i>	T3	
<i>desipramine oral tablet 100 mg, 150 mg, 75 mg</i>	T4	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>desvenlafaxine oral tablet extended release 24 hr 100 mg</i>	T4	QL (124 EA per 31 days)
<i>desvenlafaxine oral tablet extended release 24 hr 50 mg</i>	T4	QL (31 EA per 31 days)
<i>desvenlafaxine succinate</i>	T3	QL (31 EA per 31 days)
<i>dexmethylphenidate oral capsule,er biphasic 50-50</i>	T2	QL (31 EA per 31 days)
<i>dexmethylphenidate oral tablet 10 mg</i>	T2	QL (62 EA per 31 days)
<i>dexmethylphenidate oral tablet 2.5 mg, 5 mg</i>	T2	QL (93 EA per 31 days)
<i>dextroamphetamine sulfate oral solution</i>	T3	
<i>dextroamphetamine sulfate oral tablet 10 mg</i>	T4	QL (186 EA per 31 days)
<i>dextroamphetamine sulfate oral tablet 15 mg, 20 mg, 30 mg</i>	T4	QL (62 EA per 31 days)
<i>dextroamphetamine sulfate oral tablet 5 mg</i>	T4	QL (341 EA per 31 days)
<i>dextroamphetamine-amphetamine oral capsule,extended release 24hr</i>	T3	QL (31 EA per 31 days)
<i>dextroamphetamine-amphetamine oral tablet 10 mg, 30 mg</i>	T2	QL (62 EA per 31 days)
<i>dextroamphetamine-amphetamine oral tablet 12.5 mg, 15 mg, 5 mg, 7.5 mg</i>	T1	QL (62 EA per 31 days)
<i>dextroamphetamine-amphetamine oral tablet 20 mg</i>	T2	QL (93 EA per 31 days)
DIACOMIT ORAL CAPSULE 250 MG	T5	PA-NS; QL (341 EA per 31 days)
DIACOMIT ORAL CAPSULE 500 MG	T5	PA-NS; QL (186 EA per 31 days)
DIACOMIT ORAL POWDER IN PACKET 250 MG	T5	PA-NS; QL (341 EA per 31 days)
DIACOMIT ORAL POWDER IN PACKET 500 MG	T5	PA-NS; QL (186 EA per 31 days)
DIAZEPAM INTENSOL	T2	PA-NS; QL (248 ML per 31 days)
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	T2	PA-NS; QL (1500 ML per 31 days)
<i>diazepam oral tablet</i>	T2	PA-NS; QL (124 EA per 31 days)
<i>diazepam rectal</i>	T4	
<i>diclofenac epolamine</i>	T4	PA; QL (62 EA per 31 days)
<i>diclofenac potassium oral powder in packet</i>	T4	
<i>diclofenac potassium oral tablet 50 mg</i>	T1	
<i>diclofenac sodium oral</i>	T1	
<i>diclofenac sodium topical drops</i>	T2	QL (450 ML per 28 days)
<i>diclofenac-misoprostol</i>	T3	

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Drug Name	Drug Tier	Requirements/Limits
<i>diflunisal</i>	T2	
<i>dihydroergotamine nasal</i>	T4	PA; QL (8 ML per 31 days)
DILANTIN	T4	
DILANTIN EXTENDED	T4	
DILANTIN INFATABS	T4	
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg (14)- 240 mg (46)</i>	T5	PA; QL (120 EA per 365 days)
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg, 240 mg</i>	T5	PA; QL (62 EA per 31 days)
<i>divalproex oral capsule, delayed rel sprinkle</i>	T2	
<i>divalproex oral tablet extended release 24 hr 250 mg</i>	T2	
<i>divalproex oral tablet extended release 24 hr 500 mg</i>	T3	
<i>divalproex oral tablet, delayed release (dr/ec)</i>	T2	
<i>donepezil oral tablet 10 mg, 5 mg</i>	T1	
<i>donepezil oral tablet 23 mg</i>	T3	QL (31 EA per 31 days)
<i>donepezil oral tablet, disintegrating</i>	T2	
<i>doxepin oral capsule</i>	T2	PA-NS
<i>doxepin oral concentrate</i>	T2	PA-NS
<i>doxepin oral tablet</i>	T2	PA
<i>duloxetine oral capsule, delayed release(dr/ec) 20 mg, 60 mg</i>	T2	QL (62 EA per 31 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 30 mg</i>	T2	QL (31 EA per 31 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 40 mg</i>	T3	QL (31 EA per 31 days)
DUOPA	T5	PA-BvD
<i>eletriptan oral tablet 20 mg</i>	T4	QL (12 EA per 28 days)
<i>eletriptan oral tablet 40 mg</i>	T4	QL (6 EA per 28 days)
EMGALITY PEN	T3	PA; QL (1 ML per 28 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML	T3	PA; QL (1 ML per 28 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3)	T5	PA; QL (3 ML per 28 days)
EMSAM	T5	QL (30 EA per 30 days)
ENDOCET ORAL TABLET 10-325 MG, 2.5-325 MG	T3	PA; QL (372 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
ENDOCET ORAL TABLET 5-325 MG, 7.5-325 MG	T2	PA; QL (372 EA per 31 days)
<i>entacapone</i>	T2	
EPIDIOLEX	T5	PA-NS
EPITOL	T1	
EPRONTIA	T4	PA-NS; QL (496 ML per 31 days)
EQUETRO	T4	
<i>ergoloid</i>	T4	PA
<i>ergotamine-caffeine</i>	T3	PA
<i>escitalopram oxalate oral solution</i>	T4	QL (620 ML per 31 days)
<i>escitalopram oxalate oral tablet 10 mg</i>	T2	QL (45 EA per 30 days)
<i>escitalopram oxalate oral tablet 20 mg, 5 mg</i>	T2	QL (30 EA per 30 days)
<i>estazolam</i>	T2	PA
<i>eszopiclone</i>	T2	PA; QL (31 EA per 31 days)
<i>ethosuximide oral capsule</i>	T3	
<i>ethosuximide oral solution</i>	T2	
<i>etodolac oral capsule</i>	T3	
<i>etodolac oral tablet</i>	T2	
<i>etodolac oral tablet extended release 24 hr</i>	T3	
EVRYSDI	T5	PA; QL (240 ML per 31 days)
FANAPT ORAL TABLET 1 MG	T4	QL (62 EA per 31 days)
FANAPT ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	T5	QL (62 EA per 31 days)
FANAPT ORAL TABLETS,DOSE PACK	T4	QL (16 EA per 365 days)
<i>felbamate oral suspension</i>	T5	
<i>felbamate oral tablet</i>	T4	
<i>fenopropfen oral capsule 400 mg</i>	T4	
<i>fentanyl citrate buccal lozenge on a handle 1,200 mcg</i>	T5	PA; QL (40 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 1,600 mcg</i>	T5	PA; QL (30 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 200 mcg</i>	T5	PA; QL (124 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 400 mcg</i>	T5	PA; QL (119 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 600 mcg</i>	T5	PA; QL (79 EA per 31 days)
<i>fentanyl citrate buccal lozenge on a handle 800 mcg</i>	T5	PA; QL (59 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>fentanyl citrate buccal tablet, effervescent 100 mcg, 200 mcg</i>	T5	PA; QL (124 EA per 31 days)
<i>fentanyl citrate buccal tablet, effervescent 400 mcg</i>	T5	PA; QL (119 EA per 31 days)
<i>fentanyl citrate buccal tablet, effervescent 600 mcg</i>	T5	PA; QL (79 EA per 31 days)
<i>fentanyl citrate buccal tablet, effervescent 800 mcg</i>	T5	PA; QL (59 EA per 31 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr</i>	T4	PA; QL (10 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 12 mcg/hr</i>	T4	PA; QL (20 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 25 mcg/hr</i>	T2	PA; QL (20 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 50 mcg/hr</i>	T2	PA; QL (17 EA per 30 days)
<i>fentanyl transdermal patch 72 hour 75 mcg/hr</i>	T4	PA; QL (12 EA per 30 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 100 MCG, 200 MCG	T5	PA; QL (124 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 400 MCG	T5	PA; QL (119 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 600 MCG	T5	PA; QL (79 EA per 31 days)
FENTORA BUCCAL TABLET, EFFERVESCENT 800 MCG	T5	PA; QL (59 EA per 31 days)
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)	T4	PA-NS; QL (56 EA per 365 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 40 MG, 80 MG	T4	PA-NS; QL (31 EA per 31 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 20 MG	T4	PA-NS; QL (93 EA per 31 days)
<i>fingolimod</i>	T5	PA; QL (31 EA per 31 days)
FINTEPLA	T5	PA-NS; QL (360 ML per 30 days)
FIRDAPSE	T5	PA; QL (248 EA per 31 days)
FLECTOR	T4	PA; QL (62 EA per 31 days)
<i>fluoxetine (pmd)</i>	T1	
<i>fluoxetine oral capsule</i>	T1	
<i>fluoxetine oral solution</i>	T1	
<i>fluoxetine oral tablet 10 mg, 20 mg</i>	T1	
<i>fluphenazine decanoate</i>	T2	
<i>fluphenazine hcl injection</i>	T2	
<i>fluphenazine hcl oral concentrate</i>	T2	
<i>fluphenazine hcl oral tablet</i>	T1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>flurazepam</i>	T2	PA
<i>flurbiprofen oral tablet 100 mg</i>	T2	
<i>fluvoxamine</i>	T2	
<i>frovatriptan</i>	T4	QL (12 EA per 28 days)
FYCOMPA ORAL SUSPENSION	T5	QL (744 ML per 31 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG	T5	QL (31 EA per 31 days)
FYCOMPA ORAL TABLET 2 MG	T4	QL (31 EA per 31 days)
<i>gabapentin oral capsule 100 mg, 400 mg</i>	T2	PA-NS; QL (270 EA per 30 days)
<i>gabapentin oral capsule 300 mg</i>	T2	PA-NS; QL (360 EA per 30 days)
<i>gabapentin oral solution 250 mg/5 ml</i>	T3	PA-NS; QL (2160 ML per 30 days)
<i>gabapentin oral tablet 600 mg</i>	T2	PA-NS; QL (180 EA per 30 days)
<i>gabapentin oral tablet 800 mg</i>	T2	PA-NS; QL (120 EA per 30 days)
<i>galantamine oral capsule, ext rel. pellets 24 hr</i>	T3	
<i>galantamine oral solution</i>	T3	
<i>galantamine oral tablet</i>	T2	
<i>glatiramer subcutaneous syringe 20 mg/ml</i>	T5	PA; QL (31 ML per 31 days)
<i>glatiramer subcutaneous syringe 40 mg/ml</i>	T5	PA; QL (12 ML per 28 days)
GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML	T5	PA; QL (31 ML per 31 days)
GLATOPA SUBCUTANEOUS SYRINGE 40 MG/ML	T5	PA; QL (12 ML per 28 days)
<i>guanfacine oral tablet extended release 24 hr</i>	T2	PA
<i>haloperidol decanoate</i>	T2	
<i>haloperidol lactate injection</i>	T1	
<i>haloperidol lactate oral</i>	T2	
<i>haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 5 mg</i>	T1	
<i>haloperidol oral tablet 20 mg</i>	T2	
HETLIOZ	T5	PA; QL (31 EA per 31 days)
HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG	T4	PA; QL (90 EA per 30 days)
HORIZANT ORAL TABLET EXTENDED RELEASE 600 MG	T4	PA; QL (60 EA per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	T2	PA; QL (372 EA per 31 days)
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg</i>	T3	PA; QL (155 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>hydromorphone oral liquid</i>	T4	PA; QL (1550 ML per 31 days)
<i>hydromorphone oral tablet</i>	T2	PA; QL (186 EA per 31 days)
IBU ORAL TABLET 600 MG, 800 MG	T1	
<i>ibuprofen oral suspension</i>	T1	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	T1	
<i>imipramine hcl</i>	T2	PA-NS
<i>imipramine pamoate</i>	T4	PA-NS
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE	T5	PA; QL (300 EA per 30 days)
<i>indomethacin oral capsule</i>	T1	
<i>indomethacin oral capsule, extended release</i>	T1	
<i>indomethacin oral suspension</i>	T4	
INGREZZA INITIATION PK(TARDIV)	T5	PA; QL (56 EA per 365 days)
INGREZZA ORAL CAPSULE 40 MG	T5	PA; QL (62 EA per 31 days)
INGREZZA ORAL CAPSULE 60 MG, 80 MG	T5	PA; QL (31 EA per 31 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	T5	QL (3.5 ML per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML	T5	QL (5 ML per 180 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	T5	QL (0.75 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	T5	QL (1 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	T5	QL (1.5 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	T4	QL (0.25 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	T5	QL (0.5 ML per 28 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML	T5	QL (0.88 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML	T5	QL (1.32 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	T5	QL (1.75 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML	T5	QL (2.63 ML per 84 days)
KESIMPTA PEN	T5	PA; QL (0.4 ML per 28 days)
<i>ketoprofen oral capsule 25 mg, 50 mg</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>ketoprofen oral capsule,ext rel. pellets 24 hr 200 mg</i>	T2	
<i>ketorolac oral</i>	T2	
KIPROFEN	T2	
KLOXXADO	T3	
<i>lacosamide oral</i>	T4	
<i>lamotrigine oral tablet</i>	T2	
<i>lamotrigine oral tablet extended release 24hr</i>	T4	
<i>lamotrigine oral tablet, chewable dispersible</i>	T2	
<i>lamotrigine oral tablet,disintegrating</i>	T2	
<i>levetiracetam oral solution 100 mg/ml</i>	T2	
<i>levetiracetam oral tablet</i>	T2	
<i>levetiracetam oral tablet extended release 24 hr</i>	T2	
LIBERVANT	T5	PA-NS; QL (10 EA per 30 days)
<i>lisdexamfetamine oral capsule</i>	T4	ST; QL (31 EA per 31 days)
<i>lithium carbonate</i>	T1	
<i>lithium citrate</i>	T1	
LORAZEPAM INTENSOL	T2	PA; QL (155 ML per 31 days)
<i>lorazepam oral tablet 0.5 mg</i>	T2	PA; QL (124 EA per 31 days)
<i>lorazepam oral tablet 1 mg</i>	T2	PA; QL (186 EA per 31 days)
<i>lorazepam oral tablet 2 mg</i>	T2	PA; QL (155 EA per 31 days)
<i>loxapine succinate</i>	T2	
LUCEMYRA	T5	
<i>lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg</i>	T5	PA-NS; QL (31 EA per 31 days)
<i>lurasidone oral tablet 80 mg</i>	T5	PA-NS; QL (62 EA per 31 days)
MARPLAN	T3	
MAVENCLAD (10 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAVENCLAD (4 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAVENCLAD (5 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAVENCLAD (6 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAVENCLAD (7 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAVENCLAD (8 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
MAVENCLAD (9 TABLET PACK)	T5	PA; QL (40 EA per 365 days)
<i>mefenamic acid</i>	T4	
<i>meloxicam oral tablet</i>	T1	
<i>memantine oral capsule,sprinkle,er 24hr</i>	T3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>memantine oral solution</i>	T3	
<i>memantine oral tablet</i>	T2	
<i>memantine oral tablets,dose pack</i>	T4	
<i>metaxalone oral tablet 400 mg</i>	T2	PA
<i>metaxalone oral tablet 800 mg</i>	T3	PA
<i>methadone oral solution 10 mg/5 ml</i>	T2	PA; QL (1033 ML per 31 days)
<i>methadone oral solution 5 mg/5 ml</i>	T2	PA; QL (2066 ML per 31 days)
<i>methadone oral tablet 10 mg</i>	T2	PA; QL (206 EA per 31 days)
<i>methadone oral tablet 5 mg</i>	T2	PA; QL (248 EA per 31 days)
<i>methsuximide</i>	T4	
<i>methylphenidate</i>	T4	PA; QL (30 EA per 30 days)
<i>methylphenidate hcl oral cap,er sprinkle,biphasic 40-60</i>	T4	QL (31 EA per 31 days)
<i>methylphenidate hcl oral capsule, er biphasic 30-70 10 mg, 20 mg, 40 mg, 50 mg, 60 mg</i>	T4	QL (31 EA per 31 days)
<i>methylphenidate hcl oral capsule, er biphasic 30-70 30 mg</i>	T2	QL (31 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 10 mg</i>	T2	QL (186 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 20 mg</i>	T4	QL (93 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 30 mg</i>	T4	QL (62 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 40 mg</i>	T2	QL (62 EA per 31 days)
<i>methylphenidate hcl oral capsule,er biphasic 50-50 60 mg</i>	T4	QL (31 EA per 31 days)
<i>methylphenidate hcl oral tablet</i>	T2	QL (93 EA per 31 days)
<i>methylphenidate hcl oral tablet extended release 10 mg</i>	T2	QL (186 EA per 31 days)
<i>methylphenidate hcl oral tablet extended release 20 mg</i>	T2	QL (93 EA per 31 days)
<i>methylphenidate hcl oral tablet extended release 24hr 18 mg, 18 mg (bx rating), 27 mg, 27 mg (bx rating), 36 mg, 36 mg (bx rating), 54 mg, 54 mg (bx rating)</i>	T4	QL (31 EA per 31 days)
<i>methylphenidate hcl oral tablet,chewable 10 mg</i>	T2	QL (186 EA per 31 days)
<i>methylphenidate hcl oral tablet,chewable 2.5 mg, 5 mg</i>	T2	QL (93 EA per 31 days)
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>mirtazapine oral tablet 7.5 mg</i>	T3	
<i>mirtazapine oral tablet, disintegrating</i>	T3	
<i>modafinil</i>	T2	PA; QL (31 EA per 31 days)
<i>molindone</i>	T4	
<i>morphine concentrate oral solution</i>	T2	PA; QL (310 ML per 31 days)
<i>morphine oral capsule, er multiphase 24 hr 120 mg</i>	T3	PA; QL (51 EA per 31 days)
<i>morphine oral capsule, er multiphase 24 hr 30 mg, 45 mg, 60 mg, 75 mg, 90 mg</i>	T3	PA; QL (62 EA per 31 days)
<i>morphine oral solution 10 mg/5 ml</i>	T2	PA; QL (2800 ML per 31 days)
<i>morphine oral solution 20 mg/5 ml (4 mg/ml)</i>	T2	PA; QL (1400 ML per 31 days)
<i>morphine oral tablet</i>	T2	PA; QL (186 EA per 31 days)
<i>morphine oral tablet extended release 100 mg</i>	T3	PA; QL (62 EA per 31 days)
<i>morphine oral tablet extended release 15 mg, 30 mg, 60 mg</i>	T3	PA; QL (100 EA per 31 days)
<i>morphine oral tablet extended release 200 mg</i>	T3	PA; QL (31 EA per 31 days)
<i>nabumetone</i>	T1	
<i>naloxone injection solution</i>	T2	
<i>naloxone injection syringe</i>	T2	
<i>naloxone nasal</i>	T3	
<i>naltrexone</i>	T2	
NAMENDA TITRATION PAK	T4	PA
NAMZARIC	T4	PA
<i>naproxen oral suspension</i>	T1	
<i>naproxen oral tablet</i>	T1	
<i>naproxen oral tablet, delayed release (dr/ec)</i>	T2	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	T1	
<i>naproxen sodium oral tablet, er multiphase 24 hr 750 mg</i>	T4	
<i>naratriptan oral tablet 1 mg</i>	T2	QL (20 EA per 28 days)
<i>naratriptan oral tablet 2.5 mg</i>	T2	QL (9 EA per 28 days)
NAYZILAM	T4	PA-NS; QL (10 EA per 30 days)
<i>nefazodone</i>	T2	
NEUPRO	T4	
<i>nortriptyline</i>	T2	
NOURIANZ	T5	PA; QL (31 EA per 31 days)
NUCYNTA ORAL TABLET 100 MG	T5	PA; QL (186 EA per 31 days)
NUCYNTA ORAL TABLET 50 MG, 75 MG	T4	PA; QL (186 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
NUEDEXTA	T3	PA; QL (62 EA per 31 days)
NUPLAZID	T5	PA-NS; QL (31 EA per 31 days)
NURTEC ODT	T5	PA; QL (18 EA per 28 days)
<i>olanzapine intramuscular</i>	T2	
<i>olanzapine oral</i>	T2	QL (31 EA per 31 days)
<i>olanzapine-fluoxetine</i>	T2	
ONGENTYS	T4	PA; QL (31 EA per 31 days)
ONZETRA XSAIL	T4	QL (16 EA per 28 days)
<i>oxaprozin oral tablet</i>	T2	
<i>oxazepam</i>	T4	PA
<i>oxcarbazepine oral suspension</i>	T2	
<i>oxcarbazepine oral tablet</i>	T2	
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 300 MG	T4	
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 600 MG	T5	
<i>oxycodone oral capsule</i>	T2	PA; QL (186 EA per 31 days)
<i>oxycodone oral concentrate</i>	T2	PA; QL (180 ML per 31 days)
<i>oxycodone oral solution</i>	T2	PA; QL (4133 ML per 31 days)
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 5 mg</i>	T2	PA; QL (186 EA per 31 days)
<i>oxycodone oral tablet 30 mg</i>	T3	PA; QL (138 EA per 31 days)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg</i>	T3	PA; QL (372 EA per 31 days)
<i>oxycodone-acetaminophen oral tablet 5-325 mg, 7.5-325 mg</i>	T2	PA; QL (372 EA per 31 days)
<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg</i>	T4	QL (31 EA per 31 days)
<i>paliperidone oral tablet extended release 24hr 6 mg</i>	T4	QL (62 EA per 31 days)
<i>paroxetine hcl oral suspension</i>	T4	
<i>paroxetine hcl oral tablet</i>	T1	
<i>paroxetine hcl oral tablet extended release 24 hr</i>	T3	
<i>perphenazine</i>	T2	
<i>perphenazine-amitriptyline</i>	T2	PA-NS
PERSERIS	T5	QL (1 EA per 28 days)
<i>phenelzine</i>	T2	
<i>phenobarbital</i>	T2	PA-NS

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>phenytoin oral suspension 125 mg/5 ml</i>	T2	
<i>phenytoin oral tablet, chewable</i>	T2	
<i>phenytoin sodium extended</i>	T2	
<i>pimozide</i>	T4	
<i>piroxicam</i>	T2	
PONVORY	T5	PA; QL (31 EA per 31 days)
PONVORY 14-DAY STARTER PACK	T5	PA; QL (28 EA per 365 days)
<i>pramipexole oral tablet</i>	T2	
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg</i>	T2	PA-NS; QL (93 EA per 31 days)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	T2	PA-NS; QL (62 EA per 31 days)
<i>pregabalin oral solution</i>	T2	PA-NS; QL (930 ML per 31 days)
<i>pregabalin oral tablet extended release 24 hr</i>	T4	PA; QL (31 EA per 31 days)
<i>primidone oral tablet 125 mg</i>	T4	
<i>primidone oral tablet 250 mg, 50 mg</i>	T2	
PROCENTRA	T3	
<i>protriptyline</i>	T4	
<i>pyridostigmine bromide oral syrup</i>	T2	
<i>pyridostigmine bromide oral tablet 30 mg</i>	T3	
<i>pyridostigmine bromide oral tablet 60 mg</i>	T2	
<i>pyridostigmine bromide oral tablet extended release</i>	T2	
<i>quetiapine oral tablet 100 mg, 200 mg, 300 mg, 400 mg, 50 mg</i>	T2	QL (62 EA per 31 days)
<i>quetiapine oral tablet 150 mg</i>	T3	QL (62 EA per 31 days)
<i>quetiapine oral tablet 25 mg</i>	T1	QL (62 EA per 31 days)
<i>quetiapine oral tablet extended release 24 hr</i>	T3	QL (62 EA per 31 days)
QUILLIVANT XR	T4	ST; QL (360 ML per 30 days)
QULIPTA	T5	PA; QL (31 EA per 31 days)
RADICAVA ORS STARTER KIT SUSP	T5	PA; QL (70 ML per 28 days)
<i>ramelteon</i>	T4	QL (31 EA per 31 days)
<i>rasagiline</i>	T3	
REXULTI ORAL TABLET	T5	PA-NS; QL (31 EA per 31 days)
REYVOW ORAL TABLET 100 MG	T4	QL (8 EA per 28 days)
REYVOW ORAL TABLET 50 MG	T4	QL (4 EA per 28 days)
<i>risperidone microspheres intramuscular suspension, extended rel recon 12.5 mg/2 ml, 25 mg/2 ml, 37.5 mg/2 ml</i>	T4	QL (2 EA per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>risperidone microspheres intramuscular suspension,extended rel recon 50 mg/2 ml</i>	T5	QL (2 EA per 28 days)
<i>risperidone oral solution</i>	T2	QL (496 ML per 31 days)
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	T1	QL (31 EA per 31 days)
<i>risperidone oral tablet 3 mg</i>	T1	QL (93 EA per 31 days)
<i>risperidone oral tablet 4 mg</i>	T1	QL (124 EA per 31 days)
<i>risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	T4	QL (31 EA per 31 days)
<i>risperidone oral tablet,disintegrating 3 mg</i>	T4	QL (93 EA per 31 days)
<i>risperidone oral tablet,disintegrating 4 mg</i>	T4	QL (124 EA per 31 days)
<i>rivastigmine</i>	T2	QL (30 EA per 30 days)
<i>rivastigmine tartrate</i>	T2	
<i>rizatriptan oral tablet 10 mg</i>	T2	QL (12 EA per 28 days)
<i>rizatriptan oral tablet 5 mg</i>	T2	QL (24 EA per 28 days)
<i>rizatriptan oral tablet,disintegrating 10 mg</i>	T2	QL (12 EA per 28 days)
<i>rizatriptan oral tablet,disintegrating 5 mg</i>	T2	QL (24 EA per 28 days)
<i>ropinirole oral tablet</i>	T2	
<i>ropinirole oral tablet extended release 24 hr</i>	T4	
ROWEEPRA ORAL TABLET 500 MG	T2	
<i>rufinamide oral suspension</i>	T5	PA-NS
<i>rufinamide oral tablet 200 mg</i>	T4	PA-NS
<i>rufinamide oral tablet 400 mg</i>	T5	PA-NS
RYTARY	T3	ST
SECUADO	T5	PA-NS; QL (31 EA per 31 days)
<i>selegiline hcl</i>	T2	
<i>sertraline oral concentrate</i>	T1	
<i>sertraline oral tablet</i>	T1	
SKYCLARYS	T5	PA; QL (93 EA per 31 days)
<i>sodium oxybate</i>	T5	PA; QL (540 ML per 30 days)
SPRITAM	T4	
SUBVENITE	T2	
<i>sulindac</i>	T2	
<i>sumatriptan nasal spray,non-aerosol 20 mg/actuation</i>	T2	QL (8 EA per 28 days)
<i>sumatriptan nasal spray,non-aerosol 5 mg/actuation</i>	T2	QL (32 EA per 28 days)
<i>sumatriptan succinate oral tablet 100 mg</i>	T2	QL (9 EA per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>sumatriptan succinate oral tablet 25 mg</i>	T2	QL (36 EA per 28 days)
<i>sumatriptan succinate oral tablet 50 mg</i>	T2	QL (18 EA per 28 days)
<i>sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml</i>	T4	QL (4 ML per 28 days)
<i>sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml</i>	T4	QL (6 ML per 28 days)
<i>sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml</i>	T4	QL (4 ML per 28 days)
<i>sumatriptan succinate subcutaneous solution</i>	T4	QL (4 ML per 28 days)
<i>sumatriptan-naproxen</i>	T4	QL (9 EA per 28 days)
SUNOSI	T4	PA; QL (31 EA per 31 days)
SYMPAZAN ORAL FILM 10 MG, 20 MG	T5	PA-NS; QL (62 EA per 31 days)
SYMPAZAN ORAL FILM 5 MG	T4	PA-NS; QL (62 EA per 31 days)
TASCENSO ODT	T5	PA; QL (31 EA per 31 days)
<i>tasimelteon</i>	T5	PA; QL (31 EA per 31 days)
TEGRETOL ORAL TABLET	T4	
TEGRETOL XR	T4	
TEGSEDI	T5	PA; QL (6 ML per 28 days)
<i>temazepam</i>	T2	PA; QL (31 EA per 31 days)
TENCON	T2	QL (372 EA per 31 days)
<i>teriflunomide</i>	T5	PA; QL (31 EA per 31 days)
<i>tetrabenazine oral tablet 12.5 mg</i>	T5	PA; QL (93 EA per 31 days)
<i>tetrabenazine oral tablet 25 mg</i>	T5	PA; QL (124 EA per 31 days)
<i>thioridazine</i>	T2	
<i>thiothixene</i>	T1	
<i>tiagabine oral tablet 12 mg, 16 mg</i>	T3	
<i>tiagabine oral tablet 2 mg, 4 mg</i>	T4	
<i>tizanidine</i>	T2	
<i>tolcapone</i>	T5	
<i>topiramate oral capsule, sprinkle</i>	T2	
<i>topiramate oral capsule, extended release 24hr</i>	T4	
<i>topiramate oral tablet</i>	T2	
<i>tramadol oral tablet 100 mg</i>	T4	PA; QL (124 EA per 31 days)
<i>tramadol oral tablet 25 mg</i>	T4	PA; QL (496 EA per 31 days)
<i>tramadol oral tablet 50 mg</i>	T2	PA; QL (240 EA per 30 days)
<i>tramadol-acetaminophen</i>	T2	PA; QL (372 EA per 31 days)
<i>tranylcypromine</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>trazodone oral tablet 100 mg, 150 mg, 50 mg</i>	T1	
<i>trazodone oral tablet 300 mg</i>	T2	
<i>triazolam</i>	T4	PA
<i>trifluoperazine</i>	T2	
<i>trihexyphenidyl</i>	T2	
<i>trimipramine</i>	T3	PA-NS
TRINTELLIX	T3	
TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 200 MG	T5	
UBRELVY ORAL TABLET 100 MG	T5	PA; QL (17 EA per 28 days)
UBRELVY ORAL TABLET 50 MG	T5	PA; QL (34 EA per 28 days)
<i>valproic acid</i>	T2	
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	T2	
VALTOCO NASAL SPRAY,NON-AEROSOL 10 MG/SPRAY (0.1 ML), 5 MG/SPRAY (0.1 ML)	T4	PA-NS; QL (10 EA per 30 days)
VALTOCO NASAL SPRAY,NON-AEROSOL 15 MG/2 SPRAY (7.5/0.1ML X 2), 20 MG/2 SPRAY (10MG/0.1ML X2)	T5	PA-NS; QL (10 EA per 30 days)
<i>venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg</i>	T2	QL (31 EA per 31 days)
<i>venlafaxine oral capsule,extended release 24hr 75 mg</i>	T2	QL (93 EA per 31 days)
<i>venlafaxine oral tablet</i>	T2	
<i>venlafaxine oral tablet extended release 24hr</i>	T4	QL (31 EA per 31 days)
VERSACLOZ	T5	QL (558 ML per 31 days)
<i>vigabatrin</i>	T5	PA-NS
VIGADRONE	T5	PA-NS
VIGPODER	T5	PA-NS
<i>vilazodone</i>	T3	QL (31 EA per 31 days)
VIVITROL	T5	
VRAYLAR ORAL CAPSULE	T5	PA-NS; QL (31 EA per 31 days)
VUMERITY	T5	PA; QL (124 EA per 31 days)
WAKIX	T5	PA; QL (62 EA per 31 days)
XCOPRI	T5	PA-NS

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
XCOPRI MAINTENANCE PACK ORAL TABLET 250MG/DAY(150 MG X1-100MG X1)	T4	PA-NS
XCOPRI MAINTENANCE PACK ORAL TABLET 350 MG/DAY (200 MG X1-150MG X1)	T5	PA-NS
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)	T4	PA-NS
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	T5	PA-NS
XYREM	T5	PA; QL (540 ML per 30 days)
XYWAV	T5	PA; QL (540 ML per 30 days)
<i>zaleplon oral capsule 10 mg</i>	T2	PA; QL (62 EA per 31 days)
<i>zaleplon oral capsule 5 mg</i>	T2	PA; QL (93 EA per 31 days)
ZAVZPRET	T5	PA; QL (8 EA per 30 days)
ZELAPAR	T5	
ZEPOSIA	T5	PA; QL (31 EA per 31 days)
ZEPOSIA STARTER KIT (28-DAY)	T5	PA; QL (56 EA per 365 days)
ZEPOSIA STARTER PACK (7-DAY)	T5	PA; QL (14 EA per 365 days)
ZILBRYSQ SUBCUTANEOUS SYRINGE 16.6 MG/0.416 ML	T5	PA; QL (11.648 ML per 28 days)
ZILBRYSQ SUBCUTANEOUS SYRINGE 23 MG/0.574 ML	T5	PA; QL (16 ML per 28 days)
ZILBRYSQ SUBCUTANEOUS SYRINGE 32.4 MG/0.81 ML	T5	PA; QL (22.68 ML per 28 days)
<i>ziprasidone hcl</i>	T3	QL (62 EA per 31 days)
<i>ziprasidone mesylate</i>	T3	
<i>zolmitriptan nasal spray,non-aerosol 5 mg</i>	T4	QL (8 EA per 28 days)
<i>zolmitriptan oral tablet 2.5 mg</i>	T2	QL (16 EA per 28 days)
<i>zolmitriptan oral tablet 5 mg</i>	T2	QL (8 EA per 28 days)
<i>zolmitriptan oral tablet,disintegrating 2.5 mg</i>	T2	QL (16 EA per 28 days)
<i>zolmitriptan oral tablet,disintegrating 5 mg</i>	T2	QL (8 EA per 28 days)
<i>zolpidem oral tablet</i>	T2	PA; QL (31 EA per 31 days)
<i>zolpidem oral tablet,ext release multiphase</i>	T2	PA; QL (31 EA per 31 days)
<i>zolpidem sublingual</i>	T3	PA; QL (31 EA per 31 days)
ZONISADE	T5	PA-NS; QL (930 ML per 31 days)
<i>zonisamide</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
ZTALMY	T5	PA-NS; QL (1100 ML per 30 days)
ZUBSOLV SUBLINGUAL TABLET 0.7-0.18 MG, 2.9-0.71 MG, 8.6-2.1 MG	T3	QL (62 EA per 31 days)
ZUBSOLV SUBLINGUAL TABLET 1.4-0.36 MG	T3	QL (93 EA per 31 days)
ZUBSOLV SUBLINGUAL TABLET 11.4-2.9 MG, 5.7-1.4 MG	T3	QL (31 EA per 31 days)
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG	T5	PA-NS; QL (28 EA per 180 days)
ZURZUVAE ORAL CAPSULE 30 MG	T5	PA-NS; QL (14 EA per 180 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	T5	QL (2 EA per 28 days)
Cardiovascular, Hypertension / Lipids		
<i>acebutolol</i>	T1	
<i>aliskiren</i>	T4	
<i>amiloride</i>	T1	
<i>amiloride-hydrochlorothiazide</i>	T1	
<i>amiodarone oral</i>	T2	
<i>amlodipine</i>	T1	
<i>amlodipine-atorvastatin</i>	T2	
<i>amlodipine-benazepril</i>	T1	
<i>amlodipine-olmesartan</i>	T3	QL (31 EA per 31 days)
<i>amlodipine-valsartan</i>	T2	
<i>aspirin-dipyridamole</i>	T2	
<i>atenolol</i>	T1	
<i>atenolol-chlorthalidone</i>	T1	
<i>atorvastatin</i>	T1	
<i>benazepril</i>	T1	
<i>benazepril-hydrochlorothiazide</i>	T1	
<i>betaxolol oral</i>	T1	
<i>bisoprolol fumarate</i>	T1	
<i>bisoprolol-hydrochlorothiazide</i>	T1	
BRILINTA	T3	
<i>bumetanide</i>	T1	
CABLIVI INJECTION KIT	T5	PA; QL (31 EA per 31 days)
CAMZYOS	T5	PA; QL (31 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>candesartan</i>	T1	
<i>candesartan-hydrochlorothiazid</i>	T1	
<i>captopril</i>	T1	
CARTIA XT	T1	
<i>carvedilol</i>	T1	
<i>carvedilol phosphate</i>	T4	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	T1	
<i>cholestyramine (with sugar) oral powder in packet</i>	T2	
CHOLESTYRAMINE LIGHT ORAL POWDER IN PACKET	T2	
<i>cilostazol</i>	T2	
<i>clonidine</i>	T2	
<i>clonidine hcl oral tablet</i>	T1	
<i>clopidogrel oral tablet 75 mg</i>	T1	
<i>colesevelam</i>	T3	
<i>colestipol oral packet</i>	T2	
<i>colestipol oral tablet</i>	T2	
CORLANOR ORAL SOLUTION	T4	PA; QL (420 ML per 28 days)
<i>digoxin oral solution</i>	T3	QL (155 ML per 31 days)
<i>digoxin oral tablet 125 mcg (0.125 mg)</i>	T1	QL (62 EA per 31 days)
<i>digoxin oral tablet 250 mcg (0.25 mg)</i>	T2	QL (31 EA per 31 days)
<i>digoxin oral tablet 62.5 mcg (0.0625 mg)</i>	T4	QL (124 EA per 31 days)
<i>diltiazem hcl oral capsule,extended release 12 hr</i>	T1	
<i>diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg</i>	T1	
<i>diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg</i>	T1	
<i>diltiazem hcl oral tablet</i>	T1	
<i>diltiazem hcl oral tablet extended release 24 hr</i>	T1	
DILT-XR	T1	
<i>dofetilide</i>	T3	
DOPTELET (10 TAB PACK)	T5	PA
DOPTELET (15 TAB PACK)	T5	PA
DOPTELET (30 TAB PACK)	T5	PA
<i>doxazosin</i>	T1	
EDARBYCLOR	T4	
ELIQUIS DVT-PE TREAT 30D START	T3	QL (74 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
ELIQUIS ORAL TABLET 2.5 MG	T3	QL (60 EA per 30 days)
ELIQUIS ORAL TABLET 5 MG	T3	QL (74 EA per 30 days)
<i>enalapril maleate oral solution</i>	T4	
<i>enalapril maleate oral tablet</i>	T1	
<i>enalapril-hydrochlorothiazide</i>	T1	
<i>enoxaparin subcutaneous syringe 100 mg/ml, 120 mg/0.8 ml, 150 mg/ml</i>	T4	
<i>enoxaparin subcutaneous syringe 30 mg/0.3 ml, 40 mg/0.4 ml, 60 mg/0.6 ml, 80 mg/0.8 ml</i>	T2	
ENTRESTO ORAL TABLET 24-26 MG	T3	QL (186 EA per 31 days)
ENTRESTO ORAL TABLET 49-51 MG	T3	QL (93 EA per 31 days)
ENTRESTO ORAL TABLET 97-103 MG	T3	QL (62 EA per 31 days)
<i>eplerenone</i>	T2	
<i>ethacrynic acid</i>	T4	
<i>ezetimibe</i>	T2	
<i>ezetimibe-simvastatin</i>	T3	QL (31 EA per 31 days)
<i>felodipine</i>	T2	
<i>fenofibrate micronized oral capsule 134 mg, 200 mg, 43 mg, 67 mg</i>	T2	
<i>fenofibrate nanocrystallized</i>	T2	
<i>fenofibrate oral tablet 120 mg, 40 mg</i>	T4	
<i>fenofibrate oral tablet 160 mg, 54 mg</i>	T2	
<i>fenofibric acid (choline)</i>	T3	
FILSPARI	T5	PA; QL (31 EA per 31 days)
<i>flecainide</i>	T2	
<i>fluvastatin oral capsule</i>	T1	
<i>fluvastatin oral tablet extended release 24 hr</i>	T3	
<i>fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml</i>	T5	
<i>fondaparinux subcutaneous syringe 2.5 mg/0.5 ml</i>	T4	
<i>fosinopril</i>	T1	
<i>fosinopril-hydrochlorothiazide</i>	T1	
FRAGMIN SUBCUTANEOUS SOLUTION 25,000 ANTI-XA UNIT/ML	T5	
FRAGMIN SUBCUTANEOUS SYRINGE 10,000 ANTI-XA UNIT/ML, 12,500 ANTI-XA UNIT/0.5 ML, 15,000 ANTI-XA UNIT/0.6 ML, 18,000 ANTI-XA UNIT/0.72 ML, 7,500 ANTI-XA UNIT/0.3 ML	T5	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
FRAGMIN SUBCUTANEOUS SYRINGE 2,500 ANTI-XA UNIT/0.2 ML, 5,000 ANTI- XA UNIT/0.2 ML	T3	
FUROSCIX	T5	PA; QL (8 EA per 30 days)
<i>furosemide injection solution</i>	T2	
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	T2	
<i>furosemide oral tablet</i>	T1	
<i>gemfibrozil</i>	T1	
<i>heparin (porcine) injection solution</i>	T2	
<i>hydralazine oral</i>	T1	
<i>hydrochlorothiazide</i>	T1	
<i>icosapent ethyl oral capsule 0.5 gram</i>	T4	QL (248 EA per 31 days)
<i>icosapent ethyl oral capsule 1 gram</i>	T4	QL (124 EA per 31 days)
<i>indapamide</i>	T1	
<i>irbesartan</i>	T1	QL (31 EA per 31 days)
<i>irbesartan-hydrochlorothiazide</i>	T2	QL (31 EA per 31 days)
<i>isosorbide dinitrate oral tablet</i>	T2	
<i>isosorbide mononitrate</i>	T1	
<i>isosorbide-hydralazine</i>	T4	
<i>isradipine</i>	T2	
<i>ivabradine oral tablet 5 mg</i>	T4	PA; QL (93 EA per 31 days)
<i>ivabradine oral tablet 7.5 mg</i>	T4	PA; QL (62 EA per 31 days)
JANTOVEN	T1	
JUXTAPID	T5	PA
KERENDIA	T4	PA; QL (31 EA per 31 days)
<i>labetalol oral</i>	T1	
LIPOFEN	T4	
<i>lisinopril</i>	T1	
<i>lisinopril-hydrochlorothiazide</i>	T1	
<i>losartan oral tablet 100 mg</i>	T1	QL (31 EA per 31 days)
<i>losartan oral tablet 25 mg</i>	T1	QL (93 EA per 31 days)
<i>losartan oral tablet 50 mg</i>	T1	QL (62 EA per 31 days)
<i>losartan-hydrochlorothiazide</i>	T1	
<i>lovastatin</i>	T1	
MATZIM LA	T2	
<i>metolazone</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>metoprolol succinate</i>	T1	
<i>metoprolol ta-hydrochlorothiaz</i>	T1	
<i>metoprolol tartrate oral</i>	T1	
<i>metyrosine</i>	T5	PA
<i>mexiletine</i>	T3	
<i>minoxidil oral</i>	T2	
<i>moexipril</i>	T1	
MULPLETA	T5	PA
MULTAQ	T4	
<i>nadolol</i>	T1	
<i>nebivolol oral tablet 10 mg, 2.5 mg</i>	T2	QL (93 EA per 31 days)
<i>nebivolol oral tablet 20 mg</i>	T2	QL (62 EA per 31 days)
<i>nebivolol oral tablet 5 mg</i>	T2	QL (217 EA per 31 days)
NEXLETOL	T4	PA; QL (31 EA per 31 days)
NEXLIZET	T4	PA; QL (31 EA per 31 days)
<i>niacin oral tablet extended release 24 hr 1,000 mg, 750 mg</i>	T3	
<i>niacin oral tablet extended release 24 hr 500 mg</i>	T3	QL (31 EA per 31 days)
<i>nicardipine oral</i>	T2	
<i>nifedipine oral tablet extended release</i>	T2	
<i>nifedipine oral tablet extended release 24hr</i>	T2	
<i>nimodipine oral capsule</i>	T2	
<i>nisoldipine</i>	T2	
NITRO-BID	T2	
<i>nitroglycerin sublingual</i>	T2	
<i>nitroglycerin transdermal patch 24 hour</i>	T2	
<i>nitroglycerin translingual</i>	T2	
<i>olmesartan oral tablet 20 mg, 40 mg</i>	T2	QL (31 EA per 31 days)
<i>olmesartan oral tablet 5 mg</i>	T2	QL (93 EA per 31 days)
<i>olmesartan-amlodipin-hcthiazyd</i>	T3	
<i>olmesartan-hydrochlorothiazide</i>	T2	QL (31 EA per 31 days)
<i>omega-3 acid ethyl esters</i>	T3	QL (124 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG	T4	PA; QL (93 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG	T5	PA; QL (186 EA per 31 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 2.5 MG	T5	PA; QL (521 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG	T5	PA; QL (261 EA per 31 days)
PACERONE ORAL TABLET 100 MG, 200 MG, 400 MG	T2	
<i>pentoxifylline</i>	T2	
<i>perindopril erbumine</i>	T1	
<i>phenoxybenzamine</i>	T5	PA
<i>pindolol</i>	T1	
<i>pitavastatin calcium</i>	T3	
<i>prasugrel</i>	T3	
<i>pravastatin</i>	T1	
<i>prazosin</i>	T1	
PREVALITE ORAL POWDER IN PACKET	T2	
PROMACTA ORAL POWDER IN PACKET 12.5 MG	T5	PA; QL (372 EA per 31 days)
PROMACTA ORAL POWDER IN PACKET 25 MG	T5	PA; QL (31 EA per 31 days)
PROMACTA ORAL TABLET 12.5 MG, 25 MG	T5	PA; QL (31 EA per 31 days)
PROMACTA ORAL TABLET 50 MG, 75 MG	T5	PA; QL (62 EA per 31 days)
<i>propafenone</i>	T2	
<i>propranolol oral capsule, extended release 24 hr</i>	T2	
<i>propranolol oral solution</i>	T1	
<i>propranolol oral tablet</i>	T1	
<i>quinapril</i>	T1	
<i>quinidine gluconate oral</i>	T4	
<i>quinidine sulfate oral tablet</i>	T2	
<i>ramipril</i>	T1	
<i>ranolazine</i>	T3	QL (62 EA per 31 days)
REPATHA PUSHTRONEX	T3	PA; QL (7 ML per 28 days)
REPATHA SURECLICK	T3	PA; QL (3 ML per 28 days)
REPATHA SYRINGE	T3	PA; QL (3 ML per 28 days)
<i>rosuvastatin</i>	T1	
<i>simvastatin</i>	T1	
SORINE ORAL TABLET 120 MG, 160 MG	T1	
SOTALOL AF	T1	
<i>sotalol oral</i>	T1	
<i>spironolactone oral tablet</i>	T1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>spironolacton-hydrochlorothiaz</i>	T1	
TAVALISSE	T5	PA; QL (62 EA per 31 days)
<i>telmisartan</i>	T1	
<i>telmisartan-amlodipine</i>	T1	
<i>telmisartan-hydrochlorothiazid</i>	T1	
<i>terazosin</i>	T1	
TIADYL ER	T2	
<i>timolol maleate oral</i>	T1	
<i>torseamide oral</i>	T1	
<i>trandolapril</i>	T1	
<i>triamterene</i>	T4	
<i>triamterene-hydrochlorothiazid</i>	T1	
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 400 MCG, 600 MCG, 800 MCG	T5	PA; QL (62 EA per 31 days)
UPTRAVI ORAL TABLET 200 MCG	T5	PA; QL (224 EA per 28 days)
UPTRAVI ORAL TABLETS,DOSE PACK	T5	PA; QL (400 EA per 365 days)
<i>valsartan oral tablet 160 mg, 40 mg, 80 mg</i>	T1	QL (62 EA per 31 days)
<i>valsartan oral tablet 320 mg</i>	T1	QL (31 EA per 31 days)
<i>valsartan-hydrochlorothiazide</i>	T2	QL (31 EA per 31 days)
<i>verapamil oral</i>	T2	
VERQUVO	T4	PA; QL (31 EA per 31 days)
VYNDAMAX	T5	PA; QL (31 EA per 31 days)
VYNDAQEL	T5	PA; QL (124 EA per 31 days)
<i>warfarin</i>	T1	
XARELTO DVT-PE TREAT 30D START	T3	QL (51 EA per 30 days)
XARELTO ORAL SUSPENSION FOR RECONSTITUTION	T3	QL (930 ML per 31 days)
XARELTO ORAL TABLET 10 MG, 20 MG	T3	QL (31 EA per 31 days)
XARELTO ORAL TABLET 15 MG	T3	QL (52 EA per 31 days)
XARELTO ORAL TABLET 2.5 MG	T3	QL (62 EA per 31 days)
ZONTIVITY	T4	
Dermatologicals/Topical Therapy		
AC CUTANE ORAL CAPSULE 10 MG, 20 MG, 40 MG	T2	
<i>acitretin</i>	T4	PA
<i>acyclovir topical cream</i>	T3	QL (5 GM per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>acyclovir topical ointment</i>	T1	QL (30 GM per 30 days)
<i>adapalene topical gel 0.3 %</i>	T2	PA
<i>adapalene topical swab</i>	T2	PA
<i>adapalene-benzoyl peroxide</i>	T4	PA
ADBRY SUBCUTANEOUS SYRINGE	T5	PA; QL (4 ML per 28 days)
ALA-CORT TOPICAL CREAM 1 %	T1	
ALA-CORT TOPICAL CREAM 2.5 %	T1	QL (30 GM per 28 days)
<i>alclometasone</i>	T1	
<i>amcinonide topical cream</i>	T2	
<i>amcinonide topical ointment</i>	T2	
<i>ammonium lactate</i>	T2	
AMNESTEEM	T2	
<i>azelaic acid</i>	T4	QL (50 GM per 28 days)
AZELEX	T4	QL (50 GM per 28 days)
<i>betamethasone dipropionate</i>	T1	
<i>betamethasone valerate topical cream</i>	T1	
<i>betamethasone valerate topical foam</i>	T4	
<i>betamethasone valerate topical lotion</i>	T1	
<i>betamethasone valerate topical ointment</i>	T1	
<i>betamethasone, augmented</i>	T2	
<i>calcipotriene scalp</i>	T2	QL (60 ML per 28 days)
<i>calcipotriene topical cream</i>	T2	QL (60 GM per 28 days)
<i>calcipotriene topical ointment</i>	T2	QL (60 GM per 28 days)
<i>calcipotriene-betamethasone</i>	T4	ST; QL (400 GM per 28 days)
<i>calcitriol topical</i>	T4	ST
CARAC	T5	PA
CIBINQO	T5	PA; QL (31 EA per 31 days)
<i>ciclopirox topical cream</i>	T2	QL (90 GM per 28 days)
<i>ciclopirox topical gel</i>	T2	QL (45 GM per 28 days)
<i>ciclopirox topical shampoo</i>	T2	QL (120 ML per 28 days)
<i>ciclopirox topical solution</i>	T2	
<i>ciclopirox topical suspension</i>	T3	QL (60 ML per 28 days)
CLARAVIS	T4	
CLINDACIN	T2	QL (100 GM per 28 days)
<i>clindamycin phosphate topical foam</i>	T4	QL (100 GM per 28 days)
<i>clindamycin phosphate topical gel</i>	T2	QL (60 GM per 28 days)
<i>clindamycin phosphate topical gel, once daily</i>	T2	QL (75 ML per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>clindamycin phosphate topical lotion</i>	T2	QL (60 ML per 28 days)
<i>clindamycin phosphate topical solution</i>	T2	QL (60 ML per 28 days)
<i>clindamycin phosphate topical swab</i>	T2	
<i>clindamycin-benzoyl peroxide topical gel</i>	T2	
<i>clindamycin-benzoyl peroxide topical gel with pump 1.2-2.5 %</i>	T2	
<i>clindamycin-tretinoin</i>	T2	PA; QL (60 GM per 28 days)
<i>clobetasol scalp</i>	T2	QL (50 ML per 28 days)
<i>clobetasol topical cream</i>	T3	QL (60 GM per 28 days)
<i>clobetasol topical foam</i>	T2	QL (100 GM per 28 days)
<i>clobetasol topical gel</i>	T2	QL (60 GM per 28 days)
<i>clobetasol topical lotion</i>	T2	QL (118 ML per 28 days)
<i>clobetasol topical ointment</i>	T3	QL (60 GM per 28 days)
<i>clobetasol topical shampoo</i>	T4	QL (118 ML per 28 days)
<i>clobetasol topical spray,non-aerosol</i>	T2	QL (125 ML per 28 days)
<i>clobetasol-emollient topical cream</i>	T3	QL (60 GM per 28 days)
<i>clobetasol-emollient topical foam</i>	T3	QL (100 GM per 28 days)
<i>clocortolone pivalate</i>	T4	
CLODAN	T2	QL (118 ML per 28 days)
<i>clotrimazole topical cream</i>	T2	QL (45 GM per 28 days)
<i>clotrimazole topical solution</i>	T2	QL (30 ML per 28 days)
<i>clotrimazole-betamethasone topical cream</i>	T2	QL (45 GM per 28 days)
<i>clotrimazole-betamethasone topical lotion</i>	T2	QL (60 ML per 28 days)
COSENTYX (2 SYRINGES)	T5	PA; QL (2 ML per 28 days)
COSENTYX PEN (2 PENS)	T5	PA; QL (2 ML per 28 days)
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
COSENTYX UNOREADY PEN	T5	PA; QL (2 ML per 28 days)
CROTAN	T4	
<i>dapsone topical</i>	T4	QL (90 GM per 28 days)
<i>desonide topical cream</i>	T3	QL (60 GM per 28 days)
<i>desonide topical gel</i>	T3	QL (60 GM per 28 days)
<i>desonide topical lotion</i>	T3	QL (118 ML per 28 days)
<i>desonide topical ointment</i>	T3	QL (60 GM per 28 days)
<i>desoximetasone topical cream</i>	T2	QL (100 GM per 28 days)
<i>desoximetasone topical gel</i>	T2	QL (60 GM per 28 days)
<i>desoximetasone topical ointment 0.25 %</i>	T2	QL (100 GM per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>desoximetasone topical spray,non-aerosol</i>	T2	QL (100 ML per 28 days)
<i>diclofenac sodium topical gel 3 %</i>	T4	PA; QL (100 GM per 28 days)
DIFFERIN TOPICAL LOTION	T4	PA
<i>doxepin topical</i>	T4	PA; QL (45 GM per 28 days)
DUOBRII	T4	PA; QL (200 GM per 28 days)
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML	T5	PA; QL (2.28 ML per 28 days)
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	T5	PA; QL (8 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 100 MG/0.67 ML	T5	PA; QL (1.34 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	T5	PA; QL (2.28 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	T5	PA; QL (8 ML per 28 days)
<i>econazole</i>	T2	QL (85 GM per 28 days)
ERY PADS	T2	
ERYGEL	T3	QL (60 GM per 28 days)
<i>erythromycin with ethanol topical gel</i>	T2	QL (60 GM per 28 days)
<i>erythromycin with ethanol topical solution</i>	T2	QL (60 ML per 28 days)
<i>erythromycin-benzoyl peroxide</i>	T2	
FILSUEVZ	T5	PA
FINACEA TOPICAL FOAM	T4	QL (50 GM per 28 days)
<i>fluocinolone and shower cap</i>	T2	QL (118.28 ML per 28 days)
<i>fluocinolone topical cream 0.01 %</i>	T2	QL (60 GM per 28 days)
<i>fluocinolone topical cream 0.025 %</i>	T2	QL (120 GM per 28 days)
<i>fluocinolone topical ointment</i>	T2	QL (120 GM per 28 days)
<i>fluocinolone topical solution</i>	T2	QL (90 ML per 28 days)
<i>fluocinonide topical cream 0.05 %</i>	T2	QL (60 GM per 28 days)
<i>fluocinonide topical gel</i>	T2	QL (60 GM per 28 days)
<i>fluocinonide topical ointment</i>	T2	QL (60 GM per 28 days)
<i>fluocinonide topical solution</i>	T2	QL (60 ML per 28 days)
<i>fluocinonide-emollient</i>	T2	QL (60 GM per 28 days)
<i>fluorouracil topical cream 5 %</i>	T2	
<i>fluorouracil topical solution</i>	T2	
<i>flurandrenolide topical cream</i>	T4	QL (120 GM per 28 days)
<i>flurandrenolide topical lotion</i>	T4	QL (120 ML per 28 days)
<i>fluticasone propionate topical cream</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>gentamicin topical</i>	T2	QL (60 GM per 28 days)
<i>halcinonide topical cream</i>	T4	QL (60 GM per 28 days)
<i>halobetasol propionate topical cream</i>	T2	QL (50 GM per 28 days)
<i>halobetasol propionate topical ointment</i>	T2	QL (50 GM per 28 days)
HALOG TOPICAL OINTMENT	T4	QL (60 GM per 28 days)
<i>hydrocortisone butyrate topical cream</i>	T2	QL (45 GM per 28 days)
<i>hydrocortisone butyrate topical lotion</i>	T4	QL (118 ML per 28 days)
<i>hydrocortisone butyrate topical ointment</i>	T2	QL (45 GM per 28 days)
<i>hydrocortisone butyrate topical solution</i>	T2	QL (60 ML per 28 days)
<i>hydrocortisone topical cream 1 %</i>	T1	
<i>hydrocortisone topical lotion 2.5 %</i>	T1	QL (118 ML per 28 days)
<i>hydrocortisone topical ointment 1 %, 2.5 %</i>	T1	
<i>hydrocortisone valerate</i>	T2	QL (60 GM per 28 days)
<i>imiquimod topical cream in metered-dose pump</i>	T5	
<i>imiquimod topical cream in packet 5 %</i>	T2	
<i>isotretinoin</i>	T2	
<i>ketoconazole topical cream</i>	T2	QL (60 GM per 28 days)
<i>ketoconazole topical shampoo</i>	T2	QL (120 ML per 28 days)
<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i>	T2	PA; QL (50 ML per 28 days)
<i>lidocaine topical adhesive patch,medicated 5 %</i>	T3	PA; QL (93 EA per 31 days)
<i>lidocaine topical ointment</i>	T2	PA; QL (50 GM per 28 days)
LIDOCAINE VISCOUS	T2	
<i>lidocaine-prilocaine topical cream</i>	T2	PA; QL (30 GM per 28 days)
LIDODERM	T5	PA; QL (93 EA per 31 days)
<i>malathion</i>	T4	
<i>metronidazole topical cream</i>	T2	
<i>metronidazole topical gel 0.75 %</i>	T2	
<i>metronidazole topical gel 1 %</i>	T1	
<i>metronidazole topical lotion</i>	T2	
<i>mometasone topical</i>	T2	
<i>mupirocin</i>	T2	
<i>naftifine topical cream 1 %</i>	T4	ST; QL (90 GM per 28 days)
<i>naftifine topical cream 2 %</i>	T4	ST; QL (60 GM per 28 days)
<i>naftifine topical gel 2 %</i>	T4	ST; QL (60 GM per 28 days)
NEO-SYNALAR	T4	
NEUAC	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
NYAMYC	T2	QL (60 GM per 28 days)
<i>nystatin topical cream</i>	T2	QL (30 GM per 28 days)
<i>nystatin topical ointment</i>	T2	QL (30 GM per 28 days)
<i>nystatin topical powder</i>	T2	QL (60 GM per 28 days)
<i>nystatin-triamcinolone</i>	T3	QL (60 GM per 28 days)
NYSTOP	T2	QL (60 GM per 28 days)
OXISTAT TOPICAL LOTION	T4	ST; QL (60 ML per 28 days)
PANDEL	T5	QL (80 GM per 28 days)
PANRETIN	T5	PA-NS
<i>penciclovir</i>	T3	QL (5 GM per 28 days)
<i>permethrin</i>	T2	
<i>pimecrolimus</i>	T3	QL (100 GM per 28 days)
<i>podofilox topical solution</i>	T2	
REGRANEX	T5	PA
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.06 %	T4	PA; QL (50 GM per 28 days)
SANTYL	T4	QL (180 GM per 30 days)
<i>selenium sulfide topical lotion</i>	T1	
SILIQ	T5	PA; QL (6 ML per 28 days)
<i>silver sulfadiazine</i>	T1	
SKYRIZI SUBCUTANEOUS PEN INJECTOR	T5	PA; QL (1 ML per 84 days)
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML	T5	PA; QL (1 ML per 84 days)
SSD	T4	
STELARA SUBCUTANEOUS SOLUTION	T5	PA; QL (0.5 ML per 84 days)
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T5	PA; QL (0.5 ML per 84 days)
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 56 days)
<i>sulfacetamide sodium (acne)</i>	T1	
SULFAMYLON TOPICAL CREAM	T3	
<i>tacrolimus topical</i>	T2	QL (100 GM per 28 days)
TALTZ AUTOINJECTOR	T5	PA; QL (1 ML per 28 days)
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 80 MG/ML	T5	PA; QL (1 ML per 28 days)
<i>tazarotene topical cream 0.1 %</i>	T4	PA; QL (60 GM per 28 days)
<i>tazarotene topical gel</i>	T4	PA; QL (100 GM per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
TAZORAC TOPICAL CREAM 0.05 %	T4	PA; QL (60 GM per 28 days)
TOVET EMOLLIENT	T3	QL (100 GM per 28 days)
<i>tretinoin topical cream</i>	T2	PA; QL (45 GM per 28 days)
<i>tretinoin topical gel 0.01 %, 0.025 %</i>	T2	PA; QL (45 GM per 28 days)
<i>tretinoin topical gel 0.05 %</i>	T3	PA; QL (45 GM per 28 days)
<i>triamcinolone acetonide topical cream</i>	T1	
<i>triamcinolone acetonide topical lotion</i>	T1	
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %</i>	T1	
<i>triamcinolone acetonide topical ointment 0.05 %</i>	T4	
TRIDERM TOPICAL CREAM	T1	
VALCHLOR	T5	PA-NS
VEREGEN	T5	QL (30 GM per 28 days)
ZYCLARA TOPICAL CREAM IN METERED-DOSE PUMP 2.5 %	T5	
Diagnostics / Miscellaneous Agents		
<i>acamprosate</i>	T2	
<i>anagrelide</i>	T3	
ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG	T5	PA
AURYXIA	T5	PA; QL (372 EA per 31 days)
<i>bupropion hcl (smoking deter)</i>	T2	QL (62 EA per 31 days)
<i>carglumic acid</i>	T5	PA
<i>cevimeline</i>	T2	
CHEMET	T4	
CLINIMIX 4.25%/D5W SULFIT FREE	T4	PA-BvD
CLINIMIX E 2.75%/D5W SULF FREE	T4	PA-BvD
<i>d10 %-0.45 % sodium chloride</i>	T2	
<i>d2.5 %-0.45 % sodium chloride</i>	T2	
<i>d5 % and 0.9 % sodium chloride</i>	T2	
<i>d5 %-0.45 % sodium chloride</i>	T2	
<i>deferasirox oral tablet, dispersible 125 mg</i>	T4	PA
<i>deferasirox oral tablet, dispersible 250 mg, 500 mg</i>	T5	PA
<i>deferiprone</i>	T5	PA
<i>dextrose 10 % in water (d10w)</i>	T2	
<i>dextrose 5 % in water (d5w) intravenous piggyback</i>	T2	

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Drug Name	Drug Tier	Requirements/Limits
<i>dextrose 5%-0.2 % sod chloride</i>	T2	
<i>disulfiram</i>	T2	
<i>droxidopa oral capsule 100 mg</i>	T5	PA; QL (465 EA per 31 days)
<i>droxidopa oral capsule 200 mg, 300 mg</i>	T5	PA; QL (186 EA per 31 days)
DUVYZAT	T5	PA; QL (420 ML per 35 days)
FABHALTA	T5	PA; QL (62 EA per 31 days)
GLASSIA	T5	PA
INCRELEX	T5	PA
JOENJA	T5	PA; QL (60 EA per 30 days)
KIONEX (WITH SORBITOL)	T2	
<i>lanthanum oral tablet,chewable 1,000 mg</i>	T5	
<i>lanthanum oral tablet,chewable 500 mg, 750 mg</i>	T4	
<i>levocarnitine (with sugar)</i>	T2	PA-BvD
<i>levocarnitine oral tablet</i>	T2	PA-BvD
LITFULO	T5	PA; QL (28 EA per 28 days)
LITHOSTAT	T4	
LOKELMA	T3	PA; QL (93 EA per 31 days)
<i>midodrine</i>	T2	
NICOTROL	T4	
NICOTROL NS	T5	
<i>nitisinone</i>	T5	PA
NITYR	T5	PA
OXBRYTA ORAL TABLET 300 MG	T5	PA; QL (248 EA per 31 days)
OXBRYTA ORAL TABLET 500 MG	T5	PA; QL (155 EA per 31 days)
OXBRYTA ORAL TABLET FOR SUSPENSION	T5	PA; QL (248 EA per 31 days)
PHEBURANE	T5	PA; QL (620 GM per 31 days)
<i>pilocarpine hcl oral</i>	T2	
PROLASTIN-C INTRAVENOUS SOLUTION	T5	PA
PYRUKYND ORAL TABLET 20 MG, 5 MG (4-WEEK PACK), 50 MG	T5	PA; QL (56 EA per 28 days)
RAVICTI	T5	PA
REVCOVI	T5	
REZDIFFRA	T5	PA; QL (31 EA per 31 days)
<i>riluzole</i>	T4	
<i>risedronate oral tablet 30 mg</i>	T3	
<i>sevelamer carbonate</i>	T3	

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Drug Name	Drug Tier	Requirements/Limits
<i>sevelamer hcl</i>	T4	
<i>sodium chloride 0.9 % intravenous parenteral solution</i>	T2	
<i>sodium chloride irrigation</i>	T2	
<i>sodium phenylbutyrate</i>	T5	PA
<i>sodium polystyrene sulfonate oral powder</i>	T2	
SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 2.5 MG, 5 MG	T5	PA; QL (31 EA per 31 days)
SOHONOS ORAL CAPSULE 10 MG	T5	PA; QL (62 EA per 31 days)
SPS (WITH SORBITOL) ORAL	T2	
TAVNEOS	T5	PA; QL (186 EA per 31 days)
<i>tiopronin</i>	T5	PA
<i>trientine oral capsule 250 mg</i>	T5	QL (248 EA per 31 days)
<i>varenicline oral tablet</i>	T4	QL (60 EA per 30 days)
<i>varenicline oral tablets,dose pack</i>	T4	QL (106 EA per 365 days)
VELPHORO	T5	
XURIDEN	T5	PA; QL (124 EA per 31 days)
ZEMAIRA INTRAVENOUS RECON SOLN 1,000 MG	T5	PA
ZOKINVY	T5	PA
Ear, Nose / Throat Medications		
<i>acetic acid otic (ear)</i>	T2	
<i>azelastine nasal spray,non-aerosol 137 mcg (0.1 %)</i>	T2	QL (30 ML per 25 days)
<i>chlorhexidine gluconate mucous membrane</i>	T1	
CIPRO HC	T4	
<i>ciprofloxacin-dexamethasone</i>	T3	
<i>ciprofloxacin-fluocinolone</i>	T4	
<i>fluocinolone acetonide oil</i>	T2	
<i>hydrocortisone-acetic acid</i>	T2	
<i>ipratropium bromide nasal spray,non-aerosol 21 mcg (0.03 %)</i>	T1	QL (30 ML per 28 days)
<i>ipratropium bromide nasal spray,non-aerosol 42 mcg (0.06 %)</i>	T1	QL (15 ML per 28 days)
KOURZEQ	T2	
<i>neomycin-polymyxin-hc otic (ear)</i>	T2	
<i>ofloxacin otic (ear)</i>	T2	
<i>olopatadine nasal</i>	T2	QL (30.5 GM per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
OTOVEL	T4	
PERIOGARD	T1	
<i>triamcinolone acetonide dental</i>	T2	
Endocrine/Diabetes		
<i>acarbose</i>	T1	QL (93 EA per 31 days)
ALCOHOL PADS	T2	
ALKINDI SPRINKLE ORAL CAPSULE, SPRINKLE 0.5 MG	T4	PA
ALKINDI SPRINKLE ORAL CAPSULE, SPRINKLE 1 MG, 2 MG, 5 MG	T5	PA
AVEED	T4	PA
BAQSIMI	T3	
BASAGLAR KWIKPEN U-100 INSULIN	T4	
BASAGLAR TEMPO PEN(U-100)INSLN	T4	
<i>cabergoline</i>	T2	
<i>calcitonin (salmon) nasal</i>	T2	PA-BvD
<i>calcitriol oral capsule</i>	T2	PA-BvD
<i>calcitriol oral solution</i>	T3	PA-BvD
CERDELGA	T5	PA; QL (62 EA per 31 days)
<i>cinacalcet oral tablet 30 mg, 60 mg</i>	T3	PA-BvD; QL (62 EA per 31 days)
<i>cinacalcet oral tablet 90 mg</i>	T3	PA-BvD; QL (124 EA per 31 days)
CYCLOSET	T4	
<i>danazol</i>	T2	
<i>deflazacort</i>	T5	PA
DEPO-TESTOSTERONE INTRAMUSCULAR OIL 100 MG/ML	T4	PA
<i>desmopressin nasal spray, non-aerosol 10 mcg/spray (0.1 ml)</i>	T4	
<i>desmopressin oral</i>	T2	
<i>dexamethasone oral solution</i>	T1	
<i>dexamethasone oral tablet</i>	T1	
<i>diazoxide</i>	T4	
<i>doxercalciferol oral capsule 0.5 mcg, 2.5 mcg</i>	T2	PA-BvD
<i>doxercalciferol oral capsule 1 mcg</i>	T4	PA-BvD
FARXIGA	T3	QL (31 EA per 31 days)
FIASP FLEXTOUCH U-100 INSULIN	T3	
FIASP PENFILL U-100 INSULIN	T3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
FIASP U-100 INSULIN	T3	
<i>fludrocortisone</i>	T2	
GALAFOLD	T5	PA; QL (14 EA per 28 days)
<i>glimepiride oral tablet 1 mg, 2 mg, 4 mg</i>	T1	
<i>glipizide oral tablet 10 mg, 5 mg</i>	T1	
<i>glipizide oral tablet extended release 24hr</i>	T1	
<i>glipizide-metformin</i>	T1	
GLUCAGON EMERGENCY KIT (HUMAN)	T3	
<i>glyburide</i>	T2	
<i>glyburide micronized</i>	T2	
<i>glyburide-metformin</i>	T2	
GLYXAMBI	T3	QL (31 EA per 31 days)
GVOKE	T3	
GVOKE HYPOPEN 2-PACK	T3	
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	T3	
HUMALOG JUNIOR KWIKPEN U-100	T3	
HUMALOG KWIKPEN INSULIN	T3	
HUMALOG MIX 50-50 KWIKPEN	T3	
HUMALOG MIX 75-25 KWIKPEN	T3	
HUMALOG MIX 75-25(U-100)INSULN	T3	
HUMALOG TEMPO PEN(U-100)INSULN	T3	
HUMALOG U-100 INSULIN	T3	
HUMULIN 70/30 U-100 INSULIN	T3	
HUMULIN 70/30 U-100 KWIKPEN	T3	
HUMULIN N NPH INSULIN KWIKPEN	T3	
HUMULIN N NPH U-100 INSULIN	T3	
HUMULIN R REGULAR U-100 INSULN	T3	
HUMULIN R U-500 (CONC) INSULIN	T3	
HUMULIN R U-500 (CONC) KWIKPEN	T3	
<i>hydrocortisone oral</i>	T1	
<i>insulin asp prt-insulin aspart</i>	T3	
<i>insulin aspart u-100</i>	T3	
<i>insulin lispro</i>	T3	
<i>insulin lispro protamin-lispro</i>	T3	
INVOKAMET	T3	QL (62 EA per 31 days)
INVOKAMET XR	T3	QL (62 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
INVOKANA ORAL TABLET 100 MG	T3	QL (62 EA per 31 days)
INVOKANA ORAL TABLET 300 MG	T3	QL (31 EA per 31 days)
ISTURISA ORAL TABLET 1 MG	T5	PA; QL (248 EA per 31 days)
ISTURISA ORAL TABLET 5 MG	T5	PA; QL (62 EA per 31 days)
JANUMET	T3	QL (62 EA per 31 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG	T3	QL (31 EA per 31 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG	T3	QL (62 EA per 31 days)
JANUVIA ORAL TABLET 100 MG, 50 MG	T3	QL (31 EA per 31 days)
JANUVIA ORAL TABLET 25 MG	T3	QL (93 EA per 31 days)
JARDIANCE ORAL TABLET 10 MG	T3	QL (62 EA per 31 days)
JARDIANCE ORAL TABLET 25 MG	T3	QL (31 EA per 31 days)
JAVYGTOR	T5	PA
JENTADUETO ORAL TABLET 2.5-1,000 MG, 2.5-500 MG	T3	QL (62 EA per 31 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG	T3	QL (62 EA per 31 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	T3	QL (31 EA per 31 days)
JYNARQUE ORAL TABLET	T5	PA; QL (112 EA per 28 days)
JYNARQUE ORAL TABLETS, SEQUENTIAL	T5	PA; QL (56 EA per 28 days)
LANTUS SOLOSTAR U-100 INSULIN	T3	
LANTUS U-100 INSULIN	T3	
LEVEMIR FLEXPEN	T3	
LEVEMIR U-100 INSULIN	T3	
<i>levothyroxine oral capsule</i>	T4	
<i>levothyroxine oral tablet</i>	T1	
LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	T3	
<i>liothyronine oral</i>	T2	
MEDROL ORAL TABLET 2 MG	T4	
<i>metformin oral solution</i>	T4	ST; QL (791 ML per 31 days)
<i>metformin oral tablet 1,000 mg, 500 mg, 850 mg</i>	T1	
<i>metformin oral tablet extended release 24 hr</i>	T1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>metformin oral tablet extended release 24hr</i>	NF	
<i>metformin oral tablet,er gast.retention 24 hr</i>	NF	
<i>methimazole oral tablet 10 mg, 5 mg</i>	T2	
<i>methylprednisolone</i>	T2	
<i>mifepristone oral tablet 300 mg</i>	T5	PA; QL (124 EA per 31 days)
<i>miglitol</i>	T2	
<i>miglustat</i>	T5	PA; QL (93 EA per 31 days)
MOUNJARO	T3	PA; QL (2 ML per 28 days)
MYALEPT	T5	PA
<i>nateglinide</i>	T1	QL (93 EA per 31 days)
NOVOLIN 70/30 U-100 INSULIN	T3	
NOVOLIN 70-30 FLEXPEN U-100	T3	
NOVOLIN N FLEXPEN	T3	
NOVOLIN N NPH U-100 INSULIN	T3	
NOVOLIN R FLEXPEN	T3	
NOVOLIN R REGULAR U100 INSULIN	T3	
NOVOLOG FLEXPEN U-100 INSULIN	T3	
NOVOLOG MIX 70-30 U-100 INSULN	T3	
NOVOLOG MIX 70-30FLEXPEN U-100	T3	
NOVOLOG PENFILL U-100 INSULIN	T3	
NOVOLOG U-100 INSULIN ASPART	T3	
ORILISSA ORAL TABLET 150 MG	T5	PA; QL (31 EA per 31 days)
ORILISSA ORAL TABLET 200 MG	T5	PA; QL (62 EA per 31 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)	T3	PA; QL (3 ML per 28 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	T5	PA; QL (15 ML per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML	T5	PA; QL (4 ML per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 20 MG/ML	T5	PA; QL (90 ML per 30 days)
<i>paricalcitol oral</i>	T2	PA-BvD
<i>pioglitazone</i>	T1	QL (31 EA per 31 days)
<i>pioglitazone-glimepiride</i>	T1	QL (31 EA per 31 days)
<i>pioglitazone-metformin</i>	T1	QL (93 EA per 31 days)
<i>prednisolone oral solution</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>prednisolone sodium phosphate oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml), 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	T2	
<i>prednisolone sodium phosphate oral tablet, disintegrating</i>	T4	
<i>prednisone oral solution</i>	T2	
<i>prednisone oral tablet</i>	T1	
<i>prednisone oral tablets, dose pack</i>	T2	
<i>propylthiouracil</i>	T2	
RECORLEV	T5	PA; QL (248 EA per 31 days)
<i>repaglinide oral tablet 0.5 mg</i>	T1	QL (124 EA per 31 days)
<i>repaglinide oral tablet 1 mg</i>	T2	QL (124 EA per 31 days)
<i>repaglinide oral tablet 2 mg</i>	T2	QL (248 EA per 31 days)
RYBELSUS	T3	PA; QL (31 EA per 31 days)
<i>sapropterin</i>	T5	PA
SOLIQUA 100/33	T3	QL (18 ML per 30 days)
SOMAVERT	T5	PA
SYMLINPEN 120	T5	QL (10.8 ML per 28 days)
SYMLINPEN 60	T5	QL (6 ML per 28 days)
SYNAREL	T5	PA
SYNJARDY	T3	QL (62 EA per 31 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 5-1,000 MG	T3	QL (62 EA per 31 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 25-1,000 MG	T3	QL (31 EA per 31 days)
SYNTHROID	T3	
<i>testosterone cypionate</i>	T2	PA
<i>testosterone enanthate</i>	T2	PA
<i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i>	T3	PA
<i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)</i>	T3	PA
<i>testosterone transdermal solution in metered pump w/app</i>	T4	PA
TIROSINT	T4	
TIROSINT-SOL	T4	
<i>tolvaptan</i>	T5	PA
TOUJEO MAX U-300 SOLOSTAR	T3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
TOUJEO SOLOSTAR U-300 INSULIN	T3	
TRADJENTA	T3	QL (31 EA per 31 days)
TRESIBA FLEXTOUCH U-100	T3	
TRESIBA FLEXTOUCH U-200	T3	
TRESIBA U-100 INSULIN	T3	
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 25-5-1,000 MG	T3	QL (31 EA per 31 days)
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG	T3	QL (62 EA per 31 days)
TRULICITY	T3	PA; QL (2 ML per 28 days)
UNITHROID	T3	
VICTOZA 3-PAK	T3	PA; QL (9 ML per 30 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG, 5-500 MG	T3	QL (31 EA per 31 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG	T3	QL (62 EA per 31 days)
XULTOPHY 100/3.6	T3	QL (15 ML per 30 days)
YARGESA	T5	PA; QL (93 EA per 31 days)
ZEGALOGUE AUTOINJECTOR	T3	
ZEGALOGUE SYRINGE	T3	
Gastroenterology		
<i>alose tron oral tablet 0.5 mg</i>	T5	PA; QL (93 EA per 31 days)
<i>alose tron oral tablet 1 mg</i>	T5	PA; QL (62 EA per 31 days)
<i>amoxicil-clarithromy-lansopraz</i>	T4	
<i>aprepitant</i>	T4	PA-BvD
<i>balsalazide</i>	T2	
<i>betaine</i>	T5	
<i>bismuth subcit k-metronidz-tcn</i>	T4	
<i>budesonide oral capsule, delayed, extend. release</i>	T4	
<i>budesonide oral tablet, delayed and ext. release</i>	T5	
CHENODAL	T5	PA
CHOLBAM	T5	PA
<i>cimetidine</i>	T2	
CIMZIA POWDER FOR RECONST	T5	PA; QL (2 EA per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)	T5	PA; QL (2 EA per 28 days)
CLENPIQ	T4	
COMPRO	T3	
CONSTULOSE	T2	
CREON	T3	
<i>cromolyn oral</i>	T4	
<i>dicyclomine oral capsule</i>	T2	
<i>dicyclomine oral solution</i>	T2	
<i>dicyclomine oral tablet</i>	T2	
<i>diphenoxylate-atropine oral liquid</i>	T3	
<i>diphenoxylate-atropine oral tablet</i>	T2	
<i>dronabinol</i>	T4	PA-BvD
EMEND ORAL SUSPENSION FOR RECONSTITUTION	T4	PA-BvD
ENULOSE	T2	
<i>esomeprazole magnesium oral capsule, delayed release(dr/ec)</i>	T2	QL (31 EA per 31 days)
<i>famotidine oral suspension for reconstitution</i>	T1	
<i>famotidine oral tablet 20 mg, 40 mg</i>	T1	
GATTEX 30-VIAL	T5	PA
GAVILYTE-C	T2	
GAVILYTE-G	T2	
GENERLAC	T2	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	T2	
<i>granisetron hcl oral</i>	T4	PA-BvD
<i>hydrocortisone rectal</i>	T3	
<i>hydrocortisone topical cream with perineal applicator 2.5 %</i>	T1	
<i>hydrocortisone-pramoxine rectal cream 1-1 %</i>	T4	
IBSRELA	T5	PA; QL (62 EA per 31 days)
<i>lactulose oral solution 10 gram/15 ml</i>	T1	
<i>lansoprazole oral capsule, delayed release(dr/ec) 15 mg</i>	T3	QL (31 EA per 31 days)
<i>lansoprazole oral capsule, delayed release(dr/ec) 30 mg</i>	T3	QL (62 EA per 31 days)
LINZESS	T3	QL (31 EA per 31 days)
<i>loperamide oral capsule</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>lubiprostone</i>	T3	QL (62 EA per 31 days)
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	T2	
<i>mesalamine oral capsule (with del rel tablets)</i>	T3	QL (186 EA per 31 days)
<i>mesalamine oral capsule, extended release</i>	T4	QL (248 EA per 31 days)
<i>mesalamine oral capsule, extended release 24hr</i>	T4	QL (124 EA per 31 days)
<i>mesalamine oral tablet, delayed release (dr/ec) 1.2 gram</i>	T3	QL (124 EA per 31 days)
<i>mesalamine rectal enema</i>	T4	QL (1860 ML per 31 days)
<i>methscopolamine</i>	T2	
<i>metoclopramide hcl oral solution</i>	T2	
<i>metoclopramide hcl oral tablet</i>	T2	
<i>misoprostol</i>	T2	
MOVANTI	T3	QL (31 EA per 31 days)
MYTESI	T5	QL (62 EA per 31 days)
<i>nitroglycerin rectal</i>	T4	
<i>nizatidine oral capsule</i>	T2	
OICALIVA	T5	PA; QL (31 EA per 31 days)
<i>omeprazole oral capsule, delayed release (dr/ec)</i>	T1	
<i>ondansetron hcl oral solution</i>	T2	PA-BvD
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	T2	PA-BvD
<i>ondansetron oral tablet, disintegrating 4 mg, 8 mg</i>	T2	PA-BvD
<i>pantoprazole oral tablet, delayed release (dr/ec)</i>	T1	
<i>peg 3350-electrolytes</i>	T2	
<i>peg3350-sod sul-nacl-kcl-asb-c</i>	T4	
<i>peg-electrolyte soln</i>	T2	
<i>prochlorperazine</i>	T3	
<i>prochlorperazine maleate</i>	T2	
PROCTOSOL HC TOPICAL	T2	
PROCTOZONE-HC	T2	
<i>rabeprazole oral tablet, delayed release (dr/ec)</i>	T2	QL (62 EA per 31 days)
RECTIV	T4	
RELISTOR ORAL	T5	PA; QL (93 EA per 31 days)
RELISTOR SUBCUTANEOUS SOLUTION	T5	PA; QL (18.6 ML per 31 days)
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML	T5	PA; QL (18.6 ML per 31 days)
RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML	T5	PA; QL (12.4 ML per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>scopolamine base</i>	T3	QL (10 EA per 30 days)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML)	T5	PA; QL (1.2 ML per 56 days)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 360 MG/2.4 ML (150 MG/ML)	T5	PA; QL (2.4 ML per 56 days)
<i>sodium,potassium,mag sulfates</i>	T3	
SUCRAID	T5	PA
<i>sucralfate</i>	T2	
<i>sulfasalazine</i>	T2	
SYMPROIC	T4	PA; QL (31 EA per 31 days)
<i>ursodiol oral capsule 300 mg</i>	T3	
<i>ursodiol oral tablet</i>	T3	
VARUBI	T4	PA-BvD
VIBERZI	T5	PA; QL (62 EA per 31 days)
VOWST	T5	PA; QL (12 EA per 14 days)
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 -14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT, 60,000-189,600- 252,600 UNIT	T3	
Immunology, Vaccines / Biotechnology		
ABRYSVO (PF)	T3	QL (2 EA per 365 days)
ACTHIB (PF)	T3	
ACTIMMUNE	T5	PA
ADACEL(TDAP ADOLESN/ADULT)(PF)	T3	
ARCALYST	T5	PA
AREXVY (PF)	T3	QL (2 EA per 365 days)
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	T5	PA; QL (4 EA per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	T5	PA; QL (4 EA per 28 days)
<i>bcg vaccine, live (pf)</i>	T4	
BESREMI	T5	PA-NS; QL (2 ML per 28 days)
BETASERON SUBCUTANEOUS KIT	T5	PA; QL (14 EA per 28 days)
BEXSERO	T3	
BIVIGAM	T5	PA
BOOSTRIX TDAP	T3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
DAPTACEL (DTAP PEDIATRIC) (PF)	T3	
ENGERIX-B (PF)	T3	PA-BvD
ENGERIX-B PEDIATRIC (PF)	T3	PA-BvD
FULPHILA	T5	
GAMMAGARD LIQUID	T5	PA
GAMMAGARD S-D (IGA < 1 MCG/ML)	T5	PA
GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)	T5	PA
GAMMAPLEX	T5	PA
GAMMAPLEX (WITH SORBITOL)	T5	PA
GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)	T5	PA
GARDASIL 9 (PF)	T3	
GENOTROPIN	T5	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.2 MG/0.25 ML	T4	PA
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.4 MG/0.25 ML, 0.6 MG/0.25 ML, 0.8 MG/0.25 ML, 1 MG/0.25 ML, 1.2 MG/0.25 ML, 1.4 MG/0.25 ML, 1.6 MG/0.25 ML, 1.8 MG/0.25 ML, 2 MG/0.25 ML	T5	PA
GRASTEK	T4	PA
HAVRIX (PF)	T3	
HEPLISAV-B (PF)	T3	PA-BvD
HIBERIX (PF)	T3	
HUMATROPE INJECTION CARTRIDGE 12 MG (36 UNIT), 24 MG (72 UNIT)	T5	PA
HUMATROPE INJECTION CARTRIDGE 6 MG (18 UNIT)	T4	PA
IMOVAX RABIES VACCINE (PF)	T3	PA-BvD
INFANRIX (DTAP) (PF)	T3	
IPOL	T3	
IXCHIQ (PF)	T3	
IXIARO (PF)	T3	
JYNNEOS (PF)	T3	PA-BvD
KINRIX (PF)	T3	
LEUKINE INJECTION RECON SOLN	T5	PA

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
MENACTRA (PF) INTRAMUSCULAR SOLUTION	T3	
MENQUADFI (PF)	T4	
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT	T3	
M-M-R II (PF)	T3	
NEULASTA	T5	
NIVESTYM	T5	
NORDITROPIN FLEXPPO	T5	PA
NUTROPIN AQ NUSPIN	T5	PA
OCTAGAM	T5	PA
ODACTRA	T4	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 10 MG/1.5 ML (6.7 MG/ML)	T5	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 5 MG/1.5 ML (3.3 MG/ML)	T4	PA
OMNITROPE SUBCUTANEOUS RECON SOLN	T5	PA
ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY	T4	PA
PANZYGA	T5	PA
PEDIARIX (PF)	T3	PA-BvD
PEDVAX HIB (PF)	T3	
PEGASYS	T5	PA
PENBRAYA (PF)	T3	
PENTACEL (PF) INTRAMUSCULAR KIT 15LF-48MCG-62DU -10 MCG/0.5ML	T3	
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML	T5	PA; QL (1 ML per 28 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	T5	PA; QL (1 ML per 28 days)
PREHEVBRIO (PF)	T3	PA-BvD
PRIORIX (PF)	T3	
PRIVIGEN	T5	PA
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T3	PA-BvD
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	T5	PA-BvD
PROQUAD (PF)	T3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
QUADRACEL (PF)	T3	
RABA VERT (PF)	T3	PA-BvD
RECOMBIVAX HB (PF)	T3	PA-BvD
RETACRIT	T3	PA-BvD
ROTARIX	T3	
ROTATEQ VACCINE	T3	
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	T5	PA
SHINGRIX (PF)	T3	QL (2 EA per 999 days)
TDVAX	T3	
TENIVAC (PF)	T3	
<i>tetanus, diphtheria tox ped(pf)</i>	T4	
TICOVAC	T3	
TRUMENBA	T3	
TWINRIX (PF)	T3	
TYPHIM VI	T3	
VAQTA (PF)	T3	
VARIVAX (PF)	T3	
XOLREMDI	T5	PA; QL (124 EA per 31 days)
YF-VAX (PF)	T3	
ZARXIO	T5	
ZIEXTENZO	T5	
Miscellaneous Supplies		
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"	T4	
GAUZE PAD TOPICAL BANDAGE 2 X 2 "	T2	
<i>insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 1 ml 29 gauge x 1/2", 1/2 ml 28 gauge</i>	T3	
<i>pen needle, diabetic needle 29 gauge x 1/2"</i>	T4	
Musculoskeletal / Rheumatology		
ACTEMRA ACTPEN	T5	PA; QL (3.6 ML per 28 days)
ACTEMRA SUBCUTANEOUS	T5	PA; QL (3.6 ML per 28 days)
<i>adalimumab-adaz</i>	T5	PA; QL (0.8 ML per 28 days)
<i>adalimumab-adbm subcutaneous pen injector kit 40 mg/0.4 ml</i>	T5	PA; QL (2 EA per 28 days)
<i>adalimumab-adbm subcutaneous pen injector kit 40 mg/0.8 ml</i>	T5	PA; QL (1.6 EA per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>adalimumab-adbm subcutaneous syringe kit 10 mg/0.2 ml</i>	T5	PA; QL (0.4 EA per 28 days)
<i>adalimumab-adbm subcutaneous syringe kit 20 mg/0.4 ml</i>	T5	PA; QL (0.8 EA per 28 days)
<i>adalimumab-adbm subcutaneous syringe kit 40 mg/0.4 ml</i>	T5	PA; QL (2 EA per 28 days)
<i>adalimumab-adbm subcutaneous syringe kit 40 mg/0.8 ml</i>	T5	PA; QL (1.6 EA per 28 days)
ADALIMUMAB-ADBM(CF) PEN CROHNS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	T5	PA; QL (12 EA per 365 days)
ADALIMUMAB-ADBM(CF) PEN CROHNS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	T5	PA; QL (9.6 EA per 365 days)
ADALIMUMAB-ADBM(CF) PEN PS-UV SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	T5	PA; QL (8 EA per 365 days)
ADALIMUMAB-ADBM(CF) PEN PS-UV SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	T5	PA; QL (6.4 EA per 365 days)
<i>alendronate oral solution</i>	T1	
<i>alendronate oral tablet 10 mg, 35 mg, 70 mg</i>	T1	
<i>allopurinol oral tablet 100 mg, 300 mg</i>	T1	
BENLYSTA SUBCUTANEOUS	T5	PA; QL (4 ML per 28 days)
<i>colchicine oral capsule</i>	T3	QL (62 EA per 31 days)
CYLTEZO(CF)	T5	PA; QL (2 EA per 28 days)
CYLTEZO(CF) PEN	T5	PA; QL (2 EA per 28 days)
CYLTEZO(CF) PEN CROHN'S-UC-HS	T5	PA; QL (12 EA per 365 days)
CYLTEZO(CF) PEN PSORIASIS-UV	T5	PA; QL (8 EA per 365 days)
ENBREL MINI	T5	PA; QL (8 ML per 28 days)
ENBREL SUBCUTANEOUS SOLUTION	T5	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5)	T5	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (1 ML)	T5	PA; QL (8 ML per 28 days)
ENBREL SURECLICK	T5	PA; QL (8 ML per 28 days)
EVENITY SUBCUTANEOUS SYRINGE 210MG/2.34ML (105MG/1.17MLX2)	T5	PA; QL (2.34 ML per 28 days)
HUMIRA PEN	T5	PA; QL (2 EA per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF)	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF) PEN	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF) PEN CROHNS-UC-HS	T5	PA; QL (3 EA per 28 days)
HUMIRA(CF) PEN PEDIATRIC UC	T5	PA; QL (4 EA per 28 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T5	PA; QL (3 EA per 28 days)
HYRIMOZ PEN CROHN'S-UC STARTER	T5	PA; QL (4.8 ML per 365 days)
HYRIMOZ PEN PSORIASIS STARTER	T5	PA; QL (3.2 ML per 365 days)
HYRIMOZ(CF) PEDI CROHN STARTER SUBCUTANEOUS SYRINGE 80 MG/0.8 ML	T5	PA; QL (4.8 ML per 365 days)
HYRIMOZ(CF) PEDI CROHN STARTER SUBCUTANEOUS SYRINGE 80 MG/0.8 ML-40 MG/0.4 ML	T5	PA; QL (2.4 ML per 365 days)
HYRIMOZ(CF) PEN SUBCUTANEOUS PEN INJECTOR 40 MG/0.4 ML	T5	PA; QL (0.8 ML per 28 days)
HYRIMOZ(CF) PEN SUBCUTANEOUS PEN INJECTOR 80 MG/0.8 ML	T5	PA; QL (1.6 ML per 28 days)
HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 10 MG/0.1 ML	T5	PA; QL (0.2 ML per 28 days)
HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 20 MG/0.2 ML	T5	PA; QL (0.4 ML per 28 days)
HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	T5	PA; QL (0.8 ML per 28 days)
<i>ibandronate oral</i>	T2	
KEVZARA	T5	PA; QL (2.28 ML per 28 days)
KINERET	T5	PA; QL (18.76 ML per 28 days)
<i>leflunomide</i>	T2	
MITIGARE	T3	QL (62 EA per 31 days)
OLUMIANT	T5	PA; QL (31 EA per 31 days)
ORENCIA CLICKJECT	T5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	T5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML	T5	PA; QL (1.6 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	T5	PA; QL (2.8 ML per 28 days)
OTEZLA ORAL TABLET 30 MG	T5	PA; QL (62 EA per 31 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	T5	PA; QL (55 EA per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
OTREXUP (PF)	T4	PA
<i>penicillamine</i>	T5	
<i>probenecid</i>	T2	
<i>probenecid-colchicine</i>	T2	
PROLIA	T4	PA; QL (1 ML per 180 days)
<i>raloxifene</i>	T3	
RASUVO (PF)	T4	PA
RIDAURA	T5	
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG	T5	PA; QL (31 EA per 31 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG	T5	PA; QL (168 EA per 365 days)
<i>risedronate oral tablet 150 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg</i>	T3	
<i>risedronate oral tablet, delayed release (dr/ec)</i>	T3	
SAVELLA	T4	PA
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML	T5	PA; QL (1 ML per 28 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 50 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML	T5	PA; QL (1 ML per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 50 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
<i>teriparatide subcutaneous pen injector 20 mcg/dose (620mcg/2.48ml)</i>	T5	PA; QL (2.48 ML per 28 days)
TYMLOS	T5	PA; QL (1.56 ML per 30 days)
XELJANZ ORAL SOLUTION	T5	PA; QL (310 ML per 31 days)
XELJANZ ORAL TABLET	T5	PA; QL (62 EA per 31 days)
XELJANZ XR	T5	PA; QL (31 EA per 31 days)
Obstetrics / Gynecology		
ALTAVERA (28)	T2	
ALYACEN 1/35 (28)	T2	
ANGELIQ ORAL TABLET 0.5-1 MG	T4	
APRI	T2	
ARANELLE (28)	T2	
AVIANE	T2	
BALZIVA (28)	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
BLISOVI 24 FE	T2	
BLISOVI FE 1.5/30 (28)	T2	
BRIELLYN	T2	
CAMILA	T2	
CLEOCIN VAGINAL SUPPOSITORY	T4	
CLIMARA PRO	T4	
<i>clindamycin phosphate vaginal</i>	T2	
CLINDESSE	T4	
CRYSELLE (28)	T2	
CYRED EQ	T2	
DEPO-ESTRADIOL	T4	
DEPO-SUBQ PROVERA 104	T4	
<i>desog-e.estradiol/e.estradiol</i>	T2	
<i>desogestrel-ethinyl estradiol</i>	T2	
DOLISHALE	T2	
DOTTI	T2	
<i>drospirenone-ethinyl estradiol</i>	T2	
ELURYNG	T3	
ENPRESSE	T2	
ENSKYCE	T2	
ERRIN	T2	
ESTARYLLA	T2	
<i>estradiol oral</i>	T1	
<i>estradiol transdermal patch semiweekly</i>	T2	
<i>estradiol transdermal patch weekly</i>	T2	
<i>estradiol vaginal</i>	T4	
<i>estradiol-norethindrone acet</i>	T2	
ESTRING	T4	
<i>ethynodiol diac-eth estradiol</i>	T2	
<i>etonogestrel-ethinyl estradiol</i>	T3	
EVAMIST	T4	
FEMRING	T4	
FYAVOLV	T4	
HAILEY 24 FE	T2	
HALOETTE	T3	
HEATHER	T2	
ICLEVIA	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
IMVEXXY MAINTENANCE PACK	T3	
IMVEXXY STARTER PACK	T3	
INCASSIA	T2	
INTROVALE	T2	
ISIBLOOM	T2	
JASMIEL (28)	T2	
JINTELI	T2	
JULEBER	T2	
JUNEL 1.5/30 (21)	T2	
JUNEL 1/20 (21)	T2	
JUNEL FE 1.5/30 (28)	T2	
JUNEL FE 1/20 (28)	T2	
JUNEL FE 24	T2	
KAITLIB FE	T2	
KARIVA (28)	T2	
KELNOR 1/35 (28)	T2	
KELNOR 1/50 (28)	T2	
KURVELO (28)	T2	
LESSINA	T2	
LEVONEST (28)	T2	
<i>levonorgestrel-ethinyl estrad</i>	T2	
<i>levonorg-eth estrad triphasic</i>	T2	
LEVORA-28	T2	
LILETTA	T4	
LORYNA (28)	T2	
LOW-OGESTREL (28)	T2	
LUTERA (28)	T2	
LYLEQ	T2	
LYLLANA	T2	
LYZA	T2	
MARLISSA (28)	T2	
<i>medroxyprogesterone</i>	T2	
MENEST	T4	
<i>metronidazole vaginal gel 0.75 % (37.5mg/5 gram)</i>	T3	
MICONAZOLE-3 VAGINAL SUPPOSITORY	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
MICROGESTIN 1.5/30 (21)	T2	
MICROGESTIN 1/20 (21)	T2	
MICROGESTIN FE 1.5/30 (28)	T2	
MICROGESTIN FE 1/20 (28)	T2	
MILI	T2	
MYFEMBREE	T5	PA; QL (31 EA per 31 days)
NECON 0.5/35 (28)	T2	
<i>noreth-ethinyl estradiol-iron</i>	T2	
<i>norethindrone (contraceptive)</i>	T2	
<i>norethindrone acetate</i>	T2	
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-20 mg-mcg, 1-5 mg-mcg</i>	T2	
<i>norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7)</i>	T2	
<i>norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-35 mcg (28), 0.25-35 mg-mcg</i>	T2	
NORTREL 0.5/35 (28)	T2	
NORTREL 1/35 (21)	T2	
NORTREL 1/35 (28)	T2	
NORTREL 7/7/7 (28)	T2	
NYLIA 1/35 (28)	T2	
NYLIA 7/7/7 (28)	T2	
NYMYO	T2	
ORIAHNN	T5	PA; QL (56 EA per 28 days)
PIMTREA (28)	T2	
PORTIA 28	T2	
PREMARIN VAGINAL	T3	
<i>progesterone micronized</i>	T2	
RECLIPSEN (28)	T2	
SETLAKIN	T2	
SPRINTEC (28)	T2	
SRONYX	T2	
SYEDA	T2	
<i>terconazole</i>	T2	
<i>tranexamic acid oral</i>	T2	
TRI-ESTARYLLA	T2	
TRI-MILI	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
TRI-NYMYO	T2	
TRI-SPRINTEC (28)	T2	
TRIVORA (28)	T2	
TRI-VYLIBRA	T2	
TURQOZ (28)	T2	
VANAZOLE	T3	
VELIVET TRIPHASIC REGIMEN (28)	T2	
VESTURA (28)	T2	
VIENVA	T2	
VYFEMLA (28)	T2	
VYLIBRA	T2	
YUVAFEM	T4	
ZOVIA 1-35 (28)	T2	
Ophthalmology		
<i>acetazolamide</i>	T2	
ACUVAIL (PF)	T4	
ALOMIDE	T4	
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	T3	
<i>apraclonidine</i>	T2	
<i>atropine ophthalmic (eye) drops 1 %</i>	T2	
AZASITE	T4	
<i>azelastine ophthalmic (eye)</i>	T2	
<i>bacitracin ophthalmic (eye)</i>	T2	
<i>bacitracin-polymyxin b</i>	T2	
BESIVANCE	T4	
<i>betaxolol ophthalmic (eye)</i>	T2	
BETIMOL	T4	
BETOPTIC S	T4	
<i>bimatoprost ophthalmic (eye)</i>	T2	
<i>brimonidine ophthalmic (eye) drops 0.1 %</i>	T3	
<i>brimonidine ophthalmic (eye) drops 0.15 %, 0.2 %</i>	T2	
<i>brimonidine-timolol</i>	T3	
<i>brinzolamide</i>	T4	
<i>bromfenac ophthalmic (eye) drops 0.09 %</i>	T2	
<i>carteolol</i>	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
CILOXAN OPHTHALMIC (EYE) OINTMENT	T3	
<i>ciprofloxacin hcl ophthalmic (eye)</i>	T1	
COMBIGAN	T3	
<i>cromolyn ophthalmic (eye)</i>	T2	
<i>cyclosporine ophthalmic (eye)</i>	T3	QL (60 EA per 30 days)
CYSTADROPS	T5	PA; QL (20 ML per 28 days)
CYSTARAN	T5	PA; QL (60 ML per 28 days)
<i>dexamethasone sodium phosphate ophthalmic (eye)</i>	T2	
<i>diclofenac sodium ophthalmic (eye)</i>	T1	
<i>difluprednate</i>	T4	
<i>dorzolamide</i>	T2	
<i>dorzolamide-timolol</i>	T2	
<i>epinastine</i>	T2	
<i>erythromycin ophthalmic (eye)</i>	T2	
<i>fluorometholone</i>	T2	
<i>flurbiprofen sodium</i>	T2	
<i>gatifloxacin</i>	T3	
<i>gentamicin ophthalmic (eye) drops</i>	T1	
ILEVRO	T3	
<i>ketorolac ophthalmic (eye)</i>	T2	
<i>latanoprost</i>	T1	
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	T1	
<i>levofloxacin ophthalmic (eye) drops 0.5 %</i>	T2	
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	T3	QL (5 ML per 31 days)
<i>methazolamide</i>	T2	
<i>moxifloxacin ophthalmic (eye) drops</i>	T3	
NATACYN	T3	
<i>neomycin-bacitracin-poly-hc</i>	T2	
<i>neomycin-bacitracin-polymyxin</i>	T2	
<i>neomycin-polymyxin b-dexameth</i>	T2	
<i>neomycin-polymyxin-gramicidin</i>	T2	
<i>neomycin-polymyxin-hc ophthalmic (eye)</i>	T2	
NEO-POLYCIN	T2	
NEO-POLYCIN HC	T2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
NEVANAC	T4	
<i>ofloxacin ophthalmic (eye)</i>	T2	
OXERVATE	T5	PA; QL (112 ML per 56 days)
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	T2	
POLYCIN	T2	
<i>polymyxin b sulf-trimethoprim</i>	T1	
<i>prednisolone acetate</i>	T2	
<i>prednisolone sodium phosphate ophthalmic (eye)</i>	T2	
RESTASIS	T3	QL (60 EA per 30 days)
RESTASIS MULTIDOSE	T3	QL (5.5 ML per 27 days)
SIMBRINZA	T4	
<i>sulfacetamide sodium ophthalmic (eye) drops</i>	T2	
<i>sulfacetamide sodium ophthalmic (eye) ointment</i>	T1	
<i>sulfacetamide-prednisolone</i>	T2	
<i>tafluprost (pf)</i>	T4	
<i>timolol maleate ophthalmic (eye) drops</i>	T1	
<i>timolol maleate ophthalmic (eye) drops, once daily</i>	T4	
<i>timolol maleate ophthalmic (eye) gel forming solution</i>	T2	
TOBRADEX OPHTHALMIC (EYE) OINTMENT	T3	
TOBRADEX ST	T3	
<i>tobramycin ophthalmic (eye)</i>	T1	
<i>tobramycin-dexamethasone</i>	T2	
TOBREX OPHTHALMIC (EYE) OINTMENT	T3	
<i>travoprost</i>	T3	
<i>trifluridine</i>	T2	
XDEMVY	T5	PA; QL (10 ML per 42 days)
XIIDRA	T3	QL (60 EA per 30 days)
ZIRGAN	T4	ST
ZYLET	T4	
Respiratory And Allergy		
<i>acetylcysteine</i>	T2	PA-BvD
ADEMPAS	T5	PA; QL (93 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation</i>	T3	QL (17 GM per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020503)</i>	T3	QL (13.4 GM per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020983)</i>	NF	
<i>albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg/3 ml (0.083 %), 2.5 mg/0.5 ml</i>	T2	PA-BvD
<i>albuterol sulfate oral syrup</i>	T1	
<i>albuterol sulfate oral tablet</i>	T1	
ALYQ	T5	PA; QL (62 EA per 31 days)
<i>ambrisentan</i>	T5	PA; QL (31 EA per 31 days)
ANORO ELLIPTA	T3	QL (60 EA per 30 days)
<i>arformoterol</i>	T4	PA-BvD
ASMANEX HFA	T3	QL (13 GM per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	T3	QL (1 EA per 30 days)
ATROVENT HFA	T3	QL (25.8 GM per 30 days)
<i>azelastine-fluticasone</i>	T4	QL (23 GM per 30 days)
BERINERT INTRAVENOUS KIT	T5	PA
<i>bosentan</i>	T5	PA; QL (62 EA per 31 days)
BREO ELLIPTA	T3	QL (60 EA per 30 days)
BREYNA	T3	QL (10.3 GM per 30 days)
BREZTRI AEROSPHERE	T3	QL (10.7 GM per 30 days)
BRONCHITOL	T5	PA; QL (560 EA per 28 days)
<i>budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml</i>	T3	PA-BvD
<i>budesonide inhalation suspension for nebulization 1 mg/2 ml</i>	T4	PA-BvD
<i>budesonide-formoterol</i>	T3	QL (10.2 GM per 30 days)
<i>cetirizine oral solution 1 mg/ml</i>	T1	QL (310 ML per 31 days)
CINRYZE	T5	PA; QL (20 EA per 28 days)
CLARINEX-D 12 HOUR	T4	
COMBIVENT RESPIMAT	T3	QL (4 GM per 30 days)
<i>cromolyn inhalation</i>	T5	PA-BvD

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>cyproheptadine</i>	T2	PA
<i>desloratadine oral tablet</i>	T2	QL (31 EA per 31 days)
<i>epinephrine injection auto-injector</i>	T3	
FASENRA PEN	T5	PA; QL (1 ML per 56 days)
FASENRA SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	T5	PA; QL (0.5 ML per 56 days)
FASENRA SUBCUTANEOUS SYRINGE 30 MG/ML	T5	PA; QL (1 ML per 56 days)
<i>flunisolide</i>	T2	QL (50 ML per 25 days)
<i>fluticasone propionate inhalation blister with device</i>	T3	QL (60 EA per 30 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation</i>	T3	QL (12 GM per 30 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation</i>	T3	QL (24 GM per 30 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 44 mcg/actuation</i>	T3	QL (10.6 GM per 30 days)
<i>fluticasone propionate nasal</i>	T1	QL (16 GM per 30 days)
<i>fluticasone propion-salmeterol inhalation aerosol powdr breath activated</i>	T3	QL (1 EA per 30 days)
<i>fluticasone propion-salmeterol inhalation blister with device</i>	T3	QL (60 EA per 30 days)
HAEGARDA	T5	PA
<i>hydroxyzine hcl oral solution 10 mg/5 ml</i>	T2	PA
<i>hydroxyzine hcl oral tablet</i>	T2	PA
<i>icatibant</i>	T5	PA; QL (18 ML per 30 days)
<i>ipratropium bromide inhalation</i>	T1	PA-BvD
<i>ipratropium-albuterol</i>	T2	PA-BvD
KALYDECO ORAL GRANULES IN PACKET 13.4 MG, 5.8 MG, 50 MG, 75 MG	T5	PA; QL (56 EA per 28 days)
KALYDECO ORAL GRANULES IN PACKET 25 MG	T5	PA; QL (62 EA per 31 days)
KALYDECO ORAL TABLET	T5	PA; QL (62 EA per 31 days)
<i>levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/3 ml</i>	T2	PA-BvD
<i>levalbuterol tartrate</i>	T3	QL (30 GM per 30 days)
<i>levocetirizine oral solution</i>	T2	QL (310 ML per 31 days)
<i>levocetirizine oral tablet</i>	T1	QL (31 EA per 31 days)
<i>mometasone nasal</i>	T3	QL (34 GM per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>montelukast</i>	T2	QL (31 EA per 31 days)
NUCALA SUBCUTANEOUS AUTO-INJECTOR	T5	PA; QL (3 ML per 28 days)
NUCALA SUBCUTANEOUS RECON SOLN	T5	PA; QL (3 EA per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML	T5	PA; QL (3 ML per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	T5	PA; QL (0.4 ML per 28 days)
OFEV	T5	PA; QL (62 EA per 31 days)
OPSUMIT	T5	PA; QL (31 EA per 31 days)
ORKAMBI ORAL GRANULES IN PACKET	T5	PA; QL (62 EA per 31 days)
ORKAMBI ORAL TABLET	T5	PA; QL (124 EA per 31 days)
ORLADEYO	T5	PA; QL (31 EA per 31 days)
<i>pirfenidone oral capsule</i>	T5	PA; QL (279 EA per 31 days)
<i>pirfenidone oral tablet</i>	T5	PA; QL (93 EA per 31 days)
<i>promethazine oral syrup</i>	T2	PA
<i>promethazine oral tablet</i>	T4	PA
<i>promethazine rectal suppository 12.5 mg, 25 mg</i>	T2	
PULMOZYME	T5	PA
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	T3	QL (10.6 GM per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	T3	QL (21.2 GM per 30 days)
<i>roflumilast oral tablet 250 mcg</i>	T4	QL (31 EA per 31 days)
<i>roflumilast oral tablet 500 mcg</i>	T3	QL (31 EA per 31 days)
RUCONEST	T5	PA
SAJAZIR	T5	PA; QL (18 ML per 30 days)
SEREVENT DISKUS	T3	QL (60 EA per 30 days)
<i>sildenafil (pulm.hypertension) oral suspension for reconstitution</i>	T5	PA; QL (784 ML per 31 days)
<i>sildenafil (pulm.hypertension) oral tablet</i>	T3	PA; QL (372 EA per 31 days)
SPIRIVA RESPIMAT	T3	QL (4 GM per 30 days)
SPIRIVA WITH HANDIHALER	T3	QL (30 EA per 30 days)
STIOLTO RESPIMAT	T3	QL (4 GM per 30 days)
STRIVERDI RESPIMAT	T4	QL (4 GM per 30 days)
SYMDEKO	T5	PA; QL (56 EA per 28 days)
<i>tadalafil (pulm. hypertension)</i>	T5	PA; QL (62 EA per 31 days)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
TADLIQ	T5	PA; QL (310 ML per 31 days)
TAKHZYRO SUBCUTANEOUS SOLUTION	T5	PA; QL (4 ML per 28 days)
TAKHZYRO SUBCUTANEOUS SYRINGE 150 MG/ML	T5	PA; QL (2 ML per 28 days)
TAKHZYRO SUBCUTANEOUS SYRINGE 300 MG/2 ML (150 MG/ML)	T5	PA; QL (4 ML per 28 days)
<i>terbutaline oral</i>	T4	
THEO-24	T4	
<i>theophylline oral solution</i>	T2	
<i>theophylline oral tablet extended release 12 hr</i>	T2	
<i>theophylline oral tablet extended release 24 hr</i>	T2	
<i>tiotropium bromide</i>	T3	QL (30 EA per 30 days)
TRACLEER ORAL TABLET FOR SUSPENSION	T5	PA; QL (124 EA per 31 days)
TRELEGY ELLIPTA	T3	QL (60 EA per 30 days)
TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL	T5	PA; QL (56 EA per 28 days)
TRIKAFTA ORAL TABLETS, SEQUENTIAL	T5	PA; QL (84 EA per 28 days)
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 32 MCG, 32-48 MCG, 48 MCG, 64 MCG	T5	PA
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16(112)-32(112) -48(28) MCG	T5	PA; QL (504 EA per 365 days)
VENTOLIN HFA	T3	QL (36 GM per 30 days)
WIXELA INHUB	T3	QL (60 EA per 30 days)
XOLAIR	T5	PA
YUPELRI	T5	PA-BvD
<i>zafirlukast oral tablet 10 mg</i>	T2	QL (93 EA per 31 days)
<i>zafirlukast oral tablet 20 mg</i>	T2	QL (62 EA per 31 days)
<i>zileuton</i>	T5	PA; QL (124 EA per 31 days)
ZYFLO	T5	PA; QL (124 EA per 31 days)
Urologicals		
<i>alfuzosin</i>	T2	QL (31 EA per 31 days)
<i>bethanechol chloride</i>	T2	
CIALIS ORAL TABLET 2.5 MG	T4	PA; QL (62 EA per 31 days)
CIALIS ORAL TABLET 5 MG	T4	PA; QL (31 EA per 31 days)
CYSTAGON	T3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
<i>darifenacin</i>	T3	QL (31 EA per 31 days)
<i>dutasteride</i>	T2	QL (31 EA per 31 days)
<i>dutasteride-tamsulosin</i>	T3	QL (31 EA per 31 days)
ELMIRON	T4	
<i>finasteride oral tablet 5 mg</i>	T2	
<i>flavoxate</i>	T2	
MYRBETRIQ ORAL SUSPENSION,EXTENDED REL RECON	T3	QL (300 ML per 30 days)
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR	T3	QL (31 EA per 31 days)
<i>oxybutynin chloride oral syrup</i>	T2	
<i>oxybutynin chloride oral tablet 5 mg</i>	T2	
<i>oxybutynin chloride oral tablet extended release 24hr 10 mg, 5 mg</i>	T2	QL (31 EA per 31 days)
<i>oxybutynin chloride oral tablet extended release 24hr 15 mg</i>	T3	QL (62 EA per 31 days)
OXYTROL	T4	QL (8 EA per 28 days)
<i>potassium citrate oral tablet extended release</i>	T2	
PROCYSBI ORAL GRANULES DEL RELEASE IN PACKET	T5	PA
RIVFLOZA SUBCUTANEOUS SOLUTION	T5	PA; QL (1 ML per 28 days)
RIVFLOZA SUBCUTANEOUS SYRINGE 128 MG/0.8 ML	T5	PA; QL (0.8 ML per 28 days)
RIVFLOZA SUBCUTANEOUS SYRINGE 160 MG/ML	T5	PA; QL (1 ML per 28 days)
<i>silodosin</i>	T4	
<i>solifenacin</i>	T4	QL (31 EA per 31 days)
<i>tadalafil oral tablet 2.5 mg</i>	T4	PA; QL (62 EA per 31 days)
<i>tadalafil oral tablet 5 mg</i>	T4	PA; QL (31 EA per 31 days)
<i>tamsulosin</i>	T1	
<i>tolterodine oral capsule,extended release 24hr</i>	T3	QL (31 EA per 31 days)
<i>tolterodine oral tablet</i>	T3	QL (62 EA per 31 days)
<i>trospium oral capsule,extended release 24hr</i>	T2	QL (31 EA per 31 days)
<i>trospium oral tablet</i>	T2	QL (93 EA per 31 days)
Vitamins, Hematinics / Electrolytes		
<i>calcium acetate(phosphat bind)</i>	T2	
CLINIMIX 5%/D15W SULFITE FREE	T4	PA-BvD
CLINIMIX 4.25%/D10W SULF FREE	T4	PA-BvD

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
CLINIMIX 5%-D20W(SULFITE-FREE)	T4	PA-BvD
CLINIMIX E 4.25%/D10W SUL FREE	T4	PA-BvD
CLINIMIX E 4.25%/D5W SULF FREE	T4	PA-BvD
CLINIMIX E 5%/D15W SULFIT FREE	T4	PA-BvD
CLINIMIX E 5%/D20W SULFIT FREE	T4	PA-BvD
DOJOLVI	T5	PA
<i>fluoride (sodium) oral tablet</i>	T2	
INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %	T4	PA-BvD
ISOLYTE S PH 7.4	T3	PA-BvD
ISOLYTE-P IN 5 % DEXTROSE	T4	PA-BvD
KLOR-CON	T3	
KLOR-CON 10	T3	
KLOR-CON 8	T3	
KLOR-CON M10	T1	
KLOR-CON M15	T1	
KLOR-CON M20	T1	
<i>magnesium sulfate injection</i>	T2	
PLENAMINE	T3	PA-BvD
<i>potassium chlorid-d5-0.45%nacl</i>	T2	
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<i>potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l</i>	T2	
<i>potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l</i>	T2	
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You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Drug Tier	Requirements/Limits
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PROSOL 20 %	T4	PA-BvD
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TRAVASOL 10 %	T3	PA-BvD
TROPHAMINE 10 %	T4	PA-BvD

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<i>fosfomycin tromethamine</i>	7	<i>glyburide-metformin</i>	55	UV-ADOL HS	67
<i>fosinopril</i>	41	<i>glycopyrrolate</i>	60	HUMULIN 70/30 U-100	
<i>fosinopril-hydrochlorothiazide</i> ...	41	GLYXAMBI	55	INSULIN	55
FOTIVDA	14	<i>granisetron hcl</i>	60	HUMULIN 70/30 U-100	
FRAGMIN	41, 42	GRASTEK	63	KWIKPEN	55
<i>frovatriptan</i>	28	<i>griseofulvin microsize</i>	7	HUMULIN N NPH INSULIN	
FRUZAQLA	14	<i>griseofulvin ultramicrosize</i>	7	KWIKPEN	55
FULPHILA	63	<i>guanfacine</i>	28	HUMULIN N NPH U-100	
FUROSCIX	42	GVOKE	55	INSULIN	55
<i>furosemide</i>	42	GVOKE HYPOPEN 2-PACK	55	HUMULIN R REGULAR U-	
FUZEON	7	GVOKE PFS 1-PACK		100 INSULN	55
FYAVOLV	69	SYRINGE	55	HUMULIN R U-500 (CONC)	
FYCOMPA	28	HAEGARDA	76	INSULIN	55
<i>gabapentin</i>	28	HAILEY 24 FE	69	HUMULIN R U-500 (CONC)	
GALAFOLD	55	<i>halcinonide</i>	49	KWIKPEN	55
<i>galantamine</i>	28	<i>halobetasol propionate</i>	49	<i>hydralazine</i>	42
GAMMAGARD LIQUID	63	HALOETTE	69	<i>hydrochlorothiazide</i>	42
GAMMAGARD S-D (IGA < 1		HALOG	49	<i>hydrocodone-acetaminophen</i>	28
MCG/ML)	63	<i>haloperidol</i>	28	<i>hydrocodone-ibuprofen</i>	28
GAMMAKED	63	<i>haloperidol decanoate</i>	28	<i>hydrocortisone</i>	49, 55, 60
GAMMAPLEX	63	<i>haloperidol lactate</i>	28	<i>hydrocortisone butyrate</i>	49
GAMMAPLEX (WITH		HARVONI	7	<i>hydrocortisone valerate</i>	49
SORBITOL)	63	HAVRIX (PF)	63	<i>hydrocortisone-acetic acid</i>	53
GAMUNEX-C	63	HEATHER	69	<i>hydrocortisone-pramoxine</i>	60
GARDASIL 9 (PF)	63	<i>heparin (porcine)</i>	42	<i>hydromorphone</i>	29
<i>gatifloxacin</i>	73	HEPLISAV-B (PF)	63	<i>hydroxychloroquine</i>	8
GATTEX 30-VIAL	60	HETLIOZ	28	<i>hydroxyurea</i>	14
GAUZE PAD	65	HIBERIX (PF)	63	<i>hydroxyzine hcl</i>	76
GAVILYTE-C	60	HORIZANT	28	HYRIMOZ PEN CROHN'S-	
GAVILYTE-G	60	HUMALOG JUNIOR		UC STARTER	67
GAVRETO	14	KWIKPEN U-100	55	HYRIMOZ PEN PSORIASIS	
<i>gefitinib</i>	14	HUMALOG KWIKPEN		STARTER	67
<i>gemfibrozil</i>	42	INSULIN	55	HYRIMOZ(CF)	67
GENERLAC	60	HUMALOG MIX 50-50		HYRIMOZ(CF) PEDI	
GENGRAF	14	KWIKPEN	55	CROHN STARTER	67
GENOTROPIN	63	HUMALOG MIX 75-25		HYRIMOZ(CF) PEN	67
GENOTROPIN MINIQUICK	63	KWIKPEN	55	<i>ibandronate</i>	67
<i>gentamicin</i>	7, 49, 73	HUMALOG MIX 75-25(U-		IBRANCE	14
<i>gentamicin in nacl (iso-osm)</i>	7	100)INSULN	55	IBSRELA	60
GENVOYA	7	HUMALOG TEMPO PEN(U-		IBU	29
GILOTRIF	14	100)INSULN	55	<i>ibuprofen</i>	29
GLASSIA	52	HUMALOG U-100 INSULIN ..	55	<i>icatibant</i>	76
<i>glatiramer</i>	28	HUMATROPE	63	ICLEVIA	69
GLATOPA	28	HUMIRA	67	ICLUSIG	14
GLEOSTINE	14	HUMIRA PEN	66	<i>icosapent ethyl</i>	42

IDHIFA	15	<i>isosorbide dinitrate</i>	42	KISQALI FEMARA CO-	
ILEVRO	73	<i>isosorbide mononitrate</i>	42	PACK	15
<i>imatinib</i>	15	<i>isosorbide-hydralazine</i>	42	KITABIS PAK	8
IMBRUVICA	15	<i>isotretinoin</i>	49	KLISYRI	15
<i>imipenem-cilastatin</i>	8	<i>isradipine</i>	42	KLOR-CON	80
<i>imipramine hcl</i>	29	ISTURISA	56	KLOR-CON 10	80
<i>imipramine pamoate</i>	29	<i>itraconazole</i>	8	KLOR-CON 8	80
<i>imiquimod</i>	49	<i>ivabradine</i>	42	KLOR-CON M10	80
IMOVAX RABIES		<i>ivermectin</i>	8	KLOR-CON M15	80
VACCINE (PF)	63	IWILFIN	15	KLOR-CON M20	80
IMPAVIDO	8	IXCHIQ (PF)	63	KLOXXADO	30
IMVEXXY MAINTENANCE		IXIARO (PF)	63	KOSELUGO	15
PACK	70	JAKAFI	15	KOURZEQ	53
IMVEXXY STARTER PACK	70	JANTOVEN	42	KRAZATI	15
INBRIJA	29	JANUMET	56	KURVELO (28)	70
INCASSIA	70	JANUMET XR	56	<i>labetalol</i>	42
INCRELEX	52	JANUVIA	56	<i>lacosamide</i>	30
<i>indapamide</i>	42	JARDIANCE	56	<i>lactulose</i>	60
<i>indomethacin</i>	29	JASMIEL (28)	70	LAGEVRIO (EUA)	8
INFANRIX (DTAP) (PF)	63	JAVYGTOR	56	<i>lamivudine</i>	8
INGREZZA	29	JAYPIRCA	15	<i>lamivudine-zidovudine</i>	8
INGREZZA INITIATION		JENTADUETO	56	<i>lamotrigine</i>	30
PK(TARDIV)	29	JENTADUETO XR	56	<i>lansoprazole</i>	60
INLYTA	15	JINTELI	70	<i>lanthanum</i>	52
INQOVI	15	JOENJA	52	LANTUS SOLOSTAR U-100	
INREBIC	15	JULEBER	70	INSULIN	56
<i>insulin asp prt-insulin aspart</i>	55	JULUCA	8	LANTUS U-100 INSULIN	56
<i>insulin aspart u-100</i>	55	JUNEL 1.5/30 (21)	70	<i>lapatinib</i>	15
<i>insulin lispro</i>	55	JUNEL 1/20 (21)	70	<i>latanoprost</i>	73
<i>insulin lispro protamin-lispro</i>	55	JUNEL FE 1.5/30 (28)	70	<i>ledipasvir-sofosbuvir</i>	8
<i>insulin syringe-needle u-100</i>	65	JUNEL FE 1/20 (28)	70	<i>leflunomide</i>	67
INTELENCE	8	JUNEL FE 24	70	<i>lenalidomide</i>	15
INTRALIPID	80	JUXTAPID	42	LENVIMA	15
INTROVALE	70	JYNARQUE	56	LESSINA	70
INVEGA HAFYERA	29	JYNNEOS (PF)	63	<i>letrozole</i>	15
INVEGA SUSTENNA	29	KAITLIB FE	70	<i>leucovorin calcium</i>	15
INVEGA TRINZA	29	KALYDECO	76	LEUKERAN	15
INVOKAMET	55	KARIVA (28)	70	LEUKINE	63
INVOKAMET XR	55	KELNOR 1/35 (28)	70	<i>leuprolide</i>	16
INVOKANA	56	KELNOR 1/50 (28)	70	<i>leuprolide (3 month)</i>	16
IPOL	63	KERENDIA	42	<i>levalbuterol hcl</i>	76
<i>ipratropium bromide</i>	53, 76	KESIMPTA PEN	29	<i>levalbuterol tartrate</i>	76
<i>ipratropium-albuterol</i>	76	<i>ketoconazole</i>	8, 49	LEVEMIR FLEXPEN	56
<i>irbesartan</i>	42	<i>ketoprofen</i>	29, 30	LEVEMIR U-100 INSULIN	56
<i>irbesartan-hydrochlorothiazide</i> ..	42	<i>ketorolac</i>	30, 73	<i>levetiracetam</i>	30
ISENTRESS	8	KEVZARA	67	<i>levobunolol</i>	73
ISENTRESS HD	8	KINERET	67	<i>levocarnitine</i>	52
ISIBLOOM	70	KINRIX (PF)	63	<i>levocarnitine (with sugar)</i>	52
ISOLYTE S PH 7.4	80	KIONEX (WITH		<i>levocetirizine</i>	76
ISOLYTE-P IN 5 %		SORBITOL)	52	<i>levofloxacin</i>	8, 73
DEXTROSE	80	KIPROFEN	30	<i>levofloxacin in d5w</i>	8
<i>isoniazid</i>	8	KISQALI	15	LEVONEST (28)	70

<i>levonorgestrel-ethinyl estrad</i>	70	<i>lurasidone</i>	30	<i>methazolamide</i>	73
<i>levonorg-eth estrad triphasic</i>	70	LUTERA (28)	70	<i>methenamine hippurate</i>	9
LEVORA-28	70	LYLEQ	70	<i>methimazole</i>	57
<i>levothyroxine</i>	56	LYLLANA	70	<i>methotrexate sodium</i>	17
LEVOXYL	56	LYNPARZA	16	<i>methotrexate sodium (pf)</i>	17
LIBERVANT	30	LYSODREN	16	<i>methscopolamine</i>	61
<i>lidocaine</i>	49	LYTGOBI	16	<i>methsuximide</i>	31
<i>lidocaine hcl</i>	49	LYZA	70	<i>methylphenidate</i>	31
LIDOCAINE VISCOUS	49	<i>magnesium sulfate</i>	80	<i>methylphenidate hcl</i>	31
<i>lidocaine-prilocaine</i>	49	<i>malathion</i>	49	<i>methylprednisolone</i>	57
LIDODERM	49	<i>maraviroc</i>	8, 9	<i>metoclopramide hcl</i>	61
LILETTA	70	MARLISSA (28)	70	<i>metolazone</i>	42
<i>linezolid</i>	8	MARPLAN	30	<i>metoprolol succinate</i>	43
<i>linezolid in dextrose 5%</i>	8	MATULANE	16	<i>metoprolol ta-hydrochlorothiaz</i> ..	43
LINZESS	60	MATZIM LA	42	<i>metoprolol tartrate</i>	43
<i>liothyronine</i>	56	MAVENCLAD (10 TABLET		<i>metronidazole</i>	9, 49, 70
LIPOFEN	42	PACK)	30	<i>metronidazole in nacl (iso-os)</i>	9
<i>lisdexamfetamine</i>	30	MAVENCLAD (4 TABLET		<i>metyrosine</i>	43
<i>lisinopril</i>	42	PACK)	30	<i>mexiletine</i>	43
<i>lisinopril-hydrochlorothiazide</i>	42	MAVENCLAD (5 TABLET		<i>micafungin</i>	9
LITFULO	52	PACK)	30	MICONAZOLE-3	70
<i>lithium carbonate</i>	30	MAVENCLAD (6 TABLET		MICROGESTIN 1.5/30 (21)	71
<i>lithium citrate</i>	30	PACK)	30	MICROGESTIN 1/20 (21)	71
LITHOSTAT	52	MAVENCLAD (7 TABLET		MICROGESTIN FE 1.5/30	
LIVTENCITY	8	PACK)	30	(28)	71
LOKELMA	52	MAVENCLAD (8 TABLET		MICROGESTIN FE 1/20 (28) ..	71
LONSURF	16	PACK)	30	<i>midodrine</i>	52
<i>loperamide</i>	60	MAVENCLAD (9 TABLET		<i>mifepristone</i>	57
<i>lopinavir-ritonavir</i>	8	PACK)	30	<i>miglitol</i>	57
<i>lorazepam</i>	30	MAVYRET	9	<i>miglustat</i>	57
LORAZEPAM INTENSOL	30	<i>meclizine</i>	61	MILI	71
LORBRENA	16	MEDROL	56	<i>minocycline</i>	9
LORYNA (28)	70	<i>medroxyprogesterone</i>	70	<i>minoxidil</i>	43
<i>losartan</i>	42	<i>mefenamic acid</i>	30	<i>mirtazapine</i>	31, 32
<i>losartan-hydrochlorothiazide</i>	42	<i>mefloquine</i>	9	<i>misoprostol</i>	61
<i>lovastatin</i>	42	<i>megestrol</i>	16	MITIGARE	67
LOW-OGESTREL (28)	70	MEKINIST	16	M-M-R II (PF)	64
<i>loxapine succinate</i>	30	MEKTOVI	16	<i>modafinil</i>	32
<i>lubiprostone</i>	61	<i>meloxicam</i>	30	<i>moexipril</i>	43
LUCEMYRA	30	<i>memantine</i>	30, 31	<i>molindone</i>	32
LUMAKRAS	16	MENACTRA (PF)	64	<i>mometasone</i>	49, 76
LUMIGAN	73	MENEST	70	<i>montelukast</i>	77
LUPRON DEPOT	16	MENQUADFI (PF)	64	<i>morphine</i>	32
LUPRON DEPOT (3		MENVEO A-C-Y-W-135-DIP		<i>morphine concentrate</i>	32
MONTH)	16	(PF)	64	MOUNJARO	57
LUPRON DEPOT (4		<i>mercaptopurine</i>	16	MOVANTIK	61
MONTH)	16	<i>meropenem</i>	9	<i>moxifloxacin</i>	9, 73
LUPRON DEPOT (6		<i>mesalamine</i>	61	<i>moxifloxacin-sod.chloride(iso)</i>	9
MONTH)	16	MESNEX	16	MULPLETA	43
LUPRON DEPOT-PED	16	<i>metaxalone</i>	31	MULTAQ	43
LUPRON DEPOT-PED (3		<i>metformin</i>	56, 57	<i>mupirocin</i>	49
MONTH)	16	<i>methadone</i>	31	MYALEPT	57

MYCAPSSA	17	<i>nitazoxanide</i>	9	NYLIA 1/35 (28)	71
<i>mycophenolate mofetil</i>	17	<i>nitisinone</i>	52	NYLIA 7/7/7 (28)	71
<i>mycophenolate sodium</i>	17	NITRO-BID	43	NYMYO	71
MYFEMBREE	71	<i>nitrofurantoin macrocrystal</i>	9	<i>nystatin</i>	9, 50
MYRBETRIQ	79	<i>nitrofurantoin monohyd/m-cryst</i> ... 9		<i>nystatin-triamcinolone</i>	50
MYTESI	61	<i>nitroglycerin</i>	43, 61	NYSTOP	50
<i>nabumetone</i>	32	NITYR	52	OCALIVA	61
<i>nadolol</i>	43	NIVESTYM	64	OCTAGAM	64
<i>nafacillin</i>	9	<i>nizatidine</i>	61	<i>octreotide acetate</i>	17
<i>naftifine</i>	49	NORDITROPIN FLEXPRO ... 64		ODACTRA	64
<i>naloxone</i>	32	<i>noreth-ethinyl estradiol-iron</i>	71	ODEFSEY	9
<i>naltrexone</i>	32	<i>norethindrone (contraceptive)</i> ... 71		ODOMZO	17
NAMENDA TITRATION		<i>norethindrone acetate</i>	71	OFEV	77
PAK	32	<i>norethindrone ac-eth estradiol</i> ... 71		<i>ofloxacin</i>	9, 53, 74
NAMZARIC	32	<i>norethindrone-e.estradiol-iron</i> ... 71		OGSIVEO	17
<i>naproxen</i>	32	<i>norgestimate-ethinyl estradiol</i> ... 71		OJEMDA	17
<i>naproxen sodium</i>	32	NORTREL 0.5/35 (28)	71	OJJAARA	17
<i>naratriptan</i>	32	NORTREL 1/35 (21)	71	<i>olanzapine</i>	33
NATACYN	73	NORTREL 1/35 (28)	71	<i>olanzapine-fluoxetine</i>	33
<i>nateglinide</i>	57	NORTREL 7/7/7 (28)	71	<i>olmesartan</i>	43
NAYZILAM	32	<i>nortriptyline</i>	32	<i>olmesartan-amlodipin-hcthiazyd</i> . 43	
<i>neбиволol</i>	43	NORVIR	9	<i>olmesartan-hydrochlorothiazide</i> . 43	
NECON 0.5/35 (28)	71	NOURIANZ	32	<i>olopatadine</i>	53
<i>nefazodone</i>	32	NOVOLIN 70/30 U-100		OLUMIANT	67
<i>neomycin</i>	9	INSULIN	57	<i>omega-3 acid ethyl esters</i>	43
<i>neomycin-bacitracin-poly-hc</i> 73		NOVOLIN 70-30 FLEXPEN		<i>omeprazole</i>	61
<i>neomycin-bacitracin-polymyxin</i> .. 73		U-100	57	OMNITROPE	64
<i>neomycin-polymyxin b-</i>		NOVOLIN N FLEXPEN	57	<i>ondansetron</i>	61
<i>dexameth</i>	73	NOVOLIN N NPH U-100		<i>ondansetron hcl</i>	61
<i>neomycin-polymyxin-gramicidin</i> 73		INSULIN	57	ONGENTYS	33
<i>neomycin-polymyxin-hc</i> 53, 73		NOVOLIN R FLEXPEN	57	ONUREG	17
NEO-POLYCIN	73	NOVOLIN R REGULAR		ONZETRA XSAIL	33
NEO-POLYCIN HC	73	U100 INSULIN	57	OPSUMIT	77
NEORAL	17	NOVOLOG FLEXPEN U-100		ORALAIR	64
NEO-SYNALAR	49	INSULIN	57	ORENCIA	67
NERLYNX	17	NOVOLOG MIX 70-30 U-100		ORENCIA CLICKJECT	67
NEUAC	49	INSULN	57	ORENITRAM	43, 44
NEULASTA	64	NOVOLOG MIX 70-		ORGOVYX	17
NEUPRO	32	30FLEXPEN U-100	57	ORIAHNN	71
NEVANAC	74	NOVOLOG PENFILL U-100		ORILISSA	57
<i>nevirapine</i>	9	INSULIN	57	ORKAMBI	77
NEXLETOL	43	NOVOLOG U-100 INSULIN		ORLADEYO	77
NEXLIZET	43	ASPART	57	ORSERDU	17
<i>niacin</i>	43	NUBEQA	17	<i>oseltamivir</i>	9
<i>nicardipine</i>	43	NUCALA	77	OTEZLA	67
NICOTROL	52	NUCYNTA	32	OTEZLA STARTER	67
NICOTROL NS	52	NUEDEXTA	33	OTOVEL	54
<i>nifedipine</i>	43	NUPLAZID	33	OTREXUP (PF)	68
<i>nilutamide</i>	17	NURTEC ODT	33	<i>oxacillin</i>	10
<i>nimodipine</i>	43	NUTROPIN AQ NUSPIN	64	<i>oxacillin in dextrose(iso-osm)</i> 10	
NINLARO	17	NUZYRA	9	<i>oxaprozin</i>	33
<i>nisoldipine</i>	43	NYAMYC	50	<i>oxazepam</i>	33

OXBRYTA	52	<i>pilocarpine hcl</i>	52, 74	PRENATAL VITAMIN	
<i>oxcarbazepine</i>	33	<i>pimecrolimus</i>	50	PLUS LOW IRON	81
OXERVATE	74	<i>pimozide</i>	34	PREVALITE	44
OXISTAT	50	PIMTREA (28)	71	PREVYMIS	10
OXTELLAR XR	33	<i>pindolol</i>	44	PREZCOBIX	10
<i>oxybutynin chloride</i>	79	<i>pioglitazone</i>	57	PREZISTA	10
<i>oxycodone</i>	33	<i>pioglitazone-glimepiride</i>	57	PRIFTIN	10
<i>oxycodone-acetaminophen</i>	33	<i>pioglitazone-metformin</i>	57	<i>primaquine</i>	10
OXYTROL	79	<i>piperacillin-tazobactam</i>	10	<i>primidone</i>	34
OZEMPIC	57	PIQRAY	17	PRIORIX (PF)	64
PACERONE	44	<i>pirfenidone</i>	77	PRIVIGEN	64
<i>paliperidone</i>	33	<i>piroxicam</i>	34	<i>probenecid</i>	68
PALYNZIQ	57	<i>pitavastatin calcium</i>	44	<i>probenecid-colchicine</i>	68
PANDEL	50	PLEGRIDY	64	PROCENTRA	34
PANRETIN	50	PLENAMINE	80	<i>prochlorperazine</i>	61
<i>pantoprazole</i>	61	<i>podofilox</i>	50	<i>prochlorperazine maleate</i>	61
PANZYGA	64	POLYGIN	74	PROCRIT	64
<i>paricalcitol</i>	57	<i>polymyxin b sulfate</i>	10	PROCTOSOL HC	61
<i>paroxetine hcl</i>	33	<i>polymyxin b sulf-trimethoprim</i>	74	PROCTOZONE-HC	61
PAXLOVID	10	POMALYST	18	PROCYSBI	79
<i>pazopanib</i>	17	PONVORY	34	<i>progesterone micronized</i>	71
PEDIARIX (PF)	64	PONVORY 14-DAY		PROGRAF	18
PEDVAX HIB (PF)	64	STARTER PACK	34	PROLASTIN-C	52
<i>peg 3350-electrolytes</i>	61	PORTIA 28	71	PROLIA	68
<i>peg3350-sod sul-nacl-kcl-asb-c</i> ..	61	<i>posaconazole</i>	10	PROMACTA	44
PEGASYS	64	<i>potassium chlorid-d5-</i>		<i>promethazine</i>	77
<i>peg-electrolyte soln</i>	61	<i>0.45%nacl</i>	80	<i>propafenone</i>	44
PEMAZYRE	17	<i>potassium chloride</i>	80	<i>propranolol</i>	44
<i>pen needle, diabetic</i>	65	<i>potassium chloride in 0.9%nacl</i> ..	80	<i>propylthiouracil</i>	58
PENBRAYA (PF)	64	<i>potassium chloride in 5 % dex</i>	80	PROQUAD (PF)	64
<i>penciclovir</i>	50	<i>potassium chloride in lr-d5</i>	80	PROSOL 20 %	81
<i>penicillamine</i>	68	<i>potassium chloride in water</i>	80	<i>protriptyline</i>	34
<i>penicillin g pot in dextrose</i>	10	<i>potassium chloride-0.45 % nacl</i> ..	80	PULMOZYME	77
<i>penicillin g potassium</i>	10	<i>potassium chloride-d5-</i>		PURIXAN	18
<i>penicillin g sodium</i>	10	<i>0.2%nacl</i>	80	<i>pyrazinamide</i>	10
<i>penicillin v potassium</i>	10	<i>potassium chloride-d5-</i>		<i>pyridostigmine bromide</i>	34
PENTACEL (PF)	64	<i>0.9%nacl</i>	81	<i>pyrimethamine</i>	10
<i>pentamidine</i>	10	<i>potassium citrate</i>	79	PYRUKYND	52
<i>pentoxifylline</i>	44	<i>pramipexole</i>	34	QINLOCK	18
<i>perindopril erbumine</i>	44	<i>prasugrel</i>	44	QUADRACEL (PF)	65
PERIOGARD	54	<i>pravastatin</i>	44	<i>quetiapine</i>	34
<i>permethrin</i>	50	<i>praziquantel</i>	10	QUILLIVANT XR	34
<i>perphenazine</i>	33	<i>prazosin</i>	44	<i>quinapril</i>	44
<i>perphenazine-amitriptyline</i>	33	<i>prednisolone</i>	57	<i>quinidine gluconate</i>	44
PERSERIS	33	<i>prednisolone acetate</i>	74	<i>quinidine sulfate</i>	44
PHEBURANE	52	<i>prednisolone sodium phosphate</i>		<i>quinine sulfate</i>	10
<i>phenelzine</i>	33	58, 74	QULIPTA	34
<i>phenobarbital</i>	33	<i>prednisone</i>	58	QVAR REDHALER	77
<i>phenoxybenzamine</i>	44	<i>pregabalin</i>	34	RABAVERT (PF)	65
<i>phenytoin</i>	34	PREHEVBRIO (PF)	64	<i>rabeprazole</i>	61
<i>phenytoin sodium extended</i>	34	PREMARIN	71	RADICAVA ORS STARTER	
PIFELTRO	10			KIT SUSP	34

<i>raloxifene</i>	68	RUCONEST	77	<i>sorafenib</i>	18
<i>ramelteon</i>	34	<i>rufinamide</i>	35	SORINE	44
<i>ramipril</i>	44	RUKOBIA	11	<i>sotalol</i>	44
<i>ranolazine</i>	44	RYBELSUS	58	SOTALOL AF	44
<i>rasagiline</i>	34	RYDAPT	18	SPIRIVA RESPIMAT	77
RASUVO (PF)	68	RYTARY	35	SPIRIVA WITH	
RAVICTI	52	SAJAZIR	77	HANDIHALER	77
RECLIPSEN (28)	71	SANDIMMUNE	18	<i>spironolactone</i>	44
RECOMBIVAX HB (PF)	65	SANTYL	50	<i>spironolacton-hydrochlorothiaz.</i>	45
RECORLEV	58	<i>sapropterin</i>	58	SPRINTEC (28)	71
RECTIV	61	SAVELLA	68	SPRITAM	35
REGRANEX	50	SCSEMBLIX	18	SPRYCEL	18
RELENZA DISKHALER	10	<i>scopolamine base</i>	62	SPS (WITH SORBITOL)	53
RELISTOR	61	SECUADO	35	SRONYX	71
<i>repaglinide</i>	58	<i>selegiline hcl</i>	35	SSD	50
REPATHA PUSHTRONEX	44	<i>selenium sulfide</i>	50	STELARA	50
REPATHA SURECLICK	44	SELZENTRY	11	STIOLTO RESPIMAT	77
REPATHA SYRINGE	44	SEREVENT DISKUS	77	STIVARGA	18
RESTASIS	74	SEROSTIM	65	<i>streptomycin</i>	11
RESTASIS MULTIDOSE	74	<i>sertraline</i>	35	STRIBILD	11
RETACRIT	65	SETLAKIN	71	STRIVERDI RESPIMAT	77
RETEVMO	18	<i>sevelamer carbonate</i>	52	SUBVENITE	35
RETIN-A MICRO PUMP	50	<i>sevelamer hcl</i>	53	SUCRAID	62
REVCOVI	52	SHINGRIX (PF)	65	<i>sucralfate</i>	62
REXULTI	34	SIGNIFOR	18	<i>sulfacetamide sodium</i>	74
REYATAZ	10	<i>sildenafil (pulm.hypertension)</i>	77	<i>sulfacetamide sodium (acne)</i>	50
REYVOW	34	SILIQ	50	<i>sulfacetamide-prednisolone</i>	74
REZDIFFRA	52	<i>silodosin</i>	79	<i>sulfadiazine</i>	11
REZLIDHIA	18	<i>silver sulfadiazine</i>	50	<i>sulfamethoxazole-trimethoprim</i> ..	11
<i>ribavirin</i>	10	SIMBRINZA	74	SULFAMYLON	50
RIDAURA	68	SIMPONI	68	<i>sulfasalazine</i>	62
<i>rifabutin</i>	10	<i>simvastatin</i>	44	<i>sulindac</i>	35
<i>rifampin</i>	10	<i>sirolimus</i>	18	<i>sumatriptan</i>	35
<i>riluzole</i>	52	SIRTURO	11	<i>sumatriptan succinate</i>	35, 36
<i>rimantadine</i>	11	SIVEXTRO	11	<i>sumatriptan-naproxen</i>	36
RINVOQ	68	SKYCLARYS	35	<i>sunitinib malate</i>	18
<i>risedronate</i>	52, 68	SKYRIZI	50, 62	SUNLENCA	11
<i>risperidone</i>	35	<i>sodium chloride</i>	53	SUNOSI	36
<i>risperidone microspheres</i>	34, 35	<i>sodium chloride 0.45 %</i>	81	SYEDA	71
<i>ritonavir</i>	11	<i>sodium chloride 0.9 %</i>	53	SYMDEKO	77
<i>rivastigmine</i>	35	<i>sodium chloride 3 % hypertonic</i> ..	81	SYMLINPEN 120	58
<i>rivastigmine tartrate</i>	35	<i>sodium chloride 5 % hypertonic</i> ..	81	SYMLINPEN 60	58
RIVFLOZA	79	<i>sodium oxybate</i>	35	SYMPAZAN	36
<i>rizatriptan</i>	35	<i>sodium phenylbutyrate</i>	53	SYMPROIC	62
<i>roflumilast</i>	77	<i>sodium polystyrene sulfonate</i>	53	SYMTUZA	11
<i>ropinirole</i>	35	<i>sodium,potassium,mag sulfates</i> ..	62	SYNAREL	58
<i>rosuvastatin</i>	44	<i>sofosbuvir-velpatasvir</i>	11	SYNJARDY	58
ROTARIX	65	SOHONOS	53	SYNJARDY XR	58
ROTATEQ VACCINE	65	<i>solifenacin</i>	79	SYNTHROID	58
ROWEEPRA	35	SOLIUQA 100/33	58	TABLOID	18
ROZLYTREK	18	SOLTAMOX	18	TABRECTA	18
RUBRACA	18	SOMAVERT	58	<i>tacrolimus</i>	18, 50

<i>tadalafil</i>	79	TIBSOVO	19	<i>triamcinolone acetonide</i>	51, 54
<i>tadalafil (pulm. hypertension)</i>	77	TICOVAC	65	<i>triamterene</i>	45
TADLIQ	78	<i>tigecycline</i>	11	<i>triamterene-hydrochlorothiazid</i> ..	45
TAFINLAR	18	<i>timolol maleate</i>	45, 74	<i>triazolam</i>	37
<i>tafluprost (pf)</i>	74	<i>tiopronin</i>	53	TRIDERM	51
TAGRISSE	18	<i>tiotropium bromide</i>	78	<i>trientine</i>	53
TAKHZYRO	78	TIROSINT	58	TRI-ESTARYLLA	71
TALTZ AUTOINJECTOR	50	TIROSINT-SOL	58	<i>trifluoperazine</i>	37
TALTZ SYRINGE	50	TIVICAY	11	<i>trifluridine</i>	74
TALZENNA	18	TIVICAY PD	11	<i>trihexyphenidyl</i>	37
<i>tamoxifen</i>	18	<i>tizanidine</i>	36	TRIJARDY XR	59
<i>tamsulosin</i>	79	TOBI PODHALER	11	TRIKAFTA	78
TASCENSO ODT	36	TOBRADEX	74	<i>trimethoprim</i>	11
TASIGNA	18	TOBRADEX ST	74	TRI-MILI	71
<i>tasimelteon</i>	36	<i>tobramycin</i>	11, 74	<i>trimipramine</i>	37
TAVALISSE	45	<i>tobramycin in 0.225 % nacl</i>	11	TRINTELLIX	37
TAVNEOS	53	<i>tobramycin sulfate</i>	11	TRI-NYMYO	72
<i>tazarotene</i>	50	<i>tobramycin-dexamethasone</i>	74	TRI-SPRINTEC (28)	72
TAZORAC	51	TOBREX	74	TRIUMEQ	11
TAZVERIK	18	<i>tolcapone</i>	36	TRIUMEQ PD	11
TDVAX	65	TOLSURA	11	TRIVORA (28)	72
TEFLARO	11	<i>tolterodine</i>	79	TRI-VYLIBRA	72
TEGRETOL	36	<i>tolvaptan</i>	58	TRIZIVIR	11
TEGRETOL XR	36	<i>topiramate</i>	36	TROKENDI XR	37
TEGSEDI	36	<i>toremifene</i>	19	TROPHAMINE 10 %	81
<i>telmisartan</i>	45	<i>torseamide</i>	45	<i>trospium</i>	79
<i>telmisartan-amlodipine</i>	45	TOUJEO MAX U-300	58	TRULICITY	59
<i>telmisartan-hydrochlorothiazid</i> ..	45	SOLOSTAR	58	TRUMENBA	65
<i>temazepam</i>	36	TOUJEO SOLOSTAR U-300	58	TRUQAP	19
TENCON	36	INSULIN	59	TUKYSA	19
TENIVAC (PF)	65	TOVET EMOLLIENT	51	TURALIO	19
<i>tenofovir disoproxil fumarate</i>	11	TRACLEER	78	TURQOZ (28)	72
TEPMETKO	18	TRADJENTA	59	TWINRIX (PF)	65
<i>terazosin</i>	45	<i>tramadol</i>	36	TYBOST	11
<i>terbinafine hcl</i>	11	<i>tramadol-acetaminophen</i>	36	TYMLOS	68
<i>terbutaline</i>	78	<i>trandolapril</i>	45	TYPHIM VI	65
<i>terconazole</i>	71	<i>tranexamic acid</i>	71	TYVASO DPI	78
<i>teriflunomide</i>	36	<i>tranylcypromine</i>	36	UBRELVY	37
<i>teriparatide</i>	68	TRAVASOL 10 %	81	UNITHROID	59
<i>testosterone</i>	58	<i>travoprost</i>	74	UPTRAVI	45
<i>testosterone cypionate</i>	58	<i>trazodone</i>	37	<i>ursodiol</i>	62
<i>testosterone enanthate</i>	58	TRECATOR	11	<i>valacyclovir</i>	12
<i>tetanus, diphtheria tox ped(pf)</i>	65	TRELEGY ELLIPTA	78	VALCHLOR	51
<i>tetrabenazine</i>	36	TRELSTAR	19	<i>valganciclovir</i>	12
<i>tetracycline</i>	11	TRESIBA FLEXTOUCH U- 100	59	<i>valproic acid</i>	37
THALOMID	19	TRESIBA FLEXTOUCH U- 200	59	<i>valproic acid (as sodium salt)</i>	37
THEO-24	78	TRESIBA U-100 INSULIN	59	<i>valsartan</i>	45
<i>theophylline</i>	78	TRESIBA	59	<i>valsartan-hydrochlorothiazide</i> ...	45
<i>thioridazine</i>	36	<i>tretinoin</i>	51	VALTOCO	37
<i>thiothixene</i>	36	<i>tretinoin (antineoplastic)</i>	19	<i>vancomycin</i>	12
TIADYLT ER	45	TREXALL	19	VANDAZOLE	72
<i>tiagabine</i>	36			VANFLYTA	19

VAQTA (PF)	65	XCOPRI	37	ZIRGAN	74
<i>varenicline</i>	53	XCOPRI MAINTENANCE		ZOKINVY	53
VARIVAX (PF)	65	PACK	38	ZOLINZA	20
VARUBI	62	XCOPRI TITRATION PACK	38	<i>zolmitriptan</i>	38
VELIVET TRIPHASIC		XDEMZY	74	<i>zolpidem</i>	38
REGIMEN (28)	72	XELJANZ	68	ZONISADE	38
VELPHORO	53	XELJANZ XR	68	<i>zonisamide</i>	38
VEMLIDY	12	XERMELO	19	ZONTIVITY	45
VENCLEXTA	19	XGEVA	19	ZOSYN IN DEXTROSE	
VENCLEXTA STARTING		XIFAXAN	12	(ISO-OSM)	12
PACK	19	XIGDUO XR	59	ZOVIA 1-35 (28)	72
<i>venlafaxine</i>	37	XIIDRA	74	ZTALMY	39
VENTOLIN HFA	78	XOFLUZA	12	ZUBSOLV	39
<i>verapamil</i>	45	XOLAIR	78	ZURZUVAE	39
VEREGEN	51	XOLREMDI	65	ZYCLARA	51
VERQUVO	45	XOSPATA	19	ZYDELIG	20
VERSACLOZ	37	XPOVIO	20	ZYFLO	78
VERZENIO	19	XTANDI	20	ZYKADIA	20
VESTURA (28)	72	XULTOPHY 100/3.6	59	ZYLET	74
VIBERZI	62	XURIDEN	53	ZYPREXA RELPREVV	39
VICTOZA 3-PAK	59	XYREM	38		
VIENVA	72	XYWAV	38		
<i>vigabatrin</i>	37	YARGESA	59		
VIGADRONE	37	YF-VAX (PF)	65		
VIGPODER	37	YONSA	20		
VIJOICE	19	YUPELRI	78		
<i>vilazodone</i>	37	YUVAFEM	72		
VIRACEPT	12	<i>zafirlukast</i>	78		
VIREAD	12	<i>zaleplon</i>	38		
VITRAKVI	19	ZARXIO	65		
VIVITROL	37	ZAVZPRET	38		
VIVJOA	12	ZEGALOGUE			
VIZIMPRO	19	AUTOINJECTOR	59		
VONJO	19	ZEGALOGUE SYRINGE	59		
<i>voriconazole</i>	12	ZEJULA	20		
VOSEVI	12	ZELAPAR	38		
VOWST	62	ZELBORAF	20		
VRAYLAR	37	ZEMAIRA	53		
VUMERITY	37	ZEMDRI	12		
VYFEMLA (28)	72	ZENPEP	62		
VYLIBRA	72	ZEPATIER	12		
VYNDAMAX	45	ZEPOSIA	38		
VYNDAQEL	45	ZEPOSIA STARTER KIT			
WAKIX	37	(28-DAY)	38		
<i>warfarin</i>	45	ZEPOSIA STARTER PACK			
WELIREG	19	(7-DAY)	38		
WIXELA INHUB	78	<i>zidovudine</i>	12		
XALKORI	19	ZIEXTENZO	65		
XARELTO	45	ZILBRYSQ	38		
XARELTO DVT-PE TREAT		<i>zileuton</i>	78		
30D START	45	<i>ziprasidone hcl</i>	38		
XATMEP	19	<i>ziprasidone mesylate</i>	38		

Acitretin

Products Affected

- *acitretin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Actemra

Products Affected

- **ACTEMRA ACTPEN**
- **ACTEMRA SUBCUTANEOUS**

PA Criteria	Criteria Details
Exclusion Criteria	Part A covered for Covid-19 in hospitalized patients
Required Medical Information	Documentation of diagnosis. For rheumatoid arthritis, patients must have an inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide). For giant cell arteritis, patients must have therapeutic failure or intolerance to one systemic corticosteroid (e.g., prednisone). For polyarticular juvenile idiopathic arthritis, patients must have an inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For systemic sclerosis-associated interstitial lung disease (SSc-ILD), patients must have therapeutic failure or intolerance to one immunosuppressant (e.g., mycophenolate mofetil, corticosteroids, cyclophosphamide). Documentation of systemic juvenile idiopathic arthritis.
Age Restrictions	Deny if less than 18 years of age for systemic sclerosis-associated interstitial lung disease (SSc-ILD), Rheumatoid Arthritis, and Giant Cell Arteritis or less than 2 years of age for Polyarticular Juvenile Idiopathic Arthritis and Systemic Juvenile Idiopathic Arthritis
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Actimmune

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Adbry

Products Affected

- **ADBRY SUBCUTANEOUS SYRINGE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe atopic dermatitis, documentation of one of the following (1 or 2): 1) trial & failure or intolerance to at least one topical corticosteroid or one topical calcineurin inhibitor (e.g., tacrolimus, pimecrolimus) -OR- 2) severe atopic dermatitis and the member is incapable of applying topical therapies due to the extent of body surface area involvement or severe atopic dermatitis and topical therapies are contraindicated due to severely damaged skin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For Atopic Dermatitis, patients must have a trial/failure, intolerance, or contraindication to both preferred products: 1) Dupixent and 2) If 18 years or older, Rinvoq. For induction therapy, doses above plan quantity limit will be approved when aligned with recommended induction therapy dosing regimen.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ADHD Drugs

Products Affected

- *clonidine hcl oral tablet extended release 12 hr*
- *guanfacine oral tablet extended release 24 hr*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of ADHD -AND- trial/failure, intolerance or contraindication to a stimulant
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Afinitor

Products Affected

- *everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *everolimus (antineoplastic) oral tablet for suspension 2 mg, 3 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) HR mutation status and HER2 mutation status 2) Alternatives tried/failed 3) Concomitant therapy 4) Candidacy for surgical resection
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Aimovig

Products Affected

- **AIMOVIG AUTOINJECTOR
SUBCUTANEOUS AUTO-INJECTOR
140 MG/ML, 70 MG/ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For Episodic Migraine, defined as 4-14 migraine days per month OR Chronic Migraine, defined as 15 or more headaches per month, the following criteria will apply (1-3). 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound or overutilization (e.g. not taking triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use). 3) Trial and failure or intolerance to one agent from 2 unique prophylactic migraine medication classes: e.g. Anti-epileptic drugs (e.g. topiramate), beta-blockers (e.g. propranolol), calcium-channel blockers (e.g. verapamil), tricyclic antidepressants (e.g. amitriptyline) -OR- contraindication to all prophylactic medication classes.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of reduction in migraine frequency
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ajovy

Products Affected

- AJOVY AUTOINJECTOR
- AJOVY SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For Episodic Migraine, defined as 4-14 migraine days per month OR Chronic Migraine, defined as 15 or more headaches per month, the following criteria will apply (1-3). 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound or overutilization (e.g. not taking triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use). 3) Trial and failure or intolerance to one agent from 2 unique prophylactic migraine medication classes: e.g. Anti-epileptic drugs (e.g. topiramate), beta-blockers (e.g. propranolol), calcium-channel blockers (e.g. verapamil), tricyclic antidepressants (e.g. amitriptyline) -OR- contraindication to all prophylactic medication classes.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of reduction in migraine frequency
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Akeega

Products Affected

- **AKEEGA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- All of the following, if applicable to diagnosis: 1) BRCA mutations, 2) Comcomitant therapy with prednisone, 3) Concomitant therapy with a gonadotropin-releasing hormone analog or a bilateral orchiectomy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Alecensa

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK) positive -AND- One of the following (1 or 2): 1) metastatic disease, or 2) will be used as adjuvant treatment following tumor resection of node positive or greater than or equal to 4 cm tumor(s).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Alkindi

Products Affected

- **ALKINDI SPRINKLE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of adrenocortical insufficiency -AND- Therapeutic failure or intolerance to oral generic hydrocortisone tablets.
Age Restrictions	Deny if greater than 17 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Alpha1-Proteinase Inhibitors

Products Affected

- **ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG**
- **GLASSIA**
- **PROLASTIN-C INTRAVENOUS SOLUTION**
- **ZEMAIRA INTRAVENOUS RECON SOLN 1,000 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of panacinar emphysema AND documentation of a decline in forced expiratory volume in 1 second (fev1) despite medical therapy (bronchodilators, corticosteroids) AND documentation of phenotype (pi*zz, pi*znull or pi*nullnull) associated with causing serum alpha 1-antitrypsin of less than 80 mg/dl AND documentation of an alpha 1-antitrypsin serum level below the value of 35% of normal (less than 80 mg/dl).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Covered under Part B when furnished incident to a physician service and is not self-administered.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Alunbrig

Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK) positive
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ampyra

Products Affected

- *dalfampridine*

PA Criteria	Criteria Details
Exclusion Criteria	History of seizure disorder, Cr Cl less than 50ml/min
Required Medical Information	Documentation of diagnosis -AND- documentation that the patient is ambulatory and has walking impairment as evidenced by one of the following. 1. Functional status score (EDSS score). 2. Timed 25-foot Walk Test (T25W).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, documentation supporting improvement in walking impairment from baseline is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Apokyn

Products Affected

- *apomorphine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Parkinson's disease -AND- for use in acute, intermittent treatment of hypomobility off episodes -AND- experiencing off episodes despite the use of oral carbidopa/levodopa -AND- Therapeutic failure, intolerance, or contraindication to one of the following generic products: pramipexole, ropinirole, entacapone, selegiline or rasagiline
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Arikayce

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Mycobacterium avium complex lung disease -AND- Attestation of not achieving negative sputum cultures despite at least 6 months with a multidrug background regimen containing 2 of the following: 1) macrolide 2) rifamycin or 3) ethambutal -AND- Arikayce will be used in conjunction with a background multidrug regimen.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of positive sputum cultures -OR- negative sputum cultures for insufficient period of time (e.g. less than 12 months).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ATTR-CM drugs

Products Affected

- VYNDAMAX
- VYNDAQEL

PA Criteria	Criteria Details
Exclusion Criteria	Concomitantly with transthyretin-lowering agents
Required Medical Information	Documentation of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) with amyloid deposits on cardiac biopsy or scintigraphy with heart contralateral greater than 1.5 (Grade III) -AND- Cardiac involvement supported by cardiac magnetic resonance, echocardiography or serum cardiac biomarker (e.g. B-type natriuretic peptide, cardiac troponin) - AND- Primary (light chain) amyloidosis has been ruled out by immunohistochemistry, mass spectrometry or scintigraphy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of improvement or delayed disease progression from baseline demonstrated by 6-minute walk test, cardiac function (e.g. LVEF, NYHA class), Kansas City Cardiomyopathy Questionnaire-Overall Summary, number of cardiovascular-related hospitalizations or serum cardiac biomarkers (e.g. B-type natriuretic peptide, cardiac troponin)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Atypical Antipsychotics

Products Affected

- *aripiprazole*
- **REXULTI ORAL TABLET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. If medication is being used for major depressive disorder, documentation of adjunctive therapy and therapeutic failure, contraindication or intolerance to one other generic antidepressant in addition to the antidepressant currently being used for the treatment of MDD (e.g. SSRI, SNRI, NDRIs, TCA, MAOI). For Rexulti used for schizophrenia, therapeutic failure, intolerance, or contraindication to one other generic atypical antipsychotic (e.g. quetiapine).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Aubagio

Products Affected

- *teriflunomide*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying agents such as fingolimod, interferons, Copaxone, Tysabri
Required Medical Information	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Augtyro

Products Affected

- AUGTYRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of locally advanced or metastatic non-small cell lung cancer (NSCLC) that is ROS1-positive. Documentation of solid tumors - AND- disease harbors a NTRK gene fusion -AND- one of the following (1-2): 1) disease is locally advanced or metastatic, or 2) surgical resection is likely to result in severe morbidity -AND- one of the following (3-4): 3) disease has progressed following treatment, or 4) the member has no satisfactory alternative therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Auryxia

Products Affected

- AURYXIA

PA Criteria	Criteria Details
Exclusion Criteria	Treatment of iron deficiency anemia
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Auvelity

Products Affected

- AUVELITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of major depressive disorder (MDD) -AND- Therapeutic failure or intolerance to generic bupropion hydrochloride tablets -AND- Therapeutic failure, intolerance or contraindication to one other generic antidepressant (e.g. SNRI, SSRI).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ayvakit

Products Affected

- **AYVAKIT**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) PDGFRA exon 18 mutation status 2) platelet count greater than or equal to 50 x 10 ⁹ /L
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Bafiertam

Products Affected

- **BAFIERTAM**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying agents such as interferons, Copaxone, Tysabri, Aubagio, Gilenya
Required Medical Information	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease) -AND- Therapeutic failure or intolerance to generic dimethyl fumarate
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Balversa

Products Affected

- **BALVERSA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following: 1) FGFR3 mutation status as detected by an FDA approved test 2) disease progression on or after at least on prior line of systemic therapy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Banzel

Products Affected

- *rufinamide*

PA Criteria	Criteria Details
Exclusion Criteria	Patients with familial short QT syndrome
Required Medical Information	Documentation of seizures due to Lennox-Gastaut Syndrome -AND- documentation of adjunctive therapy -AND- therapeutic failure or intolerance of a previous antiepileptic therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Benlysta

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>Documentation of active systemic lupus erythematosus (SLE) -AND- documentation of positive anti-nuclear antibody (ANA) titer (greater than or equal to 1:80) or anti-double-stranded DNA antibody (anti-dsDNA) greater than or equal to 30IU/mL -AND- member will continue to receive concomitant standard of care treatment with use of at least one of the following (alone or in combination): 1.) corticosteroids (e.g. prednisone) 2.) antimalarials (e.g. hydroxychloroquine) 3.) immunosuppressants (e.g. azathioprine, mycophenolate mofetil, or methotrexate) -OR- Documentation of active lupus nephritis -AND- documentation of positive ANA titer (greater than or equal to 1:80) or anti-dsDNA greater than or equal to 30 IU/mL -AND- member will continue to receive concomitant standard of care treatment which includes corticosteroids (e.g. prednisone) with at least one of the following: 1.) mycophenolate for induction followed by mycophenolate for maintenance 2.) cyclophosphamide for induction followed by azathioprine for maintenance</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	<p>For SLE reauthorization, attestation of disease stability or improvement -AND- attestation the member will continue to receive standard of care therapy with corticosteroids, antimalarials, or immunosuppressives. For active LN reauthorization, attestation of disease stability or improvement -AND- attestation the member will continue to receive standard of care therapy with mycophenolate or azathioprine. For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens per indication.</p>

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

Berinert

Products Affected

- **BERINERT INTRAVENOUS KIT**

PA Criteria	Criteria Details
Exclusion Criteria	Member should not be on two acute therapies simultaneously and acute therapy should not be used as prophylactic therapy
Required Medical Information	<p>For the treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) type I & II with the following (1-4): 1) Low C4 level of less than or equal to 14mg/dL or C4 below lower limit of laboratory reference range and 1 of the following (A or B). A) C1 inhibitor (C1INH) antigen level less than or equal to 19mg/dL or below lower limit of laboratory reference range. B) Normal C1INH antigen level and a low C1INH functional level below laboratory reference range. 2) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 3) Medications known to cause angioedema have been evaluated and discontinued. 4) Documentation of member's weight. For the treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) type III with the following (5-9): 5) Documentation of clinical laboratory performance C4, C1INH antigen, or C1INH functional level are within normal limits of laboratory reference ranges. 6) Documentation of family history of HAE or FXII mutation 7) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 8) Medications known to cause angioedema have been evaluated and discontinued. 9) Documentation of member's weight.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For 18 years of age or older, therapeutic failure, intolerance or contraindication to icatibant.

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

Besremi

Products Affected

- **BESREMI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of polycythemia vera
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Bosulif

Products Affected

- **BOSULIF ORAL CAPSULE 100 MG, 50 MG**
- **BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For members 18 years of age and older, one of the following (1, 2): 1) newly diagnosed Philadelphia chromosome (PH) -positive CML in the chronic phase 2) diagnosis of Ph-positive CML in the chronic, accelerated, or blast phase and no longer responding to or intolerant to at least 1 prior therapy. For pediatric patients 1 year of age and older, one of the following (3, 4): 3) newly diagnosed PH-positive CML in the chronic phase 4) diagnosis of Ph-positive CML in the chronic phase and no longer responding to or intolerant to at least 1 prior therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For Bosutinib capsules and 18 years of age or older, inability to swallow tablets is required. For Bosutinib 100mg capsules and pediatric 1 year of age or older, inability to swallow tablets is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Braftovi

Products Affected

- BRAFTOVI

PA Criteria	Criteria Details
Exclusion Criteria	Use in wild-type BRAF melanoma or wild-type BRAF CRC
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) BRAF V600E or V600K mutation status 2) alternatives tried/failed 3) concomitant therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Bronchitol

Products Affected

- BRONCHITOL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cystic fibrosis -AND- Passed a Bronchitol Tolerance Test -AND- Used in conjunction with standard therapies for the management of cystic fibrosis to improve pulmonary function (e.g. bronchodilators, antibiotics, anti-inflammatory therapy).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of increase in FEV1
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Brukinsa

Products Affected

- BRUKINSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For mantle cell lymphoma (MCL), previous treatment with at least 1 prior therapy. For marginal zone lymphoma (MZL), previous treatment with at least 1 anti-CD20-based regimen. For follicular lymphoma (FL), using in combination with obinutuzumab and previous treatment with at least 2 prior lines of systemic therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Buphenyl

Products Affected

- *sodium phenylbutyrate*

PA Criteria	Criteria Details
Exclusion Criteria	Treatment of acute hyperammonemia in urea cycle disorders
Required Medical Information	Documentation of chronic management of urea cycle disorders involving deficiencies of carbamylphosphate synthetase, argininosuccinic acid synthetase, or ornithine transcarbamylase.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cablivi

Products Affected

- CABLIVI INJECTION KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of acquired thrombocytopenic purpura (aTTP) -AND- Used in conjunction with plasma exchange and immunosuppressive therapy (i.e. systemic corticosteroids or rituximab)
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	75 days initial authorization, 28 days reauthorization
Other Criteria	For reauthorization, attestation of remaining signs and symptoms of persistent disease (e.g. suppressed ADAMTS 13 activity level remain present)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cabometyx

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) alternatives tried/failed 2) attestation of first line use 3) concomitant therapy 4) radioactive iodine refractory status
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Calquence

Products Affected

- CALQUENCE
- CALQUENCE (ACALABRUTINIB MAL)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- if applicable to diagnosis, alternatives tried/failed
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Camzyos

Products Affected

- CAMZYOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy -AND- Left ventricular ejection fraction of greater than or equal to 55% -AND- Valsalva left ventricular outflow tract peak gradient of greater than or equal to 50 mmHg at rest or after provocation -AND- Therapeutic failure or intolerance to one of the following (1 or 2) or contraindication to all: 1) Non-vasodilating beta blocker (e.g. metoprolol) 2) non-dihydropyridine calcium channel blocker (e.g. diltiazem) -AND- Not currently treated with and attestation Camzyos will not be used concomitantly with disopyramide, ranolazine, or combination therapy of beta-blocker and calcium channel blocker
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, prescriber attestation of no NYHA class worsening - AND- Not currently treated with and attestation Camzyos will not be used concomitantly with disopyramide, ranolazine, or combination therapy of beta-blocker and calcium channel blocker
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Caplyta

Products Affected

- CAPLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- therapeutic failure, intolerance, or contraindication to one other generic atypical antipsychotic (e.g. quetiapine).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Caprelsa

Products Affected

- **CAPRELSA ORAL TABLET 100 MG,
300 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of symptomatic or progressive medullary thyroid cancer in patients with unresectable locally advanced or metastatic disease
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Carac

Products Affected

- CARAC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Trial and failure of generic topical fluorouracil solution or fluorouracil 5% cream.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	If requesting brand Carac, trial and failure of fluorouracil 0.5% cream.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Carbaglu

Products Affected

- *carglumic acid*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of use as an adjunct therapy for acute hyperammonemia due to hepatic enzyme N-acetylglutamate synthase (NAGS) deficiency, propionic acidemia (PA), or methylmalonic acidemia (MMA) -OR- maintenance therapy for chronic hyperammonemia due to hepatic enzyme N-acetylglutamate synthase (NAGS) deficiency
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Cayston

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of cystic fibrosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of decrease in sputum density of pseudomonas aeruginosa, increase in FEV1 or decrease in number of hospitalizations or pulmonary exacerbations
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cerdelga

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of type 1 Gaucher disease confirmed by the following A. or B. A) With one of the following symptoms (1, 2, 3, 4, or, 5): 1)Hepatomegaly. 2)Splenomegaly. 3)Bone disease (i.e. osteonecrosis, osteopenia, secondary pathologic fractures, bone infarct). 4)Bone marrow complications as defined by anemia with hemoglobin less than or equal to 11.5 g/dL for females or 12.5 g/dL for males or thrombocytopenia with platelet count less than or equal to 120,000/mm ³ . 5)Symptomatic disease (e.g. bone pain, exertional limitation, cachexia). -OR- B) Attestation of deficiency in glucocerebrosidase activity in peripheral leukocytes or genetic testing confirms mutant alleles -AND- Documentation of CYP2D6 metabolizer status (e.g. intermediate metabolizer).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CF drugs

Products Affected

- **KITABIS PAK**
- **TOBI PODHALER**
- *tobramycin in 0.225 % nacl*
- *tobramycin inhalation*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of cystic fibrosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Inhalation solutions covered under Part B when administered in the home setting using a covered nebulizer (i.e. DME). For reauthorization of tobramycin products, attestation of decrease in sputum density of pseudomonas aeruginosa, increase in FEV1 or decrease in number of hospitalizations or pulmonary exacerbations.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Chenodal

Products Affected

- CHENODAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of radiolucent gallstones AND an inadequate response or intolerance to ursodiol therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months for initial approval with an additional 12 months upon renewal
Other Criteria	Safety of use beyond 24 months is not established. For reauthorization, attestation of partial dissolution of gallstones
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cholbam

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of bile acid synthesis disorders due to single enzyme defects (e.g. AKR1D1, CTX, CYP7A1) -OR- documentation of use as adjunctive therapy for peroxisomal disorders (PDs), including Zellweger spectrum disorders, in patients who exhibit manifestations of liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cialis

Products Affected

- **CIALIS ORAL TABLET 2.5 MG, 5 MG**
- *tadalafil oral tablet 2.5 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of benign prostatic hyperplasia (BPH) and trial/failure of at least two alternative medications in the following classes (alpha-1 adrenergic blockers and/or 5-alpha reductase inhibitors)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Cialis, trial and failure of generic tadalafil is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cibinqo

Products Affected

- CIBINQO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe atopic dermatitis, documentation of one of the following (1 or 2): 1) trial & failure or intolerance to at least one topical corticosteroid or one topical calcineurin inhibitor (e.g., tacrolimus, pimecrolimus) -OR- 2) severe atopic dermatitis and the member is incapable of applying topical therapies due to the extent of body surface area involvement or severe atopic dermatitis and topical therapies are contraindicated due to severely damaged skin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For Atopic Dermatitis, patients must have a trial/failure, intolerance, or contraindication to both preferred products: Dupixent and Rinvoq.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cimzia

Products Affected

- **CIMZIA POWDER FOR RECONST**
- **CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. leflunomide). For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For non-radiographic axial spondyloarthritis, inadequate response or intolerance to two nonsteroidal anti-inflammatory drugs (NSAIDs). For moderate to severe psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	<p>For Crohn's disease, patients must have therapeutic failure or intolerance to 2 of the following preferred biologic products: a preferred adalimumab product (i.e. Humira, Cyltezo, Hyrimoz, adalimumab-adaz, or adalimumab-adbm), Stelara, Rinvoq, and Skyrizi SC. For Rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product (i.e. Humira, Cyltezo, Hyrimoz, adalimumab-adaz, or adalimumab-adbm), Enbrel, Actemra SC, Xeljanz/Xeljanz XR and Rinvoq. For plaque psoriasis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product (i.e. Humira, Cyltezo, Hyrimoz, adalimumab-adaz, or adalimumab-adbm), Cosentyx, Taltz, Otezla, Stelara SC, Skyrizi SC, and Enbrel. For ankylosing spondylitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product (i.e. Humira, Cyltezo, Hyrimoz, adalimumab-adaz, or adalimumab-adbm), Cosentyx, Enbrel, Taltz, Rinvoq, and Xeljanz/Xeljanz XR. For Psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: Cosentyx, Taltz, Enbrel, a preferred adalimumab product (i.e. Humira, Cyltezo, Hyrimoz, adalimumab-adaz, or adalimumab-adbm), Xeljanz/Xeljanz XR, Otezla, Stelara SC, Rinvoq, and Skyrizi SC. For initial and induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended initial and induction therapy dosing regimens per indication.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cinryze

Products Affected

- CINRYZE

PA Criteria	Criteria Details
Exclusion Criteria	Member should not be on two prophylactic therapies simultaneously.
Required Medical Information	For the prophylactic treatment of abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) type I & II with the following (1-3): 1) Low C4 level of less than or equal to 14mg/dL or C4 below lower limit of laboratory reference range and 1 of the following (A or B). A) C1 inhibitor (C1INH) antigen level less than or equal to 19mg/dL or below lower limit of laboratory reference range. B) Normal C1INH antigen level and a low C1INH functional level below laboratory reference range. 2) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 3) Medications known to cause angioedema have been evaluated and discontinued. For the prophylactic treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) type III with the following (4-7): 4) Documentation of clinical laboratory performance C4, C1INH antigen, or C1INH functional level are within normal limits of laboratory reference ranges. 5) Documentation of family history of HAE or FXII mutation 6) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 7) Medications known to cause angioedema have been evaluated and discontinued.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Cometriq

Products Affected

- **COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of progressive, metastatic medullary thyroid cancer
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Copiktra

Products Affected

- **COPIKTRA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- if applicable to diagnosis, alternatives tried/failed
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Corlanor

Products Affected

- **CORLANOR ORAL SOLUTION**
- *ivabradine oral tablet 5 mg, 7.5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- All of the following: 1) Normal sinus rhythm, 2) Left ventricular ejection fraction less than or equal to 35 percent, when applicable, 3) Resting heart rate greater than or equal to 70 beats per minute, 4) In patients greater than or equal to 18 years of age, concurrent use of, therapeutic failure, intolerance to the maximum tolerated dose of at least 1 beta-blocker recommended for heart failure (i.e. bisoprolol, carvedilol, metoprolol succinate), or contraindication to beta-blocker use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For oral solution, attestation of inability to swallow tablets is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cosentyx

Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX PEN (2 PENS)
- COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML
- COSENTYX UNOREADY PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For non-radiographic axial spondyloarthritis, inadequate response or intolerance to 2 NSAIDs.
Age Restrictions	Deny if less than 6 years of age for moderate to severe plaque psoriasis -OR- less than 2 years of age for psoriatic arthritis -OR- less than 4 years of age for enthesitis-related arthritis -OR- less than 18 years of age for all other indications
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens per indication. For hidradenitis suppurativa, doses above plan quantity limit will be approved to align with recommended dosing regimen.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cotellic

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) BRAF V600E or V600K mutation status 2) Concomitant therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Cysteamine Ophthalmic Drops

Products Affected

- CYSTADROPS
- CYSTARAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cystinosis -AND- Attestation of accumulation of corneal cystine crystals
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Daraprim

Products Affected

- *pyrimethamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For primary prophylaxis of toxoplasmosis gondii infection, CD4 count less than 100 cells/mm ³ -AND- Toxoplasma IgG positive -AND- failure, intolerance or contraindication to trimethoprim-sulfamethoxazole. For secondary prophylaxis of toxoplasmosis gondii infection, CD4 count less than 200 cells/mm ³ . For secondary prophylaxis of cystoisosporiasis with CD4 count less than 200 cells/mm ³ or acute cystoisosporiasis infection: failure, intolerance or contraindication to trimethoprim-sulfamethoxazole. For primary prophylaxis of Pneumocystis jirovecii pneumonia: diagnosis of HIV - AND- CD4 count less than 200 cells/mm ³ -AND- failure, intolerance or contraindication to trimethoprim-sulfamethoxazole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Daurismo

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of newly diagnosed Acute Myeloid Leukemia -AND- Used in combination with cytarabine -AND- At least one comorbidity that preclude use of intensive induction chemotherapy defined as one of the following: 1) Age greater than or equal to 75 2) Severe cardiac or pulmonary comorbidity 3) Reduced renal function 4) Hepatic impairment 5.) Physician attests patient is not a candidate for intensive induction therapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Daybue

Products Affected

- DAYBUE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Rett syndrome confirmed by all of the following (1 thru 4): 1) Partial or complete loss of acquired purposeful hand skills, 2) Partial or complete loss of acquired spoken language, 3) Gait abnormalities: impaired or absence of ability, 4) Stereotypic hand movements such as hand wringing/squeezing, clapping/tapping, mouthing, and washing/rubbing automatisms
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Daytrana

Products Affected

- *methylphenidate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- trial/failure or intolerance to 2 of the following generic medications: methylphenidate, atomoxetine, or dextroamphetamine/amphetamine.
Age Restrictions	Deny if less than 6 years of age or greater than 17 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Deferasirox

Products Affected

- *deferasirox oral tablet, dispersible*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For chronic iron overload due to blood transfusions, transfusion history of greater than or equal to 100 mL/kg of packed red blood cells (i.e. at least 20 units of packed red blood cells for a 40 kg person or more in individuals weighing more than 40 kg) -And- history of serum ferritin consistently greater than 1,000 mcg/L or liver iron concentration (LIC) greater than or equal to 7 iron per gram of liver dry weight (mg Fe/g dw). For Chronic Iron Overload in Non-Transfusion-Dependent Thalassemia (NTDT) Syndrome, LIC of at least 5 mg Fe/g dw -AND- serum ferritin greater than 300 mcg/L.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization of chronic iron overload due to blood transfusion, continued requirement for regular blood transfusions -AND- serum ferritin level greater than or equal to 500mcg/L or LIC greater than or equal to 3 mg Fe/g dw. For reauthorization of chronic iron overload in NTDT syndrome, LIC greater than or equal to 3 mg Fe/g dw.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Diacomit

Products Affected

- **DIACOMIT ORAL CAPSULE 250 MG, 500 MG**
- **DIACOMIT ORAL POWDER IN PACKET 250 MG, 500 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Dravets syndrome - AND- Used in combination with clobazam
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation supporting reduction in seizure frequency
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Dihydroergotamine

Products Affected

- *dihydroergotamine nasal*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of acute migraine headaches with or without aura -AND- requires non-oral route of administration -AND- therapeutic failure or intolerance to generic sumatriptan nasal spray.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Dojolvi

Products Affected

- DOJOLVI

PA Criteria	Criteria Details
Exclusion Criteria	Concomitantly with another medium chain triglyceride product
Required Medical Information	Documentation of molecularly confirmed long-chain fatty acid oxidation disorders
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Doptelet

Products Affected

- **DOPTELET (10 TAB PACK)**
- **DOPTELET (15 TAB PACK)**
- **DOPTELET (30 TAB PACK)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of thrombocytopenia and chronic liver disease - AND- beneficiary is scheduled to undergo a procedure -OR- Documentation of chronic immune thrombocytopenia -AND- Trial, intolerance, or inadequate response to corticosteroid therapy, immunoglobulin therapy or splenectomy -AND- One of the following (1 or 2): 1) Platelet count less than or equal to $50 \times 10^9/L$ and has significant mucous member bleeding or at least one risk factor for bleeding (e.g. hypertension, peptic ulcer disease). 2) Platelets count of less than or equal to $30 \times 10^9/L$
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	For thrombocytopenia with chronic liver disease- 1 mo. For chronic immune thrombocytopenia- 12 mo.
Other Criteria	Platelet count is provided for applicable dosing.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Doxepin Cream

Products Affected

- *doxepin topical*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- course of therapy will not exceed 8 days -AND- experienced therapeutic failure, intolerance, or contraindication to one of the following (1 or 2): 1) at least 2 generic formulary topical corticosteroids. 2) generic topical tacrolimus or pimecrolimus for topic dermatitis with the facial or anogenital involvement.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Duobrii

Products Affected

- DUOBRII

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of plaque psoriasis -AND- therapeutic failure or intolerance to generic tazarotene cream -AND- therapeutic failure or intolerance to 1 high-potency topical corticosteroid (e.g. betamethasone dipropionate 0.05%, halobetasol propionate 0.05%)
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Dupixent

Products Affected

- **DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML, 300 MG/2 ML**
- **DUPIXENT SYRINGE**
- **SUBCUTANEOUS SYRINGE 100 MG/0.67 ML, 200 MG/1.14 ML, 300 MG/2 ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-2): 1) moderate to severe atopic dermatitis 2) trial & failure, or intolerance to at least one topical corticosteroid -OR- If 2 years of age or older, topical calcineurin inhibitor (e.g., tacrolimus, pimecrolimus) -OR- The member has severe atopic dermatitis and is incapable of applying topical therapies due to the extent of body surface area involvement or topical therapies are contraindicated due to severely damaged skin -OR- Documentation of the following (3-6): 3) moderate-to-severe asthma 4) documented pretreatment FEV1 less than 80 percent predicted in adults or FEV1 less than 90 percent predicted in adolescents or FEV1 reversibility of at least 12% after albuterol administration 5) Blood eosinophils greater than or equal to 150 cells/uL -OR- patient is currently taking daily or alternate-day oral corticosteroids 6) using a medium- or high-dose inhaled corticosteroid and a long acting beta agonist -OR- Documentation of the following (7-8): 7) chronic rhinosinusitis with nasal polyposis (CRSwNP) 8) trial & failure, intolerance or contraindication to intra-nasal corticosteroid and 14 day course of oral corticosteroids -OR- Documentation of the following (9-11): 9) eosinophilic esophagitis 10) esophageal eosinophil count greater than or equal to 15 eos/hpf on esophageal biopsy 11) clinical symptoms of esophageal dysfunction -OR- Documentation of the following (12): 12) prurigo nodularis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization

PA Criteria	Criteria Details
Other Criteria	For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For reauthorization, attestation of positive clinical response to therapy, for atopic dermatitis -OR- attestation of decreased rescue medication or oral corticosteroid use, decreased frequency of severe asthma exacerbation, increased pulmonary function from baseline (e.g. FEV1) or reduction in reported asthma related symptoms, for asthma -OR- attestation of decrease in nasal polyp score or reduction in nasal congestion/obstruction severity score, for CRSwNP -OR- attestation of histological remission (less than 15 eos/hpf) on esophageal biopsy or reduced severity or frequency of clinical symptoms of esophageal dysfunction, for EoE -OR- attestation of reduction in itch or number of nodules or lesions from baseline, for prurigo nodularis
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Duvyzat

Products Affected

- DUVYZAT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Duchenne muscular dystrophy with pathogenic mutation in the dystrophin gene.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

EGFR Tyrosine Kinase Inhibitors

Products Affected

- *erlotinib*
- **GILOTRIF**

PA Criteria	Criteria Details
Exclusion Criteria	Afatinib products: tumors with resistant EGFR mutations. Erlotinib products: use in NSCLC tumors with mutations other than those in FDA-approved indications. Use in combination with platinum based chemotherapy.
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis 1) Epidermal growth factor receptor (EGFR) mutations, including exon 19 deletions, exon 21 (L858R) substitution mutations or exon 20 insertion mutations 2) Alternatives tried/failed 3) Concomitant therapy 4) Line of therapy in which medication will be used
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Emflaza

Products Affected

- *deflazacort*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Duchenne muscular dystrophy (DMD) with mutation of dystrophin gene -AND- onset of weakness or history of DMD starting before age 5 -AND- One of the following (1, 2, or 3). 1) Documented trial/failure, intolerance or contraindication to prednisone. 2) Documented trial of prednisone has resulted in intolerable adverse events (e.g. diabetes, hypertension that is difficult to manage, Cushingoid features, truncal obesity, greater than or equal to 10 percent increase in body weight over a 6 month period). 3) Documented severe behavioral adverse event while on prednisone that warrants prednisone dose reduction impacting efficacy for management of DMD (i.e. abnormal behavior, aggression, irritability, disturbance in mood)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For generic deflazacort suspension and 5 years of age or older, therapeutic failure or intolerance to generic deflazacort tablets or inability to swallow tablets is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Emgality

Products Affected

- **EMGALITY PEN**
- **EMGALITY SYRINGE
SUBCUTANEOUS SYRINGE 120
MG/ML, 300 MG/3 ML (100 MG/ML X 3)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For Episodic Migraine, defined as 4-14 migraine days per month OR Chronic Migraine, defined as 15 or more headaches per month, the following criteria will apply (1-3). 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound or overutilization (e.g. not taking triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use). 3) Trial and failure or intolerance to one agent from 2 unique prophylactic migraine medication classes: e.g. Anti-epileptic drugs (e.g. topiramate), beta-blockers (e.g. propranolol), calcium-channel blockers (e.g. verapamil), tricyclic antidepressants (e.g. amitriptyline) -OR- contraindication to all prophylactic medication classes. For episodic cluster headaches, characterized by severe or very severe unilateral orbital, supraorbital, and/or temporal pain lasting 15 to 180 minutes when left untreated -AND- Attack frequency of at least one attack every other day during the cluster period.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For reauthorization of episodic migraine prevention, attestation of reduction in migraine frequency is required. For reauthorization of cluster headache, attestation of reduction in the number of mean weekly cluster headaches from baseline is required.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Enbrel

Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION
- ENBREL SUBCUTANEOUS SYRINGE
25 MG/0.5 ML (0.5), 50 MG/ML (1 ML)
- ENBREL SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For juvenile idiopathic rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy.
Age Restrictions	Deny if less than 18 years of age for Rheumatoid Arthritis and Ankylosing Spondylitis or less than 2 years of age for Juvenile Idiopathic Arthritis and Psoriatic Arthritis or Less than 4 years of age for Plaque Psoriasis
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For plaque psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Enspryng

Products Affected

- ENSPRYNG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of neuromyelitis optica spectrum disorder (NMOSD) - AND- Attestation of anti-aquaporin-4 (AQP4) antibody positive -AND- Not used in combination with another monoclonal antibody used for the treatment of NMOSD.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of decrease in number of NMOSD relapses. For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Epclusa

Products Affected

- **EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG, 200-50 MG**
- **EPCLUSA ORAL TABLET**
- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance
Age Restrictions	Deny if less than 3 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Epidiolex

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Lennox-Gastaut, Dravet syndromes or Tuberous Sclerosis Complex. For Lennox-Gastaut, trial and failure or intolerance of at least two standard of care treatments (e.g. lamotrigine, clobazam). For Lennox-Gastaut and Dravet syndromes, treatment is in combination with other conventional agents.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation supporting reduction in seizure frequency
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Eprontia

Products Affected

- **EPRONTIA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- inability to swallow pills or food. For migraine, therapeutic failure, intolerance, or contraindication to two generic preventive migraine therapies. For partial onset seizures, primary generalized tonic-clonic seizures, or adjunctive treatment of Lennox-Gastaut Syndrome, therapeutic failure, contraindication, or intolerance to two generic anti-epileptic drugs.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ergotamine

Products Affected

- *ergotamine-caffeine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of use to abort a vascular headache -AND- therapeutic failure or intolerance to a generic triptan -OR- documentation of use to prevent a vascular headache -AND- therapeutic failure or intolerance to generic prophylactic migraine medication
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Erivedge

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- if disease is locally advanced all of the following: 1) disease has recurred following surgery, or is not a candidate for surgery, 2) is not a candidate for radiation.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Erleada

Products Affected

- **ERLEADA ORAL TABLET 240 MG, 60 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- the member meets one of the following (1 or 2) 1. Documentation of use in combination with a GnRH analog -OR- 2. The member has had a bilateral orchiectomy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Evenity

Products Affected

- **EVENITY SUBCUTANEOUS SYRINGE
210MG/2.34ML (105MG/1.17MLX2)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Postmenopausal woman at high risk for fracture, meeting one of the following (1. thru 3.) 1) History of previous hip or vertebral fracture. 2) T-score less than or equal to -2.5. 3) T-score between -1.0 and -2.5 -AND- meets FRAX calculation (A. or B.) A) 10-year risk of major osteoporotic fracture is greater than or equal to 20 percent or B) 10-year risk of hip fracture is greater than or equal to 3 percent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Documentation of trial/failure or intolerance to at least one oral bisphosphonate or all are contraindicated. Covered under Part B for patients eligible for home health services when provider certifies that patient sustained bone fracture related to post-menopausal osteoporosis and is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug or family/caregivers are unable or unwilling to administer the drug. A cumulative lifetime approval of romosozumab will be limited to a coverage duration of 12 months.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Evrysdi

Products Affected

- EVRYSDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of spinal muscular atrophy -AND- Baseline motor function test results (e.g. MFM, CHOP, HINE, RULM, HFMSE, 6MWT) -AND- Not using concomitantly with Spinraza -AND- Molecular genetic testing of 5q SMA showing Homozygous gene deletion, Homozygous conversion mutation or Compound heterozygote
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For reauthorization, attestation of stable or clinically significant improvement in Spinal Muscular Atrophy associated symptoms (e.g. stabilization or decreased decline in motor function compared to the predicted natural history trajectory of disease) -OR- Stable or improved motor function results compared to baseline (e.g. MFM, CHOP, HINE, RULM, HFMSE, 6MWT).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Fabhalta

Products Affected

- FABHALTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) -AND- meets one of the following (1 or 2): 1) PNH mutant clones confirmed by flow cytometry, or 2) glycosylphosphatidylinositol-anchored proteins (GPI-AP)-deficient polymorphonuclear cells (PMNs) confirmed by flow cytometry -AND- meets one of the following (3-6): 3) anemia secondary to PNH (e.g. hemoglobin less than 10.5 g/dL with symptoms of anemia), 4) elevated lactate dehydrogenase (LDH) greater than or equal to 1.5 times the upper limit of normal, 5) history of a thromboembolic event, or 6) clinical findings of systemic complications (e.g. fatigue, hemoglobinuria, abdominal pain, dyspnea, dysphagia, erectile dysfunction, history of blood cell transfusion due to PNH) -AND- will not be used in combination with another complement inhibitor for PNH (e.g. Soliris (eculizumab), Ultomiris (ravulizumab), Empaveli (pegcetacoplan)) unless initially cross-titrating.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of positive clinical response defined as one of the following (1-3): 1) hemoglobin stabilization or increase from baseline, 2) decrease in transfusions from baseline, or 3) decrease in LDH levels from baseline or reduction of hemolysis -AND- will not be used in combination with another complement inhibitor for PNH (e.g. Soliris (eculizumab), Ultomiris (ravulizumab), Empaveli (pegcetacoplan)).
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Fasenra

Products Affected

- **FASENRA PEN**
- **FASENRA SUBCUTANEOUS SYRINGE**
10 MG/0.5 ML, 30 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of severe asthma -AND- history of at least one asthma exacerbations requiring oral or systemic corticosteroid treatment in the past 12 months -AND- documented pretreatment FEV1 less than 80 percent predicted in adults or FEV1 less than 90 percent predicted in children or FEV1 reversibility of at least 12% after albuterol administration despite regular treatment with (a. or b.): a) high dose inhaled corticosteroid and additional asthma controller medication or b.) a medium or high dose inhaled corticosteroid plus a long-acting beta agonist with or without oral corticosteroids and additional asthma controller medication
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Blood eosinophil count (in the absence of other potential causes of eosinophilia, including hypereosinophilic syndromes, neoplastic disease, and known or suspected parasitic infection) greater than or equal to 150 cells/microliter within 6 weeks of initiation of therapy or greater than or equal to 300 cells/uL within 12 months of screening. For induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For reauthorization, attestation of one of the following is required (1-4): 1) decreased rescue medication or oral corticosteroid use, 2) decreased frequency of severe asthma exacerbation, 3) increased pulmonary function from baseline (e.g. FEV1), or 4) reduction in reported asthma related symptoms.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Fecal Microbiota Products

Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of a recent diagnosis of recurrent <i>Clostridioides difficile</i> infection (CDI) -AND- Will be used for prophylaxis and not treatment of recurrent CDI -AND- Attestation that antibiotic treatment for the most recent recurrent CDI is complete or will be completed.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	For reauthorization, attestation of recurrent CDI episodes after administration of the initial fecal microbiota product -AND- Will be used for prophylaxis and not treatment of recurrent CDI -AND- Attestation that antibiotic treatment for the most recent recurrent CDI is complete or will be completed.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ferriprox

Products Affected

- *deferiprone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of transfusional iron overload due to thalassemia syndromes, sickle cell disease and other anemias -AND- transfusion history of greater than or equal to 100 mL/kg of packed red blood cells (i.e. at least 20 units of packed red blood cells for a 40 kg person or more in individuals weighing more than 40 kg) -AND- history of serum ferritin consistently greater than 1,000 mcg/L or liver iron concentration (LIC) greater than or equal to 7 iron per gram of liver dry weight (mg Fe/g dw)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Initial authorization requires trial and failure of deferasirox (generic Exjade) and reauthorization requires failure of generic deferasirox (generic Exjade) if not previously trialed. For reauthorization, continued requirement for regular blood transfusions -AND- serum ferritin level greater than or equal to 500mcg/L or LIC greater than or equal to 3 mg Fe/g dw
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Fetzima

Products Affected

- **FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)** **CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 20 MG, 40 MG, 80 MG**
- **FETZIMA ORAL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of major depressive disorder and trial and failure of two other antidepressants.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Filspari

Products Affected

- **FILSPARI**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with renin-angiotensin system inhibitors (i.e., ACE inhibitors, ARBs, aliskiren) or endothelin receptor antagonists (e.g., Letairis, Opsumit, Tracleer)
Required Medical Information	Documentation of primary immunoglobulin A nephropathy confirmed by biopsy -AND- Risk for rapid disease progression, evidenced by urine protein-to-creatinine ratio greater than or equal to 1.5 g/g or proteinuria greater than or equal to 1 g/day -AND- Therapeutic failure, contraindication, or intolerance to an angiotensin converting enzyme inhibitor or an angiotensin receptor blocker
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, reduction in urine protein-to-creatinine ratio or proteinuria from baseline is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Filsuvez

Products Affected

- **FILSUVEZ**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of dystrophic epidermolysis bullosa (DEB) or junctional epidermolysis bullosa (JEB) -AND- at least one open wound.
Age Restrictions	Deny if less than 6 months of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of improvement in targeted wound(s) - AND- member requires additional courses of treatment.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Fintepla

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Dravet syndrome or Lennox-Gastaut syndrome. For Lennox-Gastaut syndrome, therapeutic failure, contraindication, or intolerance to at least 2 standard of care treatments (e.g. lamotrigine, clobazam).
Age Restrictions	Deny if less than 2 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Firazyr

Products Affected

- *icatibant*
- SAJAZIR

PA Criteria	Criteria Details
Exclusion Criteria	Member should not be on two acute therapies simultaneously and acute therapy should not be used as prophylactic therapy
Required Medical Information	For the treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) type I & II with the following (1-3): 1) Low C4 level of less than or equal to 14mg/dL or C4 below lower limit of laboratory reference range and 1 of the following (A or B). A) C1 inhibitor (C1INH) antigen level less than or equal to 19mg/dL or below lower limit of laboratory reference range. B) Normal C1INH antigen level and a low C1INH functional level below laboratory reference range. 2) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 3) Medications known to cause angioedema have been evaluated and discontinued. For the treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) type III with the following (4-7): 4) Documentation of clinical laboratory performance C4, C1INH antigen, or C1INH functional level are within normal limits of laboratory reference ranges. 5) Documentation of family history of HAE or FXII mutation 6) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 7) Medications known to cause angioedema have been evaluated and discontinued.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Firdapse

Products Affected

- **FIRDAPSE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of positive clinical response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Flector

Products Affected

- *diclofenac epolamine*
- **FLECTOR**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis AND one of the following (1,2 or 3): 1) trial/failure, intolerance, or contraindication to 2 oral generic NSAIDs one of which must be diclofenac 2) hypersensitivity to oral NSAIDs 3) history or high risk for adverse gastrointestinal effects associated with oral NSAID use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Forteo

Products Affected

- *teriparatide subcutaneous pen injector 20 mcg/dose (620mcg/2.48ml)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- at high risk for fracture, meeting one of the following (1. thru 4.) 1) History of previous hip or vertebral fracture. 2) T-score less than or equal to -2.5. 3) T-score between -1.0 and -2.5 -AND- meets FRAX calculation (A. or B.) A) 10-year risk of major osteoporotic fracture is greater than or equal to 20 percent or B) 10-year risk of hip fracture is greater than or equal to 3 percent. 4) Age 40 years or older with T-score between -1.0 and -2.5 -AND- History of glucocorticoid use for at least 3 months at a dose of 5mg per day or more of prednisone (or equivalent).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	Documentation of trial/failure or intolerance to at least one oral bisphosphonate or all are contraindicated. Coverage of human parathyroid hormone related peptide analogs beyond 24 months will not be approved. A cumulative lifetime approval of teriparatide will be limited to a coverage duration of 24 months in the absence of provider attestation that the member remains at or has returned to having a high risk for fracture
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Fotivda

Products Affected

- FOTIVDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- if applicable to diagnosis, previous therapies tried/failed
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Fruzaqla

Products Affected

- **FRUZAQLA ORAL CAPSULE 1 MG, 5 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Furoscix

Products Affected

- **FUROSCIX**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of heart failure classified as NYHA Class II/III - AND- chronic heart failure medication regimen includes an oral loop diuretic (e.g. furosemide, bumetanide, torsemide) -AND- treatment with oral diuretics will replace the use of Furoscix as soon as practical.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Gabapentin

Products Affected

- *gabapentin oral capsule 100 mg, 300 mg, 400 mg*
- *gabapentin oral solution 250 mg/5 ml*
- *gabapentin oral tablet 600 mg, 800 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. When using concomitantly with an opiate agonist, attestation of an intent to monitor and address concomitant drug-drug interaction adverse events for opiate potentiators
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Galafold

Products Affected

- GALAFOLD

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Fabry disease confirmed by biochemical or genetic test -AND- Presence of an amenable GLA variant causing Fabry disease in the clinical context of the patient -AND- Will not be used concomitantly with enzyme replacement therapy (ERT) e.g. Fabrazyme.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of positive clinical response to therapy - AND- Will not be used concomitantly with enzyme replacement therapy (ERT) e.g. Fabrazyme.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Gattex

Products Affected

- **GATTEX 30-VIAL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of short bowel syndrome (SBS) having less than 200 cm of functional small bowel AND if age 18 and older, dependence on parenteral nutrition or intravenous nutritional support for at least 12 months AND requiring parenteral nutrition at least 3 times per week -OR- Documentation of SBS having less than 200 cm of functional small bowel AND age 1 to 17 years of age AND Dependence on parenteral nutrition AND weight of at least 10 kg.
Age Restrictions	Deny if less than 1 year of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, continued dependence on parenteral nutrition/intravenous nutritional support -AND- attestation of increase in weight from baseline or decrease in intravenous parenteral nutrition requirements from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Gavreto

Products Affected

- GAVRETO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis 1) RET mutant or fusion status 2) Radioactive iodine-refractory (if radioactive iodine is appropriate)
Age Restrictions	Deny if less than 18 years of age for NSCLC or less than 12 years of age for thyroid cancer
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Gilenya

Products Affected

- *fingolimod*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying agents such as teriflunomide, interferons, Copaxone, Tysabri
Required Medical Information	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Glatiramer

Products Affected

- **COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML**
- *glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml*
- **GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Gleevec

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis and all of the following, if applicable to diagnosis 1) Alternatives tried 2) Concomitant therapy 3) mutation status, if applicable to diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Gleostine

Products Affected

- GLEOSTINE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) Prior surgical procedures and/or radiotherapeutic procedures 2) Concomitant therapy 3) Alternatives tried/failed
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GLP1

Products Affected

- MOUNJARO
- OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2
- MG/DOSE (8 MG/3 ML)
- RYBELSUS
- TRULICITY
- VICTOZA 3-PAK

PA Criteria	Criteria Details
Exclusion Criteria	Obesity or use for weight loss
Required Medical Information	Documentation of diabetes mellitus type 2
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Grastek

Products Affected

- **GRASTEK**

PA Criteria	Criteria Details
Exclusion Criteria	Asthma (severe, unstable or uncontrolled), concomitant sublingual or subcutaneous immunotherapy, therapy initiation during active allergy season
Required Medical Information	Documentation of allergic rhinitis and use for Timothy grass pollen or cross reactive grass pollens (Sweet Vernal, Orchard, Perennial Rye, Timothy, Kentucky Blue Grass pollen, Redtop, or meadow fescue) -AND- allergic rhinitis with or without conjunctivitis has been confirmed by a pollen specific positive skin test or in vitro testing for pollen-specific IgE antibodies -AND- trial and failure or intolerance to an intranasal steroid and an oral non-sedating antihistamine, intranasal antihistamine or intranasal anticholinergic agent
Age Restrictions	Deny if less than 5 years of age or greater than 65 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Member must also be prescribed an epinephrine auto injector. For reauthorization, attestation of improved allergy symptoms is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Growth Hormone

Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK
- HUMATROPE INJECTION CARTRIDGE
- NORDITROPIN FLEXPRO
- NUTROPIN AQ NUSPIN
- OMNITROPE
- SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis, growth chart, bone age, growth velocity, response to stimulation test, when applicable to meet standard diagnostic criteria. Additionally for growth failure due to chronic kidney disease, glomerular filtration rate is less than 89ml/min per 1.73m ² . For HIV wasting and cachexia, Concurrent use of antiretroviral therapy -AND- weight loss of at least 10 percent from baseline. For short bowel syndrome, receiving management for short bowel syndrome, including specialized nutritional support -AND- less than 200 cm of functional small bowel.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of growth velocity and bone age, as applicable to meet standard continuation of therapy guidelines. For reauthorization of HIV wasting and cachexia, attestation of increase in weight from start of therapy. For reauthorization of short bowel syndrome, continued dependence on parenteral nutrition/intravenous nutritional support -AND- attestation of increase in weight from baseline or decrease in intravenous parenteral nutrition requirements from baseline.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Haegarda

Products Affected

- HAEGARDA

PA Criteria	Criteria Details
Exclusion Criteria	Member should not be on two prophylactic therapies simultaneously.
Required Medical Information	<p>For the prophylactic treatment of abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) type I & II with the following (1-4): 1) Low C4 level of less than or equal to 14mg/dL or C4 below lower limit of laboratory reference range and 1 of the following (A or B). A) C1 inhibitor (C1INH) antigen level less than or equal to 19mg/dL or below lower limit of laboratory reference range. B) Normal C1INH antigen level and a low C1INH functional level below laboratory reference range. 2) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 3) Medications known to cause angioedema have been evaluated and discontinued. 4) Documentation of member's weight. For the prophylactic treatment of acute abdominal, facial, or laryngeal attacks of hereditary angioedema (HAE) type III with the following (5-9): 5) Documentation of clinical laboratory performance C4, C1INH antigen, or C1INH functional level are within normal limits of laboratory reference ranges. 6) Documentation of family history of HAE or FXII mutation 7) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 8) Medications known to cause angioedema have been evaluated and discontinued. 9) Documentation of member's weight.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Harvoni

Products Affected

- **HARVONI ORAL PELLETS IN PACKET**
- **HARVONI ORAL TABLET 90-400 MG**
- *ledipasvir-sofosbuvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance
Age Restrictions	Deny if less than 3 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Hetlioz

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Non-24 Sleep-Wake disorder in patient that is totally blind -AND- evidenced by all the following (1 through 4): 1) history of insomnia, excessive daytime sleepiness, or both alternating with asymptomatic episodes 2) symptoms persistent for at least 3 months 3) daily sleep logs for at least 1 month demonstrating a sleep/wake pattern that delays each day 4) sleep disturbances are not better explained by another current disorder or medication/substance use -OR- Documented diagnosis of Smith-Magenis Syndrome as confirmed by chromosome analysis -AND- patient is experiencing nighttime sleep disturbances (e.g. difficulty falling asleep, shortened sleep cycles, inability to enter REM sleep, or frequent awaking during the night and early in the morning)
Age Restrictions	Deny if less than 16 years of age for nighttime sleep disturbances in Smith-Magenis Syndrome or deny if less than 18 years of age for Non-24 Hour Sleep-Wake Disorder
Prescriber Restrictions	
Coverage Duration	3 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of increased total nighttime sleep or decreased daytime nap duration for Non-24 Sleep-Wake disorder -OR- attestation of positive clinical response to therapy with minimal side effects for Smith-Magenis Syndrome
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

High-risk meds

Products Affected

- *amitriptyline*
- *amitriptyline-chlordiazepoxide*
- *benztropine oral*
- *clomipramine*
- *cyproheptadine*
- *doxepin oral capsule*
- *doxepin oral concentrate*
- *doxepin oral tablet*
- *ergoloid*
- *hydroxyzine hcl oral solution 10 mg/5 ml*
- *hydroxyzine hcl oral tablet*
- *imipramine hcl*
- *imipramine pamoate*
- *metaxalone*
- *perphenazine-amitriptyline*
- *promethazine oral*
- *trimipramine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For all medications subject to this PA group, the following information (1 through 3) is required: 1. Documentation of diagnosis 2. Explanation of risk-benefit profile favoring use of the high-risk medication 3. Attestation of an intent to monitor and address treatment-related adverse events. For target tricyclic antidepressants (TCAs), in addition to criteria 1 through 3 above, trial and failure or documentation of intolerance or contraindication to at least 2 non-high risk alternative drugs for the same indication, if available, is required (e.g. SSRIs and SNRIs). If using a TCA for a medically-accepted indication not shared by the safer alternatives listed, then no trial of alternatives is required.
Age Restrictions	Automatic approval if less than 65 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Doxepin doses less than or equal to 6 mg per day will receive automatic approval.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

High-risk meds phenobarbital

Products Affected

- *phenobarbital*

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for use in sedation/insomnia
Required Medical Information	For use in seizures the following are required: 1. Explanation of risk-benefit profile favoring use of the high-risk medication 2. Attestation of an intent to monitor and address treatment-related adverse events. 3. For new starts, the trial and failure or documentation of intolerance or contraindication to at least 2 non-high risk alternative drugs used for seizures (e.g. carbamazepine, lamotrigine) is required.
Age Restrictions	Automatic approval if less than 65 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Seizure disorders
Part B Prerequisite	No

Homozygous FH

Products Affected

- JUXTAPID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of homozygous familial hypercholesterolemia (HoFH) supported by genetic confirmation of two mutant alleles at LDLR, APOB, PCSK9, or LDLRAP1 gene -OR- untreated LDL-C greater than 400mg/dL or TC greater than 500mg/dl with cutaneous or tendon xanthoma before age 10 yrs or HeFH in both parents -AND- The member has a current LDL-C greater than 100mg/dL despite use of maximally tolerated statin OR statin intolerance -AND- The member will continue to receive concurrent lipid-lowering therapies for the treatment of HoFH
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Patients must have a trial/failure or contraindication to the preferred product Repatha. For reauthorization, documentation showing an LDL-C reduction on Juxtapid therapy from baseline must be provided. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different statins which resolved upon discontinuation of statin or attestation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Horizant

Products Affected

- **HORIZANT ORAL TABLET
EXTENDED RELEASE 300 MG, 600 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of moderate to severe active primary restless leg syndrome -AND- trial and failure of pramipexole or ropinirole -AND- trial and failure of an additional dopaminergic agent, clonidine or pregabalin -OR- Documentation of post herpetic neuralgia and trial and failure of generic gabapentin. When using concomitantly with an opiate agonist, attestation of an intent to monitor and address concomitant drug-drug interaction adverse events for opiate potentiators.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Humira

Products Affected

- *adalimumab-adaz*
- *adalimumab-adbm subcutaneous pen injector kit 40 mg/0.4 ml, 40 mg/0.8 ml*
- *adalimumab-adbm subcutaneous syringe kit 10 mg/0.2 ml, 20 mg/0.4 ml, 40 mg/0.4 ml, 40 mg/0.8 ml*
- **ADALIMUMAB-ADBM(CF) PEN CROHNS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML, 40 MG/0.8 ML**
- **ADALIMUMAB-ADBM(CF) PEN PS-UV SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML, 40 MG/0.8 ML**
- **CYLTEZO(CF)**
- **CYLTEZO(CF) PEN**
- **CYLTEZO(CF) PEN CROHN'S-UC-HS**
- **CYLTEZO(CF) PEN PSORIASIS-UV**
- **HUMIRA PEN**
- **HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML**
- **HUMIRA(CF)**
- **HUMIRA(CF) PEN**
- **HUMIRA(CF) PEN CROHNS-UC-HS**
- **HUMIRA(CF) PEN PEDIATRIC UC**
- **HUMIRA(CF) PEN PSOR-UV-ADOL HS**
- **HYRIMOZ PEN CROHN'S-UC STARTER**
- **HYRIMOZ PEN PSORIASIS STARTER**
- **HYRIMOZ(CF) PEDI CROHN STARTER SUBCUTANEOUS SYRINGE 80 MG/0.8 ML, 80 MG/0.8 ML- 40 MG/0.4 ML**
- **HYRIMOZ(CF) PEN SUBCUTANEOUS PEN INJECTOR 40 MG/0.4 ML, 80 MG/0.8 ML**
- **HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For ankylosing spondylitis, inadequate response or intolerance to at least one nonsteroidal anti-inflammatory drug (NSAID). For moderate to severe juvenile idiopathic rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For uveitis, inadequate response or intolerance to 1 immunosuppressant or corticosteroid, or all are contraindicated.

PA Criteria	Criteria Details
Age Restrictions	Deny if less than 18 years of age for Rheumatoid Arthritis, Psoriatic Arthritis, Plaque Psoriasis, and Ankylosing Spondylitis or less than 12 years of age for Hidradenitis Suppurative or Less than 6 years of age for Crohn's disease or Less than 5 years of age for Ulcerative Colitis or less than 2 years of age for Juvenile Idiopathic Arthritis and Uveitis
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For plaque psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen. For rheumatoid arthritis therapy without concomitant methotrexate, doses above plan quantity limit will be approved aligned with recommended weekly dosing regimen. For pediatric ulcerative colitis and hidradenitis suppurativa, doses above plan quantity limit will be approved to align with recommended dosing regimen. Induction therapy or treatment regimens for other indications are aligned with plan quantity limit on Humira starter kit. Please Note for New Starts Only: Covered preferred adalimumab products include Humira with NDC starting 00074, Cyltezo with NDC starting 00597, Hyrimoz with NDC starting 61314, adalimumab-adaz with NDC starting 61314, and adalimumab-adbm with NDC starting 00597.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ibrance

Products Affected

- **IBRANCE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of HR-positive, HER2-negative advanced or metastatic breast cancer -AND- meets one of the following (1 or 2): 1) documentation of use with an aromatase inhibitor as initial endocrine-based therapy -OR- 2) documentation of use with fulvestrant in patients with disease progression following endocrine therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ibsrela

Products Affected

- **IBSRELA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of irritable bowel syndrome with constipation -AND- failure or intolerance to Linzess -AND- if member is female, failure or intolerance to lubiprostone.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Iclusig

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Exclusion Criteria	Treatment of newly-diagnosed chronic phase CML
Required Medical Information	Documentation of T3151+ chronic myeloid leukemia (CML) -OR- documentation of chronic phase CML and member has experienced resistance or intolerance to at least two prior kinase inhibitors -OR- documentation of accelerated phase or blast phase CML and no other kinase inhibitor is indicated -OR- member is using Iclusig as monotherapy and meets one of the following (1-2): 1) documentation of T3151+ acute lymphoblastic leukemia (ALL) 2) documentation of Ph+ ALL and no other tyrosine kinase inhibitor therapy is indicated -OR- member has newly diagnosed Ph+ ALL and is using Iclusig in combination with chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Idhifa

Products Affected

- **IDHIFA ORAL TABLET 100 MG, 50 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA approved test
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

IG

Products Affected

- **BIVIGAM**
- **GAMMAGARD LIQUID**
- **GAMMAGARD S-D (IGA**
- **GAMMAKED INJECTION SOLUTION**
- **GAMMAPLEX**
- **GAMMAPLEX (WITH SORBITOL)**
- **GAMUNEX-C INJECTION SOLUTION**
- **1 GRAM/10 ML (10 %)**
- **OCTAGAM**
- **PANZYGA**
- **PRIVIGEN**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>Documentation of diagnosis. For select diagnoses the following apply 1) For Myasthenia Gravis Syndrome, documentation that the patient is refractory to other standard therapies (e.g., cholinesterase inhibitors, corticosteroids, azathioprine) given in therapeutic doses over at least 3 months OR is intolerant/contraindication to those standard therapies. 2) For Multiple Sclerosis, patient is refractory to other standard therapies (e.g., interferons) given in therapeutic doses over at least 3 months OR is intolerant/contraindication to those standard therapies. 3) For Inflammatory Myopathies, the patient is refractory to corticosteroids given in therapeutic doses over at least 4 months OR is intolerant/contraindication to corticosteroids or immunosuppressants. 4) For B-cell CLL, associated with recurrent bacterial infections OR with Associated Hypogammaglobulinemia defined as IgG level less than 600mg/dL or evidence of a specific antibody deficiency. 5) For Bone Marrow Transplantation, the member is 20 years of age or older and within the first 100 days after transplantation. 6) For Dermatomyositis/Polymyositis, trial and failure, intolerance, or contraindication to standard fist line therapy (i.e. corticosteroids or immunosuppressants). 7) For Pediatric HIV, the patient is less than 13 y.o. who have entry CD4 lymphocyte count greater than or equal to 200/mcl and IgG less than 400mg/dL OR recurrent bacterial infections. 8) For Guillain-Barre syndrome, impaired function by objective assessment and/or objective findings on physical exam at the time of initial therapy and IVIG therapy must be initiated within 2 weeks of symptom onset. 9) For Autoimmune Mucocutaneous Blistering Diseases (e.g. Stevens-Johnson Syndrome), trial and failure, intolerance, or contraindication to conventional therapy (e.g. corticosteroids) or the patient has rapidly progressive disease in which a clinical response could not be affected quickly enough using conventional agents.</p>

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Covered under Part B when administered in the home to a member with a diagnosis of primary immunodeficiency disease
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Myasthenia Gravis syndrome, Multiple Sclerosis, Inflammatory Myopathies, Polymyositis, Bone Marrow Transplant, Pediatric HIV, Guillain-Barre syndrome, Autoimmune Mucocutaneous Blistering Diseases
Part B Prerequisite	No

Imbruvica

Products Affected

- **IMBRUVICA ORAL CAPSULE 140 MG, 280 MG, 420 MG, 70 MG**
- **IMBRUVICA ORAL SUSPENSION**
- **IMBRUVICA ORAL TABLET 140 MG,**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) 17p deletion status 2) Alternatives tried/failed 3) concomitant therapy. For suspension, members must also have an inability to swallow oral tablets or oral capsules.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Inbrija

Products Affected

- **INBRIJA INHALATION CAPSULE,
W/INHALATION DEVICE**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of use for the treatment of intermittent off episodes of Parkinson's disease while on carbidopa/levodopa
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of positive clinical response
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Increlex

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of severe primary IGF-1 deficiency and all of the following: 1) Normal or elevated response (greater than 10 ng/ml) to two (2) of the following standard growth hormone stimulation tests: arginine, clonidine, glucagon, insulin, levodopa, propranolol. 2) Serum IGF-1 concentration that is less than or equal to three (3) standard deviations below the normal value based on laboratory reference range. 3) Height less than or equal to three (3) standard deviations below normal (at or below the third percentile for gender and age). 4) If female, bone age less than or equal to 14 years. If male, bone age less than or equal to 16. - OR- Documentation of diagnosis of growth hormone deficiency caused by gene deletion and all of the following: 1) Growth velocity at least 2 standard deviations below the age-appropriate mean or height at least 2.25 standard deviations below the age-appropriate mean. 2) Subnormal response (less than 10 ng/mL) to two (2) of the following standard growth hormone stimulation tests: arginine, clonidine, glucagon, insulin, levodopa, propranolol. 3) Development of neutralizing antibodies to growth hormone product(s). 4) If female, bone age of less than or equal to 14 years. If male, bone age less than or equal to 16.
Age Restrictions	Deny if greater than 17 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of growth velocity and bone age, as applicable to meet standard continuation of therapy guidelines
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Ingrezza

Products Affected

- **INGREZZA INITIATION PK(TARDIV)**
- **INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of tardive dyskinesia -OR- documentation of chorea associated with Huntington's disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Inlyta

Products Affected

- INLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) Alternatives tried/failed 2) Concomitant therapy 3) Line of therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Inqovi

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation chronic myelomonocytic leukemia. Documentation of de novo or secondary myelodysplastic syndrome -AND- One of the following (1 or 2): 1) French American-British MDS subtypes of refractory anemia, refractory anemia with ringed sideroblasts or refractory anemia with excess blasts. 2) International Prognostic Scoring System group of intermediate-1, intermediate-2 or high-risk.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Inrebic

Products Affected

- **INREBIC**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of intermediate-2 or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis per an accepted risk stratification tool for myelofibrosis (e.g., International Prognostic Scoring System [IPSS]) -AND- If a new start, baseline platelet count of greater than $50 \times 10^9/L$
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Baseline platelet count to be provided.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Interferon Alfa

Products Affected

- PEGASYS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Interferon Beta

Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT
- BETASERON SUBCUTANEOUS KIT
- PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML
- PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Interleukin-1b Blockers

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For Deficiency of Interleukin-1 Receptor Antagonist (DIRA), documentation of need for maintenance of remission. For Recurrent Pericarditis (RP), documentation of trial/failure or intolerance to one, or contraindication to all of the following: oral nonsteroidal anti-inflammatory drug (NSAID), systemic corticosteroid, or colchicine.
Age Restrictions	Deny if less than 12 years of age for Recurrent Pericarditis and Cryopyrin-Associated Periodic Syndromes
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For DIRA: patient must weigh 10kg or more
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

IPF Agents

Products Affected

- **OFEV**
- *pirfenidone oral capsule*
- *pirfenidone oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of idiopathic pulmonary fibrosis -AND- baseline forced vital capacity (FVC) of at least 50% and a percent predicted diffusing capacity of the lungs of carbon monoxide (DLCO) of at least 30%. For Ofev only, documentation of systemic sclerosis-associated interstitial lung disease -AND- baseline forced vital capacity (FVC) of at least 40% and a percent predicted diffusing capacity of the lungs of carbon monoxide (DLCO) of at least 30% -AND- documentation of a high-resolution chest computed tomography (CT) scan demonstrating greater than or equal to 10% pulmonary fibrosis. For Ofev only, documentation of chronic fibrosing interstitial lung disease with progressive phenotype -AND- high resolution chest computing tomography (HRCT) scan demonstrating greater than 10% fibrosing disease -AND- baseline forced vital capacity (FVC) of at least 45% and a percent predicted diffusing capacity of the lungs of carbon monoxide (DLCO) of at least 30% -AND- disease progression in previous 24 months shown by one of the following : 1. Relative decline in FVC greater than or equal to 10% predicted 2. Relative decline in FVC greater than or equal to 5% but less than 10% predicted and either worsening of respiratory symptoms or increased extent of fibrotic changes on HRCT 3. Worsening of respiratory symptoms and increasing extent of fibrotic changes on HRCT
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Iressa

Products Affected

- *gefitinib*

PA Criteria	Criteria Details
Exclusion Criteria	Use in tumors with EGFR mutations other than exon 19 deletions or exon 21 (L858R) substitution mutations.
Required Medical Information	Documentation of diagnosis -AND- the following: 1) EGFR exon 19 deletion mutations or exon 21 (L858R) mutations as detected by an FDA-approved test
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Isturisa

Products Affected

- **ISTURISA ORAL TABLET 1 MG, 5 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Cushing's disease AND patient is not a candidate for pituitary surgery or surgery has not been curative
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of mean urine free cortisol (mUFC) decrease from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Itraconazole

Products Affected

- *itraconazole*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. If using for diagnosis of onychomycosis, confirmation through positive laboratory testing (e.g. KOH preparation, fungal culture, or nail biopsy) is required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Onychomycosis: 3 months. All other indications: 3 months initial, 12 months reauth
Other Criteria	Documentation of trial/failure or intolerance of amphotericin b must be provided for approval in patients with aspergillosis.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ivermectin Oral

Products Affected

- *ivermectin oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of strongyloidiasis of the intestinal tract (non-disseminated disease) or onchocerciasis -AND- Member weighs greater than or equal to 15kg.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Iwilfin

Products Affected

- IWILFIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of high-risk neuroblastoma (HRNB) -AND- partial response to anti-glycolipid disialoganglioside (GD2) immunotherapy (e.g., dinutuximab, naxitamab).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Jakafi

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis per an accepted risk stratification tool for myelofibrosis (e.g., International Prognostic Scoring System [IPSS]) and if a new start, baseline platelet count of greater than $50 \times 10^9/L$ -OR- documentation of polycythemia vera and inadequate response or intolerance to hydroxyurea -OR- Documentation of steroid refractory acute graft-versus-host disease and prior therapy with at least one systemic corticosteroid -OR- Documentation of chronic graft-versus-host disease with prior failure of at least one systemic therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Baseline platelet count to be provided.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Jaypirca

Products Affected

- **JAYPIRCA ORAL TABLET 100 MG, 50 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- if applicable to diagnosis, alternatives tried/failed
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Joenja

Products Affected

- JOENJA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of activated phosphoinositide 3-kinase delta syndrome (APDS) with genetic confirmation of variant in PIK3CD or PIK3R1 gene.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Jynarque

Products Affected

- JYNARQUE ORAL TABLET
- JYNARQUE ORAL TABLETS, SEQUENTIAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of rapidly progressing autosomal dominant polycystic kidney disease defined by one of the following: 1.) Historical decline in eGFR greater than or equal to 5mL/min/1.73 m*2 within a 12 month period. 2.) Decline in eGFR of greater than or equal to 2.5mL/min/1.73m*2 over a period of 5 years. 3.) 5% increase in total kidney volume per year by 3 repeat CT or MRI. 4.) Average kidney length greater than 16.5cm. 5.) Family history of end-stage renal disease before age 58. 6.) Mayo imaging classification of 1C, 1D, or 1E. 7.) Kidney bleeds.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, prescriber attestation of slowed decline of kidney function
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Kalydeco

Products Affected

- **KALYDECO ORAL GRANULES IN PACKET 13.4 MG, 25 MG, 5.8 MG, 50 MG, 75 MG**
- **KALYDECO ORAL TABLET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cystic fibrosis (CF) in patients who have one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR gene) that is responsive to ivacaftor based on clinical and or in vitro assay (e.g. G551D, G1244E, G1349D)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, documentation supporting improvement or stabilization of FEV1 compared to baseline FEV1 -or- increase in body mass index -or- decreased pulmonary exacerbations -or- improved quality of life as demonstrated by CF Questionnaire is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Kerendia

Products Affected

- **KERENDIA**

PA Criteria	Criteria Details
Exclusion Criteria	eGFR less than or equal to 25 mL/min/1.73 m*2, serum potassium greater than 5.5 mEq/L
Required Medical Information	Documentation of type 2 diabetes mellitus with chronic kidney disease - AND- one of the following (1. 2. or 3.): 1) concomitant use of a sodium-glucose Cotransporter-2 (SGLT2) inhibitor 2) therapeutic failure to at least one SGLT2 inhibitor or 3) contraindication or intolerance to at least one SGLT2 inhibitor.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation that signs or symptoms of hyperkalemia are not present.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Kesimpta

Products Affected

- **KESIMPTA PEN**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Kevzara

Products Affected

- KEVZARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For polymyalgia rheumatica (PMR), one of the following (1-3): 1) inadequate response to corticosteroids, 2) intolerance to corticosteroid taper, or 3) used in combination with corticosteroid tapering course. For juvenile idiopathic arthritis, weight greater than or equal to 63 kg -AND- one of the following (4-5): 4) inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide), or 5) requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage.
Age Restrictions	Deny if less than 18 years of age for rheumatoid arthritis and polymyalgia rheumatica.
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For rheumatoid arthritis, patients must have therapeutic failure or intolerance to two of the following preferred products: a preferred adalimumab product (i.e. Humira, Cyltezo, Hyrimoz, adalimumab-adaz, or adalimumab-adbm), Enbrel, Actemra SC, Xeljanz/Xeljanz XR and Rinvoq. For juvenile idiopathic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product (i.e. Humira, Cyltezo, Hyrimoz, adalimumab-adaz, or adalimumab-adbm), Enbrel, Rinvoz/Rinvoq LQ, Xeljanz/Xeljanz solution and Actemra SC.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Kineret

Products Affected

- **KINERET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For Deficiency of Interleukin-1 Receptor Antagonist (DIRA), therapeutic failure or intolerance to at least one (1) corticosteroid, or all corticosteroids are contraindicated.
Age Restrictions	Deny if less than 18 years of age for Rheumatoid Arthritis
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products Humira, Enbrel, Actemra SC, Rinvoq and Xeljanz/Xeljanz XR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Kisqali

Products Affected

- **KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG, 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG**
- **KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- disease is classified as HR-positive, HER2-negative -AND- one of the following (1-2): 1) member is using ribociclib in combination with an aromatase inhibitor as initial endocrine-based therapy 2) member is using ribociclib in combination with fulvestrant and member is using fulvestrant as initial endocrine-based therapy or member has experienced disease progression on endocrine therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Klisyri

Products Affected

- **KLISYRI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of actinic keratosis of the face or scalp -AND- Therapeutic failure or intolerance to 1 of the following 1) generic topical imiquimod 5% cream 2) generic fluorouracil 5% topical cream 3) generic fluorouracil topical solution
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For reauthorization, attestation that the member has previously experienced complete or partial clearance of actinic keratosis lesions with Klisyri -AND- additional course of therapy is required for recurrence of actinic keratosis -AND- member is restarting therapy at least 60 days after cessation of an initial Klisyri 5-day course.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Korlym

Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of hyperglycemia secondary to hypercortisolism in patients with endogenous Cushing's syndrome -AND- Patient is not a candidate for surgery or where surgery has failed -AND- one of the following (1 or 2): 1) Diagnosis of diabetes with trial and failure, intolerance, or contraindication to one previous therapy for Type 2 Diabetes (e.g. metformin, sulfonylureas, insulin) or using in addition to a therapy for Type 2 diabetes. 2) Glucose intolerance
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Koselugo

Products Affected

- **KOSELUGO ORAL CAPSULE 10 MG,
25 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- for neurofibromatosis type 1 (NF1), documentation of symptomatic, inoperable plexiform neurofibromas (PN)
Age Restrictions	Deny if less than 2 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Krazati

Products Affected

- KRAZATI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of non-small cell lung cancer -AND- disease is KRAS G12C-mutated as determined by an FDA approved test -AND- member has received at least one prior systemic therapy -AND- member is using Krazati as a single agent. Documentation of locally advanced or metastatic colorectal cancer -AND- disease is KRAS G12C-mutated as determined by an FDA-approved test -AND- member using using Krazati in combination with cetuximab -AND- member has received prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Kuvan

Products Affected

- **JAVYGTOR**
- *sapropterin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of PKU -AND- documented baseline Phe level greater than 6 mg/dL -AND- clinical documentation of current weight -AND- sapropterin dihydrochloride dose does not exceed 20 mg/kg/day
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, initial therapy has resulted in decrease in phenylalanine levels from baseline or current phenylalanine levels within the range of 120-360 micromol/L -AND- clinical documentation of current weight is required -AND- sapropterin dihydrochloride dose does not exceed 20 mg/kg/day.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Latuda

Products Affected

- *lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg, 80 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. If medication is being used for bipolar 1 disorder, documentation of trial and failure or intolerance to one other formulary medication indicated in bipolar 1 disorder (e.g. quetiapine)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lenvima

Products Affected

- LENVIMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following if applicable to diagnosis: 1) Radioactive iodine refractory status 2) Microsatellite instability-high status or mismatch repair deficient status 3) Alternatives tried/failed or attestation of first line use 4) Concomitant therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Leukine

Products Affected

- LEUKINE INJECTION RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis: following induction chemotherapy in patients who are 55 years or older with acute myelogenous leukemia (AML) -OR- mobilization of hematopoietic progenitor cells into peripheral blood for collection by leukapheresis and autologous transplantation -OR- acceleration of myeloid reconstitution following autologous bone marrow or peripheral blood progenitor cell transplantation -OR- acceleration of myeloid reconstitution following allogeneic BMT -OR- treatment of delayed neutrophil recovery or graft failure after autologous or allogeneic BMT -OR- following acute exposure to myelosuppressive doses of radiation (Hematopoietic Syndrome of Acute Radiation Syndrome [H-ARS]).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Leukotriene Modifiers

Products Affected

- *zileuton*
- **ZYFLO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of asthma -AND- trial/failure of generic montelukast and generic zafirlukast
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Libervant

Products Affected

- **LIBERVANT**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of seizure clusters or acute repetitive seizures -AND- the member is currently receiving antiepileptic maintenance therapy.
Age Restrictions	Deny if less than 2 years of age or greater than 5 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lidoderm

Products Affected

- *lidocaine topical adhesive patch, medicated 5 %*
- **LIDODERM**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of postherpetic neuralgia (PHN) -AND- trial and failure of 1 other agent used to treat PHN (e.g. gabapentin), inability to swallow oral medication or unable to take an oral medication due to potential adverse events (e.g. sedation) -OR- documentation of diabetic peripheral neuropathy (DPN) -AND- trial and failure of one other agent used to treat DPN (e.g. duloxetine), inability to swallow oral medication or unable to take an oral medication due to potential adverse events (e.g. sedation)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Diabetic peripheral neuropathy
Part B Prerequisite	No

Litfulo

Products Affected

- LITFULO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For severe alopecia areata, therapeutic failure/intolerance to an intralesional corticosteroid or high potency topical corticosteroid, or contraindication to all.
Age Restrictions	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Livtency

Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	Diagnosis of CMV prophylaxis.
Required Medical Information	Documentation of refractory cytomegalovirus infection or disease as evidenced by antigenemia or polymerase chain reaction (PCR) test -AND- all of the following (1-3): 1) member weighs at least 35 kg, 2) member is a recipient of hematopoietic stem cell transplant -OR- solid organ transplant. 3) member has experienced therapeutic failure to one of the following: ganciclovir, valganciclovir, cidofovir, or foscarnet.
Age Restrictions	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For reauthorization, attestation of a previous reduction in CMV DNA level -AND- documentation of one of the following (1-3): 1) new onset symptomatic CMV infection, 2) virologic relapse with treatment-emergent maribavir resistance or 3) continued antiviral treatment is required to achieve virologic clearance.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lokelma

Products Affected

- **LOKELMA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of hyperkalemia as defined by serum potassium level between 5.1 and 7.4 mmol/L on at least two (2) screenings -AND- Modification of medications to reduce serum potassium levels were not successful, when applicable
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of reduction in serum potassium levels following Lokelma administration and continued treatment for hyperkalemia is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lonsurf

Products Affected

- LONSURF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of metastatic colorectal cancer as a single agent or in combination with bevacizumab in patients who have previously been treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF therapy, and if RAS wild-type, an anti-EGFR therapy -OR- documentation of metastatic gastric or gastroesophageal junction adenocarcinoma previously treated with at least two prior lines of chemotherapy that included a fluoropyrimidine, a platinum, either a taxane or irinotecan, and if appropriate, HER2/neu-targeted therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lorbrena

Products Affected

- **LORBRENA ORAL TABLET 100 MG,
25 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of ALK-positive metastatic non-small cell lung cancer (NSCLC)
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lotronex

Products Affected

- *alosetron oral tablet 0.5 mg, 1 mg*

PA Criteria	Criteria Details
Exclusion Criteria	For irritable bowel syndrome (IBS): Exclude if male gender
Required Medical Information	Documentation of chronic severe diarrhea-predominant IBS -AND- trial and failure or intolerance to one anti-diarrheal (e.g. loperamide), anti-spasmodic, or tricyclic antidepressant, or contraindication to all
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 weeks initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation that symptoms of IBS continue to persist AND positive clinical response.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lumakras

Products Affected

- **LUMAKRAS ORAL TABLET 120 MG,
320 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis and all of the following, if applicable to diagnosis 1) KRAS G12C mutation status, as detected by an FDA-approved test 2) Alternatives tried
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lupron Depot Ped

Products Affected

- **LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG**
- **LUPRON DEPOT-PED INTRAMUSCULAR KIT 7.5 MG (PED)**
- **LUPRON DEPOT-PED INTRAMUSCULAR SYRINGE KIT**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of central precocious puberty -AND- advancement of bone age is beyond chronological age -AND- Basal luteinizing hormone (LH) level greater than 0.2-0.3 mIU/L or leuprolide-stimulating LH level greater than 3.3-5 mIU/L
Age Restrictions	Deny if greater than 8 years of age for females or greater than 9 years of age for males unless there is medical necessity for treatment of central precocious puberty
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of positive clinical response to therapy defined as pre-pubertal slowing/decline, normalization of FSH, normalization LH, normalization of bone age, normalization of estradiol level or normalization of testosterone level
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lynparza

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- All of the following, if applicable to diagnosis: 1) BRCA mutations 2) Genomic instability status 3) Homologous recombinant repair gene mutations 4) HER2 status 5) Alternatives tried/failed 6) Concomitant therapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lyrica

Products Affected

- *pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg*
- *pregabalin oral solution*
- *pregabalin oral tablet extended release 24 hr*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For immediate release and controlled release tablets, documentation of DPN and trial/failure or intolerance to duloxetine -OR- PHN and trial/failure or intolerance to gabapentin. For immediate release capsules, documentation of partial-onset seizures and trial/failure or intolerance to two AEDS -OR- neuropathic pain associated with spinal cord injury -OR- documentation to support a diagnosis of fibromyalgia and trial/failure or intolerance to duloxetine. When using pregabalin products concomitantly with an opiate agonist, attestation of an intent to monitor and address concomitant drug-drug interaction adverse events for opiate potentiators.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lytgobi

Products Affected

- **LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3), 16 MG/DAY (4 MG X 4), 20 MG/DAY (4 MG X 5)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) FGFR2 fusion or other rearrangement 2) Previous therapies tried/failed
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Mavenclad

Products Affected

- MAVENCLAD (10 TABLET PACK)
- MAVENCLAD (4 TABLET PACK)
- MAVENCLAD (5 TABLET PACK)
- MAVENCLAD (6 TABLET PACK)
- MAVENCLAD (7 TABLET PACK)
- MAVENCLAD (8 TABLET PACK)
- MAVENCLAD (9 TABLET PACK)

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Mavenclad and other disease modifying agents such as interferons, Copaxone, Tysabri. Treatment duration greater than 24 months.
Required Medical Information	Documentation of diagnosis of relapse-remitting multiples sclerosis or active secondary progressive disease -AND- therapeutic failure or intolerance to one other disease modifying therapy (e.g. Avonex, Gilenya, Copaxone)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	Coverage beyond 24 months will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Mavyret

Products Affected

- MAVYRET ORAL PELLETS IN PACKET
- MAVYRET ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance
Age Restrictions	Deny if less than 3 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Megace

Products Affected

- *megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)*
- *megestrol oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Mekinist

Products Affected

- **MEKINIST ORAL TABLET 0.5 MG, 2 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following. 1) BRAF mutations, if applicable to diagnosis. 2) Alternatives tried/failed. 3) Concomitant therapy, if applicable to diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Mekinist Suspension

Products Affected

- MEKINIST ORAL RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following. 1) BRAF mutations, if applicable to diagnosis. 2) Alternatives tried/failed. 3) Concomitant therapy, if applicable to diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Attestation of inability to swallow Mekinist tablets is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Mektovi

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) BRAF mutation status 2) Concomitant therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Metyrosine

Products Affected

- *metyrosine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of pheochromocytoma defined by 1 of the following (1 or 2): 1) Elevated metanephrines in plasma or urine, or 2) Tumor evidence from CT scan or MRI -AND- Documentation of 1 of the following (3., 4., or 5.): 3) Planned resection surgery, 4) Resection surgery is contraindicated, or 5) malignant pheochromocytoma. -AND- therapeutic failure, contraindication, or intolerance to a selective alpha-blocker (e.g., doxazosin, prazosin, terazosin).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

MTX Injection

Products Affected

- OTREXUP (PF)
- RASUVO (PF)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis AND trial/failure, intolerance, or contraindication to oral generic methotrexate tablets. For rheumatoid arthritis and juvenile idiopathic arthritis, disease is classified as severe and active -AND- therapeutic failure or intolerance to first-line therapy (e.g., nonsteroidal anti-inflammatory drug [NSAID]). For psoriasis, disease is classified as severe, recalcitrant, and disabling -AND- therapeutic failure or intolerance to at least one (1) other standard psoriasis therapy (e.g., cyclosporine)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Mulpleta

Products Affected

- MULPLETA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of thrombocytopenia and chronic liver disease - AND- beneficiary is scheduled to undergo a procedure -AND- trial and failure or intolerance to Doptelet
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Myalept

Products Affected

- MYALEPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of congenital or acquired generalized lipodystrophy - AND- Leptin levels less than 8 ng/mL for males or less than 12 ng/mL for females -AND- the member has a diagnosis of diabetes or fasting insulin levels greater than 30uU/mL or fasting hypertriglyceridemia greater than 200mg/dL -AND- Therapeutic failure to one previous diabetes therapy (e.g. metformin, insulin) or hypertriglyceridemia therapy (e.g. statin, fibrate)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, decrease in HbA1c from baseline, decrease in fasting plasma glucose from baseline or decrease in fasting triglycerides from baseline
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Myasthenia Gravis

Products Affected

- **ZILBRYSQ SUBCUTANEOUS
SYRINGE 16.6 MG/0.416 ML, 23
MG/0.574 ML, 32.4 MG/0.81 ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of generalized myasthenia gravis (gMG) -AND- Anti-acetylcholine receptor (AChR) antibody-positive -AND- Therapeutic failure, contraindication, or intolerance to generic pyridostigmine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of gMG signs/symptoms improvement (e.g., speech, swallowing, mobility, and/or respiratory function) -OR- decreased gMG exacerbations.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Mycapssa

Products Affected

- MYCAPSSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of acromegaly -AND- High pretreatment insulin-like growth factor-1 (IGF-1) based on laboratory reference range -AND- Previous response to and tolerated treatment with octreotide or lanreotide.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of decreased or normalized IGF-1 from baseline
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Myfembree

Products Affected

- MYFEMBREE

PA Criteria	Criteria Details
Exclusion Criteria	Diagnosis of severe hepatic impairment or osteoporosis.
Required Medical Information	Documentation of premenopausal woman with uterine leiomyomas - AND- Experiencing heavy menstrual bleeding -AND- For women of childbearing age, attestation of not pregnant -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist with or without estrogen and progestin does not exceed 24 months -OR- Documentation of premenopausal woman with endometriosis with moderate to severe pain -AND- For women of childbearing age, attestation of not pregnant - AND- Therapeutic failure or contraindication to 2 standard of care treatments (i.e. generic NSAID, combined hormonal contraceptive, progestin, GnRH agonist) -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist in combination with estrogen and progestin does not exceed 24 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 18 months reauthorization
Other Criteria	For reauthorization of uterine leiomyomas, attestation of continued experience of heavy menstrual bleeding -AND- Attestation of decrease in menstrual blood loss -AND- for women of childbearing age, attestation of not pregnant -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist with or without estrogen and progestin does not exceed 24 months. For reauthorization of endometriosis, continued pain associated with endometriosis -AND- Attestation of reduction in pain - AND - For women of childbearing age, attestation of not pregnant -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist with or without estrogen and progestin does not exceed 24 months.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Namenda

Products Affected

- **NAMENDA TITRATION PAK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis and trial/failure of generic memantine
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Namzarin

Products Affected

- NAMZARIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis and trial/failure of generic memantine and generic donepezil
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nayzilam

Products Affected

- NAYZILAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of seizure clusters or acute repetitive seizures -AND- the member is currently receiving antiepileptic maintenance therapy.
Age Restrictions	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nerlynx

Products Affected

- **NERLYNX**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following. 1) HER2 mutations, if applicable to diagnosis. 2) Alternatives tried/failed. 3) Concomitant therapy, if applicable to diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nexavar

Products Affected

- *sorafenib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For locally recurrent or metastatic, progressive, differentiated thyroid carcinoma, refractory to radioactive iodine treatment
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nexletol

Products Affected

- NEXLETOL
- NEXLIZET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>For HeFH, diagnosis supported by presence of causal mutation of FH by genetic testing OR untreated LDL-C greater than or equal to 190 mg/dL or untreated LDL-C greater than or equal to 160 mg/dL before 20 years of age with physical signs of FH (e.g. xanthomas, xanthelasma) OR diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or definite Simon Broome register criteria, or definite on the Make Early Diagnosis to Prevent Early Deaths tool -AND- LDL-C greater than 100 mg/dL -AND- Attestation of use in combination with other LDL-C lowering therapies or concomitant LDL-C lowering therapy is not possible -AND- Therapeutic failure to a maximally tolerated statin or documentation of statin intolerance -AND- Therapeutic failure, intolerance or contraindication to ezetimibe. For Hyperlipidemia with ASCVD or Hyperlipidemia with attestation of high risk for CVD, LDL-C greater than 70 mg/dL -AND- Therapeutic failure to a maximally tolerated statin or documentation of statin intolerance -AND- Therapeutic failure, intolerance or contraindication to ezetimibe. For Primary Hyperlipidemia not associated with ASCVD or HeFH, LDL-C greater than 70 mg/dL -AND- Attestation of use in combination with other LDL-C lowering therapies or concomitant LDL-C lowering therapy is not possible -AND- Therapeutic failure to a maximally tolerated statin or documentation of statin intolerance -AND- Therapeutic failure, intolerance or contraindication to ezetimibe.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization

PA Criteria	Criteria Details
Other Criteria	For reauthorization, documentation showing an LDL-C reduction from baseline -AND- for HeFH and Primary Hyperlipidemia (not associated with ASCVD or HeFH), attestation of continued use in combination with other LDL-C lowering therapies or concomitant LDL-C lowering therapy is not possible. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different statin which resolved upon discontinuation of statin or documentation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ninlaro

Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of multiple myeloma -AND- previous treatment with at least 1 prior therapy -AND- used in combination with lenalidomide and dexamethasone
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nitisinone

Products Affected

- *nitisinone*
- NITYR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of hereditary tyrosinemia type 1 (HT-1) confirmed by biochemical or genetic testing -AND- dietary restriction of tyrosine and phenylalanine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For brand Nityr, documentation of failure on generic nitisinone capsules is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Northera

Products Affected

- *droxidopa oral capsule 100 mg, 200 mg, 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of neurogenic orthostatic hypotension caused by primary autonomic failure (e.g., Parkinson's disease, multiple system atrophy, or pure autonomic failure), dopamine beta-hydroxylase deficiency or non-diabetic autonomic neuropathy -AND- documentation of inadequate response, intolerance or contraindication to preferred generic alternative midodrine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For reauthorization, attestation of increase from baseline of systolic or diastolic blood pressure upon standing -OR- attestation of decrease from baseline of neurogenic orthostatic hypotension symptoms upon standing (e.g., dizziness, feeling faint, etc.).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nourianz

Products Affected

- NOURIANZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Parkinson's disease experiencing off episodes -AND- Used as adjunct to levodopa/carbidopa -AND- trial/failure, contraindication or intolerance to one of the following generic products: ropinirole, pramipexole, entacapone, selegiline, or rasagiline
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nubeqa

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following if applicable to diagnosis: 1. Concomitant therapy 2. History of a bilateral orchiectomy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nucala

Products Affected

- NUCALA SUBCUTANEOUS AUTO-INJECTOR
- NUCALA SUBCUTANEOUS RECON SOLN
- NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML, 40 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>Documentation of diagnosis of severe asthma evidenced by pretreatment FEV1 less than 80 percent predicted in adults or FEV1 less than 90 percent predicted in adolescents or FEV1 reversibility of at least 12% after albuterol administration -AND- 1.) A history of 2 or more exacerbations in the previous year or inadequate symptom control with inhaled corticosteroid in combination with 3 months of controller medication (e.g. long-acting beta2-agonist [LABA], leukotriene receptor antagonist [LTRA], theophylline), unless intolerant of or contraindication to all agents -AND- 2 or 3. 2) Greater than or equal to 150 cells/uL screening within 6 weeks of dosing. 3) Greater than or equal to 300 cells/uL within 12 months of screening. -OR- Documentation of eosinophilic granulomatosis with polyangiitis (EGPA) in patients who have a history of relapsing or refractory disease and will be receiving concomitant glucocorticoid treatment with or without immunosuppressive therapy -OR- Documentation of hypereosinophilic syndrome (HES) without an identifiable non-hematologic secondary cause for greater than or equal to 6 months -AND- At least 2 HES flares (HES-related worsening of clinical symptoms or blood eosinophil counts requiring an escalation in therapy) within the past 12 months -AND- Stable on HES therapy for at least 4 weeks (chronic or episodic oral corticosteroids, immunosuppressive or cytotoxic therapy) -OR- Documentation of chronic rhinosinusitis with nasal polyps (CRSwNP) and trial/failure, contraindication, or intolerance to an intranasal corticosteroid.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	For Severe Asthma reauthorization, attestation of one of the following is required (1-4): 1) decreased rescue medication or oral corticosteroid use, 2) decreased frequency of severe asthma exacerbation, 3) increased pulmonary function from baseline (e.g. FEV1), or 4) reduction in reported asthma related symptoms. For EGPA reauthorization, attestation of one of the following is required (5-8): 5) reduction in frequency and/or severity of relapses, 6) reduction or discontinuation of corticosteroids and/or immunosuppressant, 7) disease remission, or 8) reduction in severity or frequency of EGPA-related symptoms. For HES reauthorization, attestation of one of the following is required (9-10): 9) reduction in frequency of HES flares, or 10) maintenance or reduction in background HES therapy requirements. For CRSwNP reauthorization, attestation of one of the following is required (11-12): 11) decrease in nasal polyp score, or 12) reduction in nasal congestion/obstruction severity score.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nuedexta

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation supporting improvement in symptoms is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nuplazid

Products Affected

- NUPLAZID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of hallucinations and delusions associated with Parkinson's disease psychosis
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nurtec

Products Affected

- NURTEC ODT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For Episodic Migraine Prevention, defined as 4-14 migraine days per month, the following criteria will apply (1-3). 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound or overutilization (e.g. not taking triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use). 3) Trial and failure or intolerance to one agent from 2 unique prophylactic migraine medication classes: e.g. Anti-epileptic drugs (e.g. topiramate), beta-blockers (e.g. propranolol), calcium-channel blockers (e.g. verapamil), tricyclic antidepressants (e.g. amitriptyline) -OR- contraindication to all prophylactic medication classes. For acute treatment of migraine with or without aura, trial and failure of one generic triptan.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization of episodic migraine prevention, attestation of reduction in migraine frequency. For reauthorization of acute treatment of migraine, attestation of reduction in migraine symptoms.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nuvigil

Products Affected

- *armodafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>Diagnosis of shift work sleep disorder (SWSD) substantiated by excessive sleepiness or insomnia that is temporarily associated with a recurring work schedule that overlaps the usual time for sleep -AND- Symptoms are accompanied by a reduction of total sleep time -AND- Symptoms experienced for at least 3 months -AND- Sleep log or actigraphy monitoring for at least 14 days including both work and free days -AND- Sleep disturbance is not better explained by another current sleep disorder, medical or neurological disorder, mental disorder, medication use, or substance use disorder. Diagnosis of narcolepsy -AND- Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) -AND- Documentation of the following (1, 2, or 3): 1) Hypocretin-1 deficiency defined by (A or B), A) Cerebrospinal fluid hypocretin-1 less than 110 pg/mL. B) Cerebrospinal fluid hypocretin-1 less than 1/3 of the normal value based on laboratory reference range -OR- 2) Multiple sleep latency test (MSLT) documenting MSL less than 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than 8 minutes and 1 SOREMP and Polysomnography substantiating 1 SOREMP. Diagnosis of obstructive sleep apnea/hypopnea syndrome (OSAHS) documented by objective polysomnography as established in accordance with ICSD or DSM V criteria acceptable for all indications</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, provider attestation of improvement in daytime sleepiness is required.

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

Ocaliva

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Exclusion Criteria	Compensated cirrhosis with evidence of portal hypertension
Required Medical Information	Documentation of primary biliary cholangitis -AND- trial and failure, contraindication, or intolerance to ursodiol monotherapy -AND- will use concomitantly with ursodiol unless contraindicated or intolerant.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Octreotide

Products Affected

- *octreotide acetate injection solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For acromegaly, high pretreatment insulin-like growth factor-1 (IGF-1) based on laboratory reference range -AND- therapeutic failure or cannot be treated with surgical resection, pituitary irradiation or bromocriptine mesylate.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization of acromegaly, decreased or normalized IGF-1 from baseline
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Odactra

Products Affected

- ODACTRA

PA Criteria	Criteria Details
Exclusion Criteria	Asthma (severe, unstable or uncontrolled), concomitant sublingual or subcutaneous immunotherapy
Required Medical Information	Documentation of allergic rhinitis due to house dust mites -AND- allergic rhinitis with or without conjunctivitis has been confirmed by skin testing for licensed house dust mite allergen extracts or in vitro testing for IgE antibodies to D. pteronyssinus or D. Farina -AND- trial and failure or intolerance to an intranasal steroid and an oral non-sedating antihistamine, intranasal antihistamine or intranasal anticholinergic agent
Age Restrictions	Deny if less than 12 years of age or greater than 65 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Member must also be prescribed an epinephrine auto injector. For reauthorization, attestation of improved allergy symptoms is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Odomzo

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of locally advanced basal cell carcinoma (laBCC) that has recurred following surgery or radiation therapy or for use in patients who are not candidates for surgery or radiation therapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ogsiveo

Products Affected

- **OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of progressing desmoid tumor(s) requiring systemic therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ojemda

Products Affected

- **OJEMDA ORAL SUSPENSION FOR RECONSTITUTION**
- **OJEMDA ORAL TABLET 500 MG/WEEK (100 MG X 5)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of relapsed or refractory pediatric low-grade glioma - AND- one of the following (1-2): 1) BRAF fusion or rearrangement, or 2) BRAF V600K mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ojjaara

Products Affected

- OJJAARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of intermediate or high-risk myelofibrosis -AND- attestation of anemia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Olumiant

Products Affected

- OLUMIANT

PA Criteria	Criteria Details
Exclusion Criteria	Part A covered for Covid-19 in hospitalized patients
Required Medical Information	Documentation of diagnosis. For moderate to severely active rheumatoid arthritis an inadequate response or intolerance to at least one non-biologic DMARD (e.g., methotrexate, leflunomide). For severe alopecia areata, inadequate response or intolerance to an intralesional corticosteroid or high potency topical corticosteroid, or contraindication to all.
Age Restrictions	Deny if less than 18 years of age for Rheumatoid Arthritis and Alopecia Areata
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products Humira, Enbrel, Actemra SC, Rinvoq and Xeljanz/Xeljanz XR, with at least 1 being a tumor necrosis factor blocker.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Onfi

Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of seizures due to Lennox-Gastaut Syndrome -AND- documentation of adjunctive therapy -AND- therapeutic failure or intolerance of a previous antiepileptic therapy
Age Restrictions	Deny if less than 2 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ongentys

Products Affected

- **ONGENTYS**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Parkinson's disease experiencing off episodes -AND- Used as adjunct to levodopa/carbidopa -AND- trial/failure, contraindication or intolerance to the following (1. and 2.): 1) entacapone 2) one of the following generic products: rasagiline, pramipexole, ropinirole, selegiline
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Onureg

Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of acute myeloid leukemia that has achieved first complete remission or complete remission with incomplete blood count recovery following intensive induction chemotherapy -AND- Inability to complete intensive curative therapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Oralair

Products Affected

- **ORALAIR SUBLINGUAL TABLET 300
INDX REACTIVITY**

PA Criteria	Criteria Details
Exclusion Criteria	Asthma (severe, unstable or uncontrolled), concomitant sublingual or subcutaneous immunotherapy, therapy initiation during active allergy season
Required Medical Information	Documentation of allergic rhinitis and use for Sweet Vernal, Orchard, Perennial Rye, Timothy or Kentucky Blue Grass pollens -AND- allergic rhinitis with or without conjunctivitis has been confirmed by a pollen specific positive skin test or in vitro testing for pollen-specific IgE antibodies -AND- trial and failure or intolerance to an intranasal steroid and an oral non-sedating antihistamine, intranasal antihistamine or intranasal anticholinergic agent
Age Restrictions	Deny if less than 5 years of age or greater than 65 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Member must also be prescribed an epinephrine auto injector. For reauthorization, attestation of improved allergy symptoms is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Orencia

Products Affected

- **ORENCIA CLICKJECT**
- **ORENCIA SUBCUTANEOUS SYRINGE**
125 MG/ML, 50 MG/0.4 ML, 87.5 MG/0.7 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. methotrexate, leflunomide). For juvenile idiopathic rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage.
Age Restrictions	Deny if less than 18 years of age for Rheumatoid Arthritis or less than 2 years of age for Juvenile Idiopathic Arthritis and Psoriatic Arthritis
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product (i.e. Humira, Cyltezo, Hyrimoz, adalimumab-adaz, or adalimumab-adbm), Enbrel, Actemra SC, Rinvoq and Xeljanz/Xeljanz XR. For psoriatic arthritis, patients over 18 years of age must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product (i.e. Humira, Cyltezo, Hyrimoz, adalimumab-adaz, or adalimumab-adbm), Cosentyx, Enbrel, Taltz, Xeljanz/Xeljanz XR, Otezla and Stelara SC, Rinvoq, and Skyrizi SC. For juvenile idiopathic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product (i.e. Humira, Cyltezo, Hyrimoz, adalimumab-adaz, or adalimumab-adbm), Enbrel, Xeljanz/Xeljanz solution and Actemra SC.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Orgovyx

Products Affected

- ORGOVYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of advanced prostate cancer
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For induction therapy dosing, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimens per indication.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Oriahnn

Products Affected

- **ORIAHNN**

PA Criteria	Criteria Details
Exclusion Criteria	Diagnosis of severe hepatic impairment or osteoporosis.
Required Medical Information	Documentation of premenopausal woman with uterine leiomyomas -AND- Experiencing heavy menstrual bleeding -AND- For women of childbearing age, attestation of not pregnant -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist with or with out estrogen and progestin does not exceed 24 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 18 months reauthorization
Other Criteria	For reauthorization, attestation of continued experience of heavy menstrual bleeding -AND- Attestation of decrease in menstrual blood loss -AND- for women of childbearing age, attestation of not pregnant -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist with or without estrogen and progestin does not exceed 24 months.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Orilissa

Products Affected

- **ORILISSA ORAL TABLET 150 MG, 200 MG**

PA Criteria	Criteria Details
Exclusion Criteria	Diagnosis of severe hepatic impairment or osteoporosis.
Required Medical Information	Documentation of premenopausal woman with diagnosis of endometriosis with moderate to severe pain -AND- For women of childbearing age, attestation of not pregnant -AND- Inadequate response, failure or contraindication to 2 standard of care treatments (e.g. NSAIDS, combined hormonal contraceptives, progestin, GnRH agonist, Danazol) -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist with or with out estrogen and progestin does not exceed 24 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 18 months reauthorization
Other Criteria	For reauthorization, Orilissa is continued to be used for pain associated with endometriosis -AND- attestation of reduction in pain -AND- For women of childbearing age, attestation of not pregnant -AND- Treatment with a gonadotropin-releasing hormone receptor antagonist with or without estrogen and progestin does not exceed 24 months.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Orkambi

Products Affected

- **ORKAMBI ORAL GRANULES IN PACKET**
- **ORKAMBI ORAL TABLET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cystic fibrosis and homozygous F508del mutation
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, documentation supporting improvement or stabilization of FEV1 compared to baseline FEV1 -or- increase in body mass index -or- decreased pulmonary exacerbations -or- improved quality of life as demonstrated by CF Questionnaire is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Orladeyo

Products Affected

- ORLADEYO

PA Criteria	Criteria Details
Exclusion Criteria	Member should not be on two prophylactic therapies simultaneously.
Required Medical Information	For the prophylactic treatment of attacks of hereditary angioedema (HAE) type I & II with the following (1-3): 1) Low C4 level of less than or equal to 14mg/dL or C4 below lower limit of laboratory reference range and 1 of the following (A or B). A) C1 inhibitor (C1INH) antigen level less than or equal to 19mg/dL or below lower limit of laboratory reference range. B) Normal C1INH antigen level and a low C1INH functional level below laboratory reference range. 2) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 3) Medications known to cause angioedema have been evaluated and discontinued. For the prophylactic treatment of attacks of hereditary angioedema (HAE) type III with the following (4-7): 4) Documentation of clinical laboratory performance C4, C1INH antigen, or C1INH functional level are within normal limits of laboratory reference ranges. 5) Documentation of family history of HAE or FXII mutation 6) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 7) Medications known to cause angioedema have been evaluated and discontinued.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Orserdu

Products Affected

- **ORSERDU ORAL TABLET 345 MG, 86 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) ER mutation status, HER2 mutation status, and ESR1 mutation status 2) Alternatives tried/failed
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OTEZLA

Products Affected

- OTEZLA ORAL TABLET 30 MG
- OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For plaque psoriasis, all of the following (1-2): 1) if the member is greater than or equal to 6 years of age and less than 18 years, weight is greater than or equal to 20 kg and member has moderate-to-severe disease -AND- 2) inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For oral ulcers associated with Behcet's Disease, inadequate response or intolerance to one systemic therapy colchicine for prevention of recurrent oral ulcers
Age Restrictions	Deny if less than 6 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Oxbryta

Products Affected

- **OXBRYTA ORAL TABLET 300 MG, 500 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of sickle cell disease -AND- Failure, intolerance or contraindication to hydroxyurea
Age Restrictions	Deny if less than 4 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of improvement of sickle cell disease signs, symptoms or complications
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Oxbryta for Suspension

Products Affected

- **OXBRYTA ORAL TABLET FOR SUSPENSION**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of sickle cell disease -AND- Failure, intolerance or contraindication to hydroxyurea -AND- one of the following (1 or 2): 1) is eleven years of age or younger -OR- 2) has an inability to swallow tablets
Age Restrictions	Deny if less than 4 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of improvement of sickle cell disease signs, symptoms or complications
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Oxervate

Products Affected

- **OXERVATE**

PA Criteria	Criteria Details
Exclusion Criteria	Treatment duration greater than 8 weeks per eye
Required Medical Information	Documentation of diagnosis -AND- affected eye (e.g. right eye, both eyes).
Age Restrictions	Deny if less than 2 years of age
Prescriber Restrictions	
Coverage Duration	8 weeks
Other Criteria	Coverage beyond 8 weeks per eye will not be approved
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Palynziq

Products Affected

- **PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML, 2.5 MG/0.5 ML, 20 MG/ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of phenylketonuria. Member meets the following criteria 1.) Baseline Phe level greater than 600 micromoles/L -AND- 2.) Failure or intolerance to existing management (i.e. Kuvan therapy) -AND- 3.) Has a prescription for epinephrine agent unless contraindicated.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of reduction in baseline pretreatment Phe levels -OR- blood Phe levels are less than or equal to 600 micromoles/L -OR- attestation that additional therapy with Palynziq is needed to allow adequate trial of maximum dose of 60mg per day for 16 weeks or member is not currently on 60mg per day dose.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Panretin

Products Affected

- PANRETIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cutaneous lesions in patients with AIDS-related Kaposi Sarcoma (KS) who are not receiving systemic therapy for KS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Pemazyre

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) FGFR2 fusion or other rearrangement as detected by an FDA-approved test 2) Attestation of previous treatment in alignment with FDA indication
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Pheburane

Products Affected

- PHEBURANE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- therapeutic failure or intolerance to generic sodium phenylbutyrate
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Phenoxybenzamine

Products Affected

- *phenoxybenzamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of excessive sweating and hypertension associated with pheochromocytoma supported by one of the following (1. or 2.): 1. Elevated metanephrines in plasma or urine. 2. Tumor evidence from CT scan or MRI
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Piqray

Products Affected

- **PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following: 1) HR-positive, HER2-negative tumor status, 2) PIK3CA mutation positive as detected by an FDA-approved test, 3) disease progression on or after an endocrine-based regimen, 4) Concomitant therapy with fulvestrant
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Pomalyst

Products Affected

- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of multiple myeloma, and combination use with dexamethasone, and previous trial of at least 2 therapies including lenalidomide and a proteasome inhibitor, and disease progression on or within 60 days of completion of the last therapy -OR- Documentation of AIDS-related Kaposi sarcoma (KS) after failure of highly active antiretroviral therapy (HAART) or in patients with KS who are HIV negative
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ponvory

Products Affected

- **PONVORY**
- **PONVORY 14-DAY STARTER PACK**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying agents such as interferons, Copaxone, Tysabri, Aubagio, Gilenya
Required Medical Information	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Posaconazole Tablet

Products Affected

- *posaconazole oral tablet, delayed release (dr/ec)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For aspergillus or candida infection prophylaxis, high risk of developing invasive Aspergillosis or Candidiasis infection due to being severely immunocompromised (e.g., hematopoietic stem cell transplant recipients with graft versus host disease, those with hematologic malignancies with prolonged neutropenia from chemotherapy) -AND- weight greater than 40 kg. For invasive aspergillosis infection, trial/failure or contraindication to voriconazole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Prenatal Vitamins

Products Affected

- **PRENATAL VITAMIN PLUS LOW IRON**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of nutritional supplementation required in a female of child-bearing potential during pre-conception, pregnancy, or lactation
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Prescription Drug Combo

Products Affected

- *acetaminophen-codeine oral solution 120-12 mg/5 ml*
- *acetaminophen-codeine oral tablet*
- **ALPRAZOLAM INTENSOL**
- *alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- *alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg, 2 mg, 3 mg*
- *buprenorphine*
- *butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg*
- *clonazepam oral tablet 0.5 mg, 1 mg, 2 mg*
- *clonazepam oral tablet, disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- *clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg*
- **DIAZEPAM INTENSOL**
- *diazepam oral solution 5 mg/5 ml (1 mg/ml)*
- *diazepam oral tablet*
- **ENDOCET**
- *estazolam*
- *eszopiclone*
- *fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr*
- *flurazepam*
- *hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg*
- *hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg*
- *hydromorphone oral liquid*
- *hydromorphone oral tablet*
- **LORAZEPAM INTENSOL**
- *lorazepam oral tablet 0.5 mg, 1 mg, 2 mg*
- *methadone oral solution 10 mg/5 ml, 5 mg/5 ml*
- *methadone oral tablet 10 mg, 5 mg*
- *morphine concentrate oral solution*
- *morphine oral capsule, er multiphase 24 hr 120 mg, 30 mg, 45 mg, 60 mg, 75 mg, 90 mg*
- *morphine oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml)*
- *morphine oral tablet*
- *morphine oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg*
- **NUCYNTA**
- *oxazepam*
- *oxycodone oral capsule*
- *oxycodone oral concentrate*
- *oxycodone oral solution*
- *oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg*
- *oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg*
- *temazepam*
- *tramadol oral tablet 100 mg, 25 mg, 50 mg*
- *tramadol-acetaminophen*
- *triazolam*
- *zaleplon oral capsule 10 mg, 5 mg*
- *zolpidem oral tablet*
- *zolpidem oral tablet, ext release multiphase*
- *zolpidem sublingual*

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	<p>For concomitant use of an opiate agonist and substance abuse therapy, documentation that the member has an acute pain condition (e.g. acute traumatic injury) in which treatment with other agents would cause insufficient pain control or if the member requires treatment for pain related to a terminal illness. For concomitant use of an opiate agonist, benzodiazepine, and a centrally acting skeletal muscle relaxant, documentation that the member has tried/failed at least 2 other skeletal muscle relaxants (e.g. methocarbamol, metaxalone), understanding these skeletal muscle relaxants are high-risk medications in geriatric patients AND attestation of an intent to monitor and address concomitant drug-drug interaction adverse events. For concomitant use of an opiate agonist and other opiate potentiators (e.g. gabapentinoids, sedative-hypnotics) attestation of an intent to monitor and address concomitant drug-drug interaction adverse events. For long acting (e.g. extended release) opioid medications, the following apply (1-5). 1)Pain is severe enough to require daily, around-the-clock, long-term opioid treatment. 2)Patient is not opioid naive. 3)Attestation that non-opiate alternative therapies have been explored (e.g. NSAIDs). 4)Attestation that controlled substance Rx history has been reviewed in the state Prescription Drug Monitoring Program. 5)Attestation of counseling on the potential adverse effects of opioid analgesics, including the risk of misuse, abuse, and addiction.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Opiate tx for pain+subs. abuse, app. opiate x 1mo. All other combos and dx approve x 12mo.
Other Criteria	<p>Opiate agonists will receive automatic approval if no recent claims for a substance abuse therapy (e.g. buprenorphine-naloxone) OR a benzodiazepine (e.g. triazolam, alprazolam) OR a benzodiazepine with a centrally acting skeletal muscle relaxant (e.g., carisoprodol) OR a gabapentinoid OR a sedative-hypnotic. Benzodiazepines (e.g. triazolam, alprazolam) will receive automatic approval if no recent claims for an opiate agonist (e.g. oxycodone, hydrocodone, oxymorphone) or an opiate agonist with a centrally acting skeletal muscle relaxant (e.g. carisoprodol). Sedative-hypnotics (e.g. zolpidem) will receive automatic approval if no recent claims for an opiate agonist. Infusible opiate agonists will be covered under Part B when administered via infusion pump.</p>
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Procysbi

Products Affected

- **PROCYSBI ORAL GRANULES DEL
RELEASE IN PACKET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- previous trial and failure, intolerance, or contraindication to Cystagon (cysteamine bitartrate immediate-release)
Age Restrictions	Deny if less than 1 year of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Prolia

Products Affected

- PROLIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -And- For osteoporosis at high risk for fracture, meeting one of the following (1. thru 4.) 1) History of previous hip or vertebral fracture. 2) T-score less than or equal to -2.5. 3) T-score between -1.0 and -2.5 (i.e. osteopenia) -AND- meets FRAX calculation (A. or B.) A) 10-year risk of major osteoporotic fracture is greater than or equal to 20 percent or B) 10-year risk of hip fracture is greater than or equal to 3 percent. 4) Age 40 years or older with T-score between -1.0 and -2.5 -AND- History of glucocorticoid use for at least 3 months at a dose of 5mg per day or more of prednisone (or equivalent).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For osteoporosis and osteopenia, documentation of trial/failure or intolerance to at least one oral bisphosphonate or all are contraindicated. Covered under Part B for patients eligible for home health services when provider certifies that patient sustained bone fracture related to post-menopausal osteoporosis and is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug or family/caregivers are unable or unwilling to administer the drug.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Provigil

Products Affected

- *modafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>Diagnosis of shift work sleep disorder (SWSD) substantiated by excessive sleepiness or insomnia that is temporarily associated with a recurring work schedule that overlaps the usual time for sleep -AND- Symptoms are accompanied by a reduction of total sleep time -AND- Symptoms experienced for at least 3 months -AND- Sleep log or actigraphy monitoring for at least 14 days including both work and free days -AND- Sleep disturbance is not better explained by another current sleep disorder, medical or neurological disorder, mental disorder, medication use, or substance use disorder. Diagnosis of narcolepsy -AND- Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) -AND- Documentation of the following (1, 2, or 3): 1) Hypocretin-1 deficiency defined by (A or B), A) Cerebrospinal fluid hypocretin-1 less than 110 pg/mL. B) Cerebrospinal fluid hypocretin-1 less than 1/3 of the normal value based on laboratory reference range -OR- 2) Multiple sleep latency test (MSLT) documenting MSL less than 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than 8 minutes and 1 SOREMP and Polysomnography substantiating 1 SOREMP. Diagnosis of obstructive sleep apnea/hypopnea syndrome (OSAHS) documented by objective polysomnography as established in accordance with ICSD or DSM V criteria acceptable for all indications. Diagnosis of fatigue associated with Multiple Sclerosis (MS)</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	For reauthorization, provider attestation of improvement in daytime sleepiness is required.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Fatigue associated with Multiple Sclerosis (MS)
Part B Prerequisite	No

Pulmonary Arterial Hypertension

Products Affected

- **ADEMPAS**
- **ALYQ**
- *ambrisentan*
- *bosentan*
- **OPSUMIT**
- **ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG**
- *sildenafil (pulm.hypertension) oral suspension for reconstitution*
- *sildenafil (pulm.hypertension) oral tablet*
- *tadalafil (pulm. hypertension)*
- **TADLIQ**
- **TRACLEER ORAL TABLET FOR SUSPENSION**
- **TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 16(112)-32(112) -48(28) MCG, 32 MCG, 32-48 MCG, 48 MCG, 64 MCG**
- **UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG**
- **UPTRAVI ORAL TABLETS,DOSE PACK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of pulmonary arterial hypertension, substantiated by results from right heart catheterization (RHC), defined as a mean pulmonary arterial pressure (mPAP) of greater than 20 mmHg at rest, with a pulmonary capillary wedge pressure (PWP) of less than or equal to 15 mmHg, and a PVR greater than or equal to 3 Wood units -AND- WHO Group. For bosentan and sildenafil in pediatric individuals, an exception to RHC will be allowed when the risk of RHC outweighs the benefit -AND- prescriber attests alternative studies have been completed (i.e. CT, MRI or specified test ruling out other causes of pulmonary hypertension). For Adempas, additional diagnosis of CTEPH as documented by right heart catheterization and V/Q scan substantiating mPAP greater than 20 mmHg at rest and PWP less than or equal to 15 mmHg and documented presence of occlusive thrombi within the pulmonary arteries will be approved.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	For brand Tadliq, trial and failure of generic tadalafil or Alyq -OR- Inability to swallow tablets is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Pulmozyme

Products Affected

- PULMOZYME

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of cystic fibrosis -AND- Used in conjunction with standard therapies for management of cystic fibrosis to improve pulmonary function.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Inhalation solutions covered under Part B when administered in the home setting using a covered nebulizer (i.e. DME). For reauthorization, attestation of increase in FEV1 or decrease in number of hospitalizations or pulmonary exacerbations.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Pyrukynd

Products Affected

- **PYRUKYND ORAL TABLET 20 MG, 5 MG (4-WEEK PACK), 50 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of hemolytic anemia with pyruvate kinase deficiency, as supported by one of the following (1-2): 1) mutations in the PKLR gene, 2) reduced activity of the pyruvate kinase enzyme.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	24 weeks initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of increase in hemoglobin level from baseline -OR- decrease in transfusion burden from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Qinlock

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of advanced gastrointestinal stromal tumor -AND- Prior treatment with imatinib and 2 other kinase inhibitors.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Quinine

Products Affected

- *quinine sulfate*

PA Criteria	Criteria Details
Exclusion Criteria	Treatment or prevention of leg cramps
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	10 days
Other Criteria	Doses for duration greater than 10 days will not be approved
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Qulipta

Products Affected

- QULIPTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of Episodic Migraine, defined as 4-14 migraine days per month OR Chronic Migraine, defined as 15 or more headaches per month, of which 8 or more are migraine days. The following criteria will apply (1-3). 1) Documentation of average monthly migraine days. 2) Attestation that headaches are not caused by medication rebound (e.g. not taking triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use). 3) Trial and failure or intolerance to one agent from 2 unique prophylactic migraine medication classes: e.g. Anti-epileptic drugs (e.g. topiramate), beta-blockers (e.g. propranolol), calcium-channel blockers (e.g. verapamil), tricyclic antidepressants (e.g. amitriptyline) -OR- contraindication to all prophylactic medication classes.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of reduction in migraine frequency
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Radicava ORS

Products Affected

- **RADICAVA ORS STARTER KIT SUSP**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of amyotrophic lateral sclerosis (ALS)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ravicti

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Exclusion Criteria	Urea cycle disorders due to N-acetylglutamate synthetase deficiency, Treatment of acute hyperammonemia in urea cycle disorders
Required Medical Information	Documentation of chronic management of a urea cycle disorders (UCDs)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Recorlev

Products Affected

- **RECORLEV**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of endogenous Cushing's syndrome AND patient is not a candidate for pituitary surgery or surgery has not been curative
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of mean urine free cortisol (mUFC) less than starting baseline value.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Regranex

Products Affected

- REGRANEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of lower-extremity diabetic neuropathic ulcer(s) that extends into the subcutaneous tissue or beyond and have an adequate blood supply -AND- being used as an adjunct to standard ulcer care practices (e.g. sharp debridement, non-weight bearing regimen, infection control) -AND- attestation of a wound care plan.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	20 weeks
Other Criteria	For reauthorization, one of the following (1-2): 1) documentation of decrease in ulcer(s) size without complete ulcer(s) closure -OR- 2) documentation of new lower extremity diabetic neuropathic ulcer(s) that extends into the subcutaneous tissue or beyond with an adequate blood supply, attestation of being used as an adjunct to standard ulcer care practices, and attestation of a wound care plan.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Relistor

Products Affected

- **RELISTOR ORAL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of opioid induced constipation (OIC) due to any of the following (1-2): 1) chronic non-cancer pain, or 2) chronic pain related to prior cancer or its treatment who do not require frequent (e.g. weekly) opioid dosage escalation -AND- documentation of opioid medication use for at least one month -AND- trial and failure, contraindication, or intolerance to 2 of the following (3-5): 3) Laxatives, 4) lubiprostone, 5) Movantik
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Relistor SC

Products Affected

- **RELISTOR SUBCUTANEOUS SOLUTION**
- **RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML, 8 MG/0.4 ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of opioid induced constipation (OIC) due to any of the following (1-3): 1) chronic non-cancer pain, 2) advanced illness or active cancer in palliative care or 3) chronic pain related to prior cancer or its treatments who do not require frequent (e.g., weekly) opioid dosage escalation -AND- documentation of opioid medication use for at least one month -AND- trial and failure, contraindication, or intolerance to 2 of the following (4 to 6): 4) Laxatives 5) lubiprostone 6) Movantik.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Repatha

Products Affected

- **REPATHA PUSHTRONEX**
- **REPATHA SURECLICK**
- **REPATHA SYRINGE**

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with another PCSK9 inhibitor or siRNA directed to PCSK9.
Required Medical Information	<p>1.HoFH supported by genetic confirmation of two mutant alleles at LDLR, APOB, PCSK9, or LDLRAP1 gene OR untreated LDL-C greater than 400mg/dL or TC greater than 500mg/dl with cutaneous or tendon xanthoma before age 10 yrs or HeFH in both parents AND The member has a current LDL-C of greater than 135 mg/dL (if 17 years of age or younger) or greater than 100mg/dL (18 years of age or older) despite use of maximally tolerated statin or statin intolerance AND The member will continue to receive concurrent lipid-lowering therapies for the treatment of HoFH. 2.HeFH supported by presence of causal mutation of FH by genetic testing OR untreated LDL-C greater than or equal to 190 mg/dL or untreated LDL-C greater than or equal to 160 mg/dL before 20 years of age with physical signs of FH (e.g. xanthomas, xanthelasma) OR diagnosis based on WHO criteria/Dutch Lipid Clinical Network criteria with score greater than 8 points, or definite on Simon Broome register, or definite on the Make Early Diagnosis to Prevent Early Deaths tool, AND LDL-C greater than 100 mg/dL if 18 and older or LDL-C greater than 130 if 17 and younger despite use of maximally tolerated statin or statin intolerance. If 17 and younger will continue to receive concurrent lipid-lowering therapies. 3.Hypercholesterolemia ASCVD or Primary Hyperlipidemia AND LDL-C greater than 70 mg/dL despite use of maximally tolerated statin or statin intolerance</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization

PA Criteria	Criteria Details
Other Criteria	For reauthorization, documentation showing an LDL-C reduction on Repatha therapy from baseline must be provided. Statin intolerance defined as follows: statin related rhabdomyolysis or skeletal muscle symptoms while receiving at least 2 separate trials of different statins which resolved upon discontinuation of statin or attestation of one of the following during any course of statin therapy: 1. CK increase to 10x upper limit of normal 2. LFTs increase to 3x upper limit of normal 3. Hospitalization due to severe statin-related AEs such as rhabdomyolysis.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Retevmo

Products Affected

- **RETEVMO ORAL CAPSULE 40 MG, 80 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of locally advanced or metastatic non-small cell lung cancer -AND- disease is classified as RET gene fusion as detected by an FDA approved test. Documentation of advanced or metastatic medullary thyroid cancer -AND- disease is classified as RET mutation as detected by an FDA approved test. Documentation of advanced or metastatic thyroid cancer -AND- all of the following (1-2): 1) disease is classified as RET gene fusion as detected by an FDA approved test 2) if radioactive iodine is appropriate for the member, the member is radioactive iodine-refractory. Documentation of locally advanced or metastatic solid tumor(s) -AND- disease harbors a RET gene fusion, as detected by an FDA-approved test -AND- one of the following (1-2): 1) the member has no satisfactory alternative treatments 2) the member's tumors have progressed following prior systemic treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Revlimid

Products Affected

- *lenalidomide*

PA Criteria	Criteria Details
Exclusion Criteria	Documentation of chronic lymphocytic leukemia outside of a controlled clinical trial
Required Medical Information	Diagnosis of multiple myeloma in combination with dexamethasone -OR- diagnosis of multiple myeloma, as maintenance following autologous hematopoietic stem cell transplant (auto-HSCT) -OR- diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes (MDS) associated with a deletion 5q abnormality with or without additional cytogenetic abnormalities -OR- diagnosis of mantle cell lymphoma (MCL) in which disease has relapsed or progressed after two prior therapies, one of which included bortezomib -OR- diagnosis of follicular lymphoma in combination with a rituximab product -OR- diagnosis of marginal zone lymphoma in combination with a rituximab product after previous treatment.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Rezdiffra

Products Affected

- REZDIFFRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) in conjunction with diet and exercise. Diagnosis of NASH confirmed by a liver biopsy or non-invasive tests (NITs) performed within the previous 6 months indicating F2 or F3 fibrosis - AND- member does not have any evidence of cirrhosis, hepatic decompensation, or hepatocellular carcinoma.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of continued use in conjunction with diet and exercise -AND- member has experienced stabilization of fibrosis as demonstrated by NIT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Rezlidhia

Products Affected

- **REZLIDHIA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA approved test
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Rinvoq

Products Affected

- **RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG, 45 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe active rheumatoid arthritis, an inadequate response or intolerance to at least one non-biologic DMARD (e.g., leflunomide, methotrexate) or all non-biologic DMARDs are contraindicated. For moderate to severe refractory atopic dermatitis whose disease is not adequately controlled with other systemic drug products, documentation of one of the following (1 or 2): 1) trial & failure, or intolerance to at least one topical corticosteroid -OR- topical calcineurin inhibitor (e.g., tacrolimus, pimecrolimus) 2) The member has severe atopic dermatitis and is incapable of applying topical therapies due to the extent of body surface area involvement or topical therapies are contraindicated due to severely damaged skin. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For Non-radiographic Axial Spondyloarthritis, trial & failure or intolerance to two nonsteroidal anti-inflammatory drugs (NSAIDs) or contraindication to all. For juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) or all non-biologic DMARDs are contraindicated or requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For diagnoses in which tumor necrosis factor (TNF) blockers are also indicated (e.g., Rheumatoid Arthritis, Psoriatic Arthritis), the member has experienced therapeutic failure or intolerance to at least 1 TNF blocker.

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

Rivfloza

Products Affected

- **RIVFLOZA SUBCUTANEOUS SOLUTION**
- **RIVFLOZA SUBCUTANEOUS SYRINGE 128 MG/0.8 ML, 160 MG/ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of all of the following (1-3): 1) genetically confirmed diagnosis of primary hyperoxaluria type 1 (PH1), 2) relatively preserved kidney function (e.g., eGFR greater than or equal to 30 mL/min/1.73 m ²), and 3) at least two elevated urinary oxalate levels greater than 1.5 times the upper reference limit.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, continued preserved kidney function (e.g., eGFR greater than or equal to 30 mL/min/1.73 m ²) -AND- a reduction in urinary oxalate levels from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Rozlytrek

Products Affected

- **ROZLYTREK ORAL CAPSULE 100 MG, 200 MG**
- **ROZLYTREK ORAL PELLETS IN PACKET**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For metastatic non-small cell lung cancer, the tumor status is ROS1-positive. For solid tumors with NTRK gene fusion without a known acquired resistance mutation, the tumors are metastatic or surgical resection is likely to result in severe morbidity - AND- There are no satisfactory alternative treatments or the tumors have progressed following treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Rubraca

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following. 1) BRCA mutations, if applicable to diagnosis. 2) Alternatives tried/failed. 3) Concomitant therapy, if applicable to diagnosis.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ruconest

Products Affected

- RUCONEST

PA Criteria	Criteria Details
Exclusion Criteria	Member should not be on two acute therapies simultaneously and acute therapy should not be used as prophylactic therapy
Required Medical Information	<p>For the treatment of attacks of hereditary angioedema (HAE) type I & II with the following (1-4): 1) Low C4 level of less than or equal to 14mg/dL or C4 below lower limit of laboratory reference range and 1 of the following (A or B). A) C1 inhibitor (C1INH) antigen level less than or equal to 19mg/dL or below lower limit of laboratory reference range. B) Normal C1INH antigen level and a low C1INH functional level below laboratory reference range. 2) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 3) Medications known to cause angioedema have been evaluated and discontinued. 4) Documentation of member's weight. For the treatment of attacks of hereditary angioedema (HAE) type III with the following (5-9): 5) Documentation of clinical laboratory performance C4, C1INH antigen, or C1INH functional level are within normal limits of laboratory reference ranges. 6) Documentation of family history of HAE or FXII mutation 7) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 8) Medications known to cause angioedema have been evaluated and discontinued. 9) Documentation of member's weight.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For 18 years of age or older, therapeutic failure, intolerance or contraindication to icatibant.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

Rydapt

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	Use as single agent induction therapy for AML
Required Medical Information	Documentation of diagnosis -AND- All of the following, if applicable to diagnosis: 1) FLT3 mutations 2) Concomitant therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Sabril

Products Affected

- *vigabatrin*
- **VIGADRONE**
- **VIGPODER**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of refractory complex partial seizures -AND- documentation of adjunctive therapy -AND- therapeutic failure or intolerance to at least two alternative treatments (e.g. carbamazepine, lamotrigine, levetiracetam, oxcarbazepine, tiagabine) -OR- documentation of use as monotherapy in treatment of infantile spasms
Age Restrictions	Deny if less than 2 years of age in treatment of refractory complex partial seizures -OR- if less than 1 month old and greater than 2 years of age in treatment of infantile spasms
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Samsca

Products Affected

- *tolvaptan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of symptomatic hypervolemic or euvolemic hyponatremia evidenced by (1. or 2.): 1.) Serum Na less than 125 mEq/L -OR- 2.) Serum NA less than 135mEq/L with symptoms (e.g. nausea, malaise, lethargy, headache, seizures)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	Doses must be initiated in the hospital setting to closely monitor serum sodium. Treatment should be limited to 30 days to minimize risk of liver injury. For reauthorization, treatment is for a new episode of a clinically significant euvolemic or hypervolemic hyponatremia -AND- on of the following (1. or 2.) 1.) Serum Na less than 125 mEq/L -OR- 2.) Serum NA less than 135mEq/L with symptoms (e.g. nausea, malaise, lethargy, headache, seizures)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Saphris

Products Affected

- *asenapine maleate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis - AND - trial and failure of one of the following: olanzapine, quetiapine, or risperidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Savella

Products Affected

- SAVELLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation to support a diagnosis of fibromyalgia and trial/failure or intolerance to duloxetine
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Scemblix

Products Affected

- **SCSEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- one of the following (1-2): 1) member has experienced therapeutic intolerance or failure to at least 2 prior kinase inhibitors 2) disease is positive for the T3151 mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Secuado

Products Affected

- **SECUADO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- trial and failure of generic asenapine sublingual tablets -AND- trial/failure or intolerance to 1 of the following or all are contraindicated (1-3): 1) olanzapine, 2) quetiapine, 3) risperidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Signifor

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Cushing's disease AND patient is not a candidate for pituitary surgery or surgery has not been curative
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of decrease in urinary free cortisol levels from baseline
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Siliq

Products Affected

- SILIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For psoriasis, patients must have therapeutic failure or intolerance to 2 preferred products: a preferred adalimumab product (i.e. Humira, Cyltezo, Hyrimoz, adalimumab-adaz, or adalimumab-adbm), Cosentyx, Taltz, Otezla, Stelara SC, Enbrel, and Skyrizi SC. For psoriasis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Simponi

Products Affected

- **SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML, 50 MG/0.5 ML**
- **SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML, 50 MG/0.5 ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. Simponi 50mg: For moderate to severe rheumatoid arthritis, inadequate response or intolerance to at least one DMARD (e.g. leflunomide) and Simponi will be used in combination with methotrexate. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). Diagnosis of psoriatic arthritis Simponi 100mg: Diagnosis of moderate to severe ulcerative colitis.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	<p>For Rheumatoid arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product (i.e. Humira, Cyltezo, Hyrimoz, adalimumab-adaz, or adalimumab-adbm), Enbrel, Actemra SC, Xeljanz/Xeljanz XR and Rinvoq. For psoriatic arthritis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product (i.e. Humira, Cyltezo, Hyrimoz, adalimumab-adaz, or adalimumab-adbm), Cosentyx, Enbrel, Taltz, Xeljanz/Xeljanz XR, Otezla, Stelara SC, Rinvoq, and Skyrizi SC. For ankylosing spondylitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products: a preferred adalimumab product (i.e. Humira, Cyltezo, Hyrimoz, adalimumab-adaz, or adalimumab-adbm), Cosentyx, Enbrel, Taltz, Rinvoq, and Xeljanz/Xeljanz XR. For ulcerative colitis, patients must have therapeutic failure or intolerance to the preferred products: a preferred adalimumab product (i.e. Humira, Cyltezo, Hyrimoz, adalimumab-adaz, or adalimumab-adbm), Stelara SC, Rinvoq, and Xeljanz/Xeljanz XR. For ulcerative colitis induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Sirturo

Products Affected

- **SIRTURO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of extensively drug resistant tuberculosis, pre-extensively drug-resistant tuberculosis, treatment-intolerant tuberculosis, or nonresponsive multidrug-resistant tuberculosis -AND- Therapeutic failure, contraindication, or intolerance to 1 of the following: isoniazid, rifampin, rifabutin, or rifapentine -AND- Used in combination with at least 3 other drugs for tuberculosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 weeks
Other Criteria	For reauthorization, additional therapy required due to doses of the regimen being missed for safety reasons
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Skyclarys

Products Affected

- SKYCLARYS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Friedreichs ataxia confirmed by genetic testing (i.e., FXN gene mutation).
Age Restrictions	Deny if less than 16 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Skyrizi

Products Affected

- **SKYRIZI SUBCUTANEOUS PEN INJECTOR**
- **SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML**
- **SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML), 360 MG/2.4 ML (150 MG/ML)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For Crohns disease, attestation of clinical response or remission following IV administration of Skyrizi within 3 months of initiating therapy with Skyrizi SC. For moderate to severe ulcerative colitis, attestation of clinical response or remission following IV administration of Skyrizi within 3 months of initiating therapy with Skyrizi SC.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For induction therapy, doses above plan quantity limit will be approved when aligned with recommended induction therapy dosing regimen.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Sohonos

Products Affected

- SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 10 MG, 2.5 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	Deny if female and less than 8 years of age -OR- if male and less than 10 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of reduction in volume of new heterotopic ossification from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Solaraze

Products Affected

- *diclofenac sodium topical gel 3 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- trial and failure, intolerance, or contraindication to one of the following (1 or 2): 1) topical fluorouracil solution or fluorouracil 5% cream 2) topical imiquimod 5% cream
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For reauthorization, attestation of 30 day washout period since optimal therapeutic effect may not be evident until 30 days following cessation of therapy AND attestation of previous response to diclofenac sodium 3% topical gel therapy
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Somavert

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For acromegaly, high pretreatment insulin-like growth factor-1 (IGF-1) based on laboratory reference range -AND- inadequate or partial response to surgery or radiotherapy or not a candidate for surgery or radiotherapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization of acromegaly, decreased or normalized IGF-1 from baseline
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Sprycel

Products Affected

- SPRYCEL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- All of the following, if applicable to diagnosis: 1) Philadelphia Chromosome status (e.g. positive) 2) Alternatives tried/failed 3) Concomitant therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Stelara

Products Affected

- **STELARA SUBCUTANEOUS SOLUTION**
- **STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- documentation of member weight and prescribed dose. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For Crohn's Disease, attestation of clinical response or remission following single induction dose of IV Stelara within 2 months of initiating therapy with Stelara SC. For Ulcerative colitis, attestation of clinical response or remission following single induction dose of IV Stelara within 2 months of initiating therapy with Stelara SC
Age Restrictions	Deny if less than 18 years of age for Crohn's Disease and Ulcerative Colitis or less than 6 years of age for Plaque Psoriasis and Psoriatic Arthritis
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Must follow recommended dosing guidelines based upon weight. Induction therapy, doses above plan quantity limit will be approved aligned with recommended induction therapy dosing regimen.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Stivarga

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of metastatic colorectal cancer and trial of a fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy, AND an anti-VEGF therapy AND if RAS wild-type, an anti-EGFR therapy -OR- documentation of locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) after treatment with both imatinib and sunitinib -OR- documentation of hepatocellular cancer AND previous treatment with sorafenib
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Sucraid

Products Affected

- SUCRAID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of congenital-sucrase-isomaltase deficiency (CSID) supported by one of the following (1 or 2): 1) small bowel biopsy with disaccharidase assay showing absent or reduced sucrase activity, reduced or normal isomaltase activity, reduced maltase activity, and reduced or normal lactase activity. 2) sucrase deficiency evidenced by sucrose breath hydrogen test or carbon-sucrose breath test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Sunosi

Products Affected

- SUNOSI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>Diagnosis of narcolepsy -AND- Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) -AND- Documentation of the following (1, 2, or 3): 1) Hypocretin-1 deficiency defined by (A or B), A) Cerebrospinal fluid hypocretin-1 less than 110 pg/mL. B) Cerebrospinal fluid hypocretin-1 less than 1/3 of the normal value based on laboratory reference range -OR- 2) Multiple sleep latency test (MSLT) documenting MSL less than 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than 8 minutes and 1 SOREMP and Polysomnography substantiating 1 SOREMP. Diagnosis of obstructive sleep apnea/hypopnea syndrome (OSAHS) documented by objective polysomnography as established in accordance with ICSD or DSM V criteria acceptable for all indications</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	<p>For narcolepsy and OSAHS, documentation of trial and failure, contraindication or intolerance to modafinil and armodafinil. For reauthorization, provider attestation of improvement in daytime sleepiness is required.</p>
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Sutent

Products Affected

- *sunitinib malate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) disease progression on or intolerance to imatinib mesylate 2) high risk of recurrent RCC following nephrectomy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Symdeko

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cystic fibrosis (CF) in patients who have either the homozygous F508del mutation or another mutation in the cystic fibrosis transmembrane conductance regulator (CFTR gene) that is responsive to tezacaftor/ivacaftor based on clinical and/or in vitro assay (e.g. E56K, R117C, A455E)
Age Restrictions	Deny if less than 6 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, documentation supporting improvement or stabilization of FEV1 compared to baseline FEV1 -or- increase in body mass index -or- decreased pulmonary exacerbations -or- improved quality of life as demonstrated by CF Questionnaire is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Sympazan

Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of seizures due to Lennox-Gastaut Syndrome -AND- documentation of adjunctive therapy -AND- therapeutic failure or intolerance of a previous antiepileptic therapy -AND- unable to tolerate generic clobazam
Age Restrictions	Deny if less than 2 years old
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Symproic

Products Affected

- SYMPROIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of opioid induced constipation (OIC) due to any of the following (1-2): 1) chronic non-cancer pain, or 2) chronic pain related to prior cancer or its treatments who do not require frequent (e.g., weekly) opioid dosage escalation -AND- documentation of opioid medication use -AND- trial and failure, contraindication, or intolerance to at least 2 of the following (3-5): 3) Laxatives, 4) lubiprostone, 5) Movantik
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Synarel

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For central precocious puberty (CPP), advancement of bone age is beyond chronological age -AND- Basal luteinizing hormone (LH) level greater than 0.2-0.3IU/L or leuprolide-stimulating LH level greater than 3.3-5 IU/L. For female with endometriosis, attestation of not pregnant if of childbearing age -AND- Therapeutic failure, contraindication or intolerance to 2 of the following standard of care treatments: NSAIDs, combination hormonal contraceptive, progestin (i.e. medroxyprogesterone injection), GnRH agonist (i.e. Leuprolide) or danazol
Age Restrictions	Deny if greater than 8 years of age for females or greater than 9 years of age for males unless there is medical necessity for treatment of central precocious puberty. Deny if less than 18 years of age for endometriosis.
Prescriber Restrictions	
Coverage Duration	Endometriosis: 6 months, CPP: 6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization for CPP, attestation of pubertal development slowing from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tabrecta

Products Affected

- **TABRECTA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of metastatic non-small cell lung cancer with MET exon 14 skipping mutation as detected by an FDA approved test.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tafinlar for Suspension

Products Affected

- **TAFINLAR ORAL TABLET FOR SUSPENSION**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- both of the following. 1) BRAF mutations, if applicable to diagnosis. 2) Alternatives tried/failed and concomitant therapy, if applicable to diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Attestation of inability to swallow Tafinlar capsules is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tagrisso

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of non-small cell lung cancer (NSCLC) and one of the following (1-4): 1) Adjuvant therapy after tumor resection -AND- disease harbors EGFR exon 19 deletions or exon 21 L858R mutations, 2) Locally advanced disease -AND- disease harbors EGFR exon 19 deletions or exon 21 L858R mutations -AND- used in combination with pemetrexed and platinum-based chemotherapy, 3) Metastatic disease -AND- using as first-line therapy -AND- disease harbors EGFR exon 19 deletions or exon 21 L858R mutations -AND- used with or without combination therapy of pemetrexed and platinum-based chemotherapy, 4) Metastatic disease -AND- using as first-line therapy -AND- disease harbors EGFR T790M mutations -AND- has progressed on or after EGFR TKI therapy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Takhzyro

Products Affected

- **TAKHZYRO SUBCUTANEOUS SOLUTION (150 MG/ML)**
- **TAKHZYRO SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML**

PA Criteria	Criteria Details
Exclusion Criteria	Member should not be on two prophylactic therapies simultaneously.
Required Medical Information	For the prophylactic treatment of attacks of hereditary angioedema (HAE) type I & II with the following (1-3): 1) Low C4 level of less than or equal to 14mg/dL or C4 below lower limit of laboratory reference range and 1 of the following (A or B). A) C1 inhibitor (C1INH) antigen level less than or equal to 19mg/dL or below lower limit of laboratory reference range. B) Normal C1INH antigen level and a low C1INH functional level below laboratory reference range. 2) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 3) Medications known to cause angioedema have been evaluated and discontinued. For the prophylactic treatment of attacks of hereditary angioedema (HAE) type III with the following (4-7): 4) Documentation of clinical laboratory performance C4, C1INH antigen, or C1INH functional level are within normal limits of laboratory reference ranges. 5) Documentation of family history of HAE or FXII mutation 6) Past medical history of at least 1 symptom of moderate or severe angioedema attack (e.g. airway swelling, painful facial distortion) in absence of concomitant hives. 7) Medications known to cause angioedema have been evaluated and discontinued.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Taltz

Products Affected

- **TALTZ AUTOINJECTOR**
- **TALTZ SYRINGE SUBCUTANEOUS SYRINGE 80 MG/ML**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severe plaque psoriasis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate) -OR- inadequate response to phototherapy -OR- contraindication to phototherapy and systemic therapy. For ankylosing spondylitis, inadequate response or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For non-radiographic axial spondyloarthritis, inadequate response or intolerance to 2 NSAIDs.
Age Restrictions	Deny if less than 18 years of age for Psoriatic Arthritis, Ankylosing Spondylitis and non-radiographic axial spondyloarthritis or less than 6 years of age for Plaque Psoriasis
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For induction therapy, doses above plan quantity limit will be approved when aligned with recommended induction therapy dosing regimen.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Talzenna

Products Affected

- **TALZENNA**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of deleterious or suspected deleterious gBRCAm, HER2-negative locally advanced or metastatic breast cancer as a single agent - OR- Documentation of HRR gene-mutated metastatic castration-resistant prostate cancer in combination with enzalutamide
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Targretin

Products Affected

- *bexarotene oral*
- *bexarotene topical*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cutaneous manifestations of cutaneous T-cell lymphoma in patients who are refractory to at least one prior systemic therapy.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tascenso ODT

Products Affected

- TASCENSO ODT

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying agents such as teriflunomide, interferons, Copaxone, Tysabri
Required Medical Information	Documentation of a relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease) -AND- Inability to swallow capsules
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tasigna

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- All of the following, if applicable to diagnosis: 1) Philadelphia Chromosome status (e.g. positive) 2) Alternatives tried/failed
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tasimelteon

Products Affected

- *tasimelteon*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Non-24 Sleep-Wake disorder in patient that is totally blind -AND- evidenced by all the following (1 through 4): 1) history of insomnia, excessive daytime sleepiness, or both alternating with asymptomatic episodes 2) symptoms persistent for at least 3 months 3) daily sleep logs for at least 1 month demonstrating a sleep/wake pattern that delays each day 4) sleep disturbances are not better explained by another current disorder or medication/substance use
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	3 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of increased total nighttime sleep or decreased daytime nap duration for Non-24 Sleep-Wake disorder
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tavalisse

Products Affected

- TAVALISSE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For diagnosis of ITP, the following criteria apply (1 and 2): 1) trial, intolerance, or inadequate response to a corticosteroid, immunoglobulin, or splenectomy. 2) One of the following (A or B): A) Platelet count less than or equal to $50 \times 10^9/L$ and has significant mucous member bleeding or at least one risk factor for bleeding (e.g. hypertension, peptic ulcer disease). B) Platelet count of less than or equal to $30 \times 10^9/L$.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tavneos

Products Affected

- TAVNEOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of severe active granulomatosis with polyangiitis or severe active microscopic polyangiitis -AND- Prescriber attests to positive test for anti-PR3 or positive test for anti-MPO -AND- Member will continue to receive concomitant standard of care treatment with systemic glucocorticoids (e.g. prednisone) and immunosuppressives (e.g. mycophenolate mofetil, azathioprine).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of therapeutic response defined by disease stability or disease improvement -AND- Member will continue to receive concomitant standard of care treatment with glucocorticoids (e.g. prednisone) and immunosuppressives (e.g. mycophenolate mofetil, azathioprine).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tazorac

Products Affected

- *tazarotene topical cream 0.1 %*
- *tazarotene topical gel*
- **TAZORAC TOPICAL CREAM 0.05 %**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of 1 of the following (A or B). A) Documentation of plaque psoriasis -AND- trial and failure or intolerance to at least one topical corticosteroid (e.g. fluocinonide, mometasone, triamcinolone, betamethasone). B) Documentation of acne vulgaris -AND- trial and failure or intolerance of at least two topical acne medications (e.g. adapalene, clindamycin, sulfacetamide, erythromycin) one of which must be generic topical tretinoin
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tazverik

Products Affected

- TAZVERIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of locally advanced or metastatic epithelioid sarcoma - AND- Disease is not eligible for complete resection. Documentation of relapsed or refractory follicular lymphoma -AND-Tumors are EZH2 mutation positive, as detected by FDA approved test, in a member that has received at least 2 prior systemic therapies -OR- Prescriber attests there are no satisfactory alternative treatment options.
Age Restrictions	For epithelioid sarcoma, deny if less than 16 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tecfidera

Products Affected

- *dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying agents such as interferons, Copaxone, Tysabri, Aubagio, Gilenya
Required Medical Information	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tegsedi

Products Affected

- TEGSEDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of polyneuropathy associated with hereditary TTR (hATTR) amyloidosis with mutation in TTR gene confirmed by genetic testing -AND- Neurologic examination shows clinical signs and symptoms of the disease (e.g. peripheral/autonomic neuropathy, motor disability, carpal tunnel, etc.) -AND- Attestation of peripheral neuropathy impairment score (NIS) of 10 or greater -AND- Not simultaneously utilizing other gene targeted therapy for polyneuropathy of hATTR
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of improvement of polyneuropathy from baseline
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tepmetko

Products Affected

- **TEPMETKO**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of metastatic non-small cell lung cancer with a MET exon 14 skipping alteration
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Testosterone (androgens)

Products Affected

- **AVEED** *pump 20.25 mg/1.25 gram (1.62 %)*
- **DEPO-TESTOSTERONE INTRAMUSCULAR OIL 100 MG/ML**
 - *testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)*
 - *testosterone transdermal solution in metered pump w/app*
- *testosterone cypionate*
- *testosterone enanthate*
- *testosterone transdermal gel in metered-dose*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of primary or secondary hypogonadism in males with testicular failure due to cryptorchidism, bilateral torsions, orchitis, vanishing testis syndrome, orchidectomy, Klinefelter's syndrome, chemotherapy, radiation or toxic damage -OR- documentation of primary or secondary hypogonadism in males with multiple symptoms of hypogonadism including at least one of the following specific symptoms: height loss due to vertebral fractures, low trauma fractures, low bone density, incomplete or delayed sexual development, breast discomfort, loss of axillar and/or pubic body hair, hot flushes -OR- documentation of HIV infection in men with weight loss -OR- documentation of chronic steroid treatment in men. In all previously noted indications, members must also have documented low total testosterone level below the normal range for the laboratory -OR- a total testosterone level near the lower limit of the normal range with a low free testosterone level which is less than normal based upon the laboratory reference range -OR- the member is not producing any testosterone. Additional approvable indications include female patients with metastatic breast cancer (testosterone enanthate only), primary or secondary hypogonadism in males with testicular failure due to double orchidectomy, and delayed puberty in males (testosterone enanthate only).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	HIV Wasting
Part B Prerequisite	No

Thalomid

Products Affected

- **THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG**

PA Criteria	Criteria Details
Exclusion Criteria	Use as monotherapy for ENL treatment in the presence of moderate to severe neuritis
Required Medical Information	Documentation of multiple myeloma in combination with dexamethasone -OR- documentation for use in the treatment of cutaneous manifestations of moderate to severe erythema nodosum leprosum (ENL) -OR- documentation of therapy for prevention and suppression of the cutaneous manifestations of ENL recurrence
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Thiola

Products Affected

- *tiopronin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Confirmation of cystinuria by at least one 24-hour urine collection with measurement of urinary cysteine levels greater than 400 mg/day -AND- Attestation of failure of urine alkalization with potassium citrate (to achieve pH of 7.0).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of urine cystine concentration decreased from baseline -OR- decrease in production of cystine stones is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Thrombopoiesis Stimulating Agents

Products Affected

- **PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG**
- **PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of chronic immune idiopathic thrombocytopenia purpura and trial and failure of corticosteroid or immunoglobulin therapy or splenectomy -OR- documentation of thrombocytopenia in patients with chronic hepatitis C to allow the initiation and maintenance of interferon-based therapy (eltrombopag only)-OR- severe aplastic anemia who have had an insufficient response to immunosuppressive therapy -OR- documentation of first line treatment for severe aplastic anemia and used in combination with at least two immunosuppressive therapies.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Platelet count to be provided
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tibsovo

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) IDH1 mutation status, 2) alternatives tried/failed, 3) comorbidity that precludes use of intensive induction chemotherapy (i.e. age greater than or equal to 75 years, severe cardiac or pulmonary comorbidity, reduced renal function, hepatic impairment, or physician attestation) 4) Concomitant therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tolsura

Products Affected

- TOLSURA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- Unable to tolerate generic itraconazole capsules
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation the member is still unable to tolerate generic itraconazole capsules
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Topical Lidocaine

Products Affected

- *lidocaine hcl mucous membrane solution 4 % (40 mg/ml)*
- *lidocaine topical ointment*
- *lidocaine-prilocaine topical cream*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Transmucosal Fentanyl Citrate

Products Affected

- *fentanyl citrate buccal lozenge on a handle*
1,200 mcg, 1,600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg
- *fentanyl citrate buccal tablet, effervescent*
100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg
- *FENTORA BUCCAL TABLET, EFFERVESCENT 100 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of therapeutic use and the member is currently receiving and tolerant to long acting opioid therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tretinoin

Products Affected

- *adapalene topical gel 0.3 %*
- *adapalene topical swab*
- *adapalene-benzoyl peroxide*
- *clindamycin-tretinoin*
- **DIFFERIN TOPICAL LOTION**
- **RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.06 %**
- *tretinoin*

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic use
Required Medical Information	Documentation of acne vulgaris -AND- trial and failure or intolerance of at least two generic topical non-retinoid acne medications (e.g. clindamycin, sulfacetamide, erythromycin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Trikafta

Products Affected

- **TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL**
- **TRIKAFTA ORAL TABLETS, SEQUENTIAL**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cystic fibrosis (CF) in patients who have at least one F508del mutation or another mutation in the cystic fibrosis transmembrane conductance regulator (CFTR gene) that is responsive to elexacaftor/tezacaftor/ivacaftor based on in vitro assay (e.g. E56K, R117C, A455E)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, documentation supporting improvement or stabilization of FEV1 compared to baseline FEV1 -or- increase in body mass index -or- decreased pulmonary exacerbations -or- improved quality of life as demonstrated by CF Questionnaire is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Truqap

Products Affected

- TRUQAP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following (1-3): 1) HR mutation status, HER2 mutation status, and PIK3CA/AKT1/PTEN status 2) concomitant therapy with fulvestrant 3) disease progression on at least one endocrine-based regimen in the metastatic setting -OR- recurrence on or within 12 months of completing adjuvant therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tukysa

Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- All of the following, if applicable to diagnosis: 1) HER2 mutations 2) RAS genetic status 3) Alternatives tried/failed 4) Concomitant therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Turalio

Products Affected

- TURALIO ORAL CAPSULE 125 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of symptomatic tenosynovial giant cell tumor associated with severe morbidity and functional limitations -AND- patient is not amenable to improvement with surgery or not a candidate for surgery
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tykerb

Products Affected

- *lapatinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- All of the following, if applicable to diagnosis: 1) HER2 mutations 2) Alternatives tried/failed 3) Concomitant therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tymlos

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	Treatment duration greater than 24 months.
Required Medical Information	Documentation of diagnosis -AND- at high risk for fracture, meeting one of the following (1. thru 3.) 1) History of previous hip or vertebral fracture. 2) T-score less than or equal to -2.5. 3) T-score between -1.0 and -2.5 -AND- meets FRAX calculation (A. or B.) A) 10-year risk of major osteoporotic fracture is greater than or equal to 20 percent or B) 10-year risk of hip fracture is greater than or equal to 3 percent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	Documentation of trial/failure or intolerance to at least one oral bisphosphonate or all are contraindicated. Additional documentation of trial/failure, intolerance or contraindication to preferred parathyroid hormone analog teriparatide. Coverage of human parathyroid hormone related peptide analogs beyond 24 months will not be approved. A cumulative lifetime approval of Tymlos will be limited to a coverage duration of 24 months.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ubrelvy

Products Affected

- **UBRELVY ORAL TABLET 100 MG, 50 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of acute treatment of migraine with or without aura -AND- trial and failure of one generic triptan.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	Patients must have therapeutic failure, intolerance, or contraindication to Nurtec ODT. For reauthorization, attestation of reduction in migraine symptoms.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Valchlor

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Stage IA or IB mycosis fungoides-type cutaneous T-cell lymphoma in patients who have received at least one prior skin-directed therapy (e.g. topical corticosteroids, topical chemotherapy, local radiation and topical retinoids).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Valtoco

Products Affected

- VALTOCO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of seizure clusters or acute repetitive seizures -AND- the member is currently receiving antiepileptic maintenance therapy.
Age Restrictions	Deny if less than 6 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vancomycin

Products Affected

- *vancomycin oral capsule 125 mg, 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vanflyta

Products Affected

- VANFLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) Induction, consolidation, or maintenance therapy 2) FLT3 ITD mutation status, as detected by an FDA-approved test 3) Concomitant therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Venclexta

Products Affected

- VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis and concomitant therapy, if applicable to diagnosis. For newly-diagnosed AML, age greater than or equal to 75 years or presence of at least one comorbidity that precludes use of intensive induction chemotherapy (i.e. severe cardiac or pulmonary comorbidity, reduced renal function, hepatic impairment, or physician attestation) is required.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Verquvo

Products Affected

- VERQUVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of heart failure (NYHA Class II to IV) -AND- Left ventricular ejection fraction less than 45% -AND- Hospitalization for heart failure or received outpatient IV diuretics for heart failure -AND- Used in combination with a angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker or Entresto -AND- Used in combination with bisoprolol, carvedilol IR/ER or metoprolol succinate ER.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Verzenio

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following: 1) HR mutation status and HER2 mutation status 2) Alternatives tried/failed 3) Concomitant therapy, if applicable to diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Viberzi

Products Affected

- **VIBERZI**

PA Criteria	Criteria Details
Exclusion Criteria	Severe (Child-Pugh C) hepatic impairment
Required Medical Information	Documentation of diarrhea predominant, irritable bowel syndrome (IBS-D) -AND- trial/failure or intolerance to one of the following medications for IBS-D or documentation of contraindication to all: antidiarrheal (e.g., loperamide), antispasmodic (e.g., dicyclomine, hyoscyamine), tricyclic antidepressant (e.g., amitriptyline, nortriptyline).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vioice

Products Affected

- **VIJOICE ORAL GRANULES IN PACKET** **MG**
- **VIJOICE ORAL TABLET 125 MG, 250 MG/DAY (200 MG X1-50 MG X1), 50**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of severe manifestations of PIK3CA Related Overgrowth Spectrum (PROS)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vittrakvi

Products Affected

- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation -AND- Tumors are metastatic or surgical resection is likely to result in severe morbidity - AND- There are no satisfactory alternative treatments or tumors have progressed following treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vivjoa

Products Affected

- VIVJOA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of recurrent vulvovaginal candidiasis defined as at least 3 episodes of vulvovaginal candidiasis in less than one year -AND Documentation the member is NOT of reproductive potential defined as postmenopausal or another reason for permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	14 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vizimpro

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of metastatic non-small cell lung cancer -AND- one of the following (1 or 2): 1. Epidermal growth factor (EGFR) exon 19 deletions - OR- 2. Epidermal growth factor receptor (EGFR) exon 21 L858R substitution mutations.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vonjo

Products Affected

- VONJO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of intermediate or high-risk myelofibrosis -AND- attestation of a platelet count of less than $50 \times 10^9/L$.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Voriconazole

Products Affected

- *voriconazole intravenous*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- attestation that the beneficiary cannot take oral voriconazole
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For reauthorization, attestation of continued indicators of active disease (e.g. histopathology, positive cultures) is required
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vosevi

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance - AND- the member has a contraindication to or is otherwise not a candidate for all regimens recommended by the AASLD/IDSA guidelines containing the following agents: ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, glecaprevir/pibrentasvir.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Votrient

Products Affected

- *pazopanib*

PA Criteria	Criteria Details
Exclusion Criteria	Documentation of adipocytic soft tissue sarcoma or gastrointestinal stromal tumor
Required Medical Information	Documentation of diagnosis. For advanced soft-tissue sarcoma, trial/failure of at least one prior chemotherapy regimen.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vraylar

Products Affected

- VRAYLAR ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For a diagnosis of schizophrenia and bipolar I disorder, therapeutic failure, intolerance, or contraindication to one other generic atypical antipsychotic (e.g. quetiapine). For major depressive disorder, documentation of adjunctive therapy and therapeutic failure, contraindication or intolerance to one other generic antidepressant in addition to the antidepressant currently being used for the treatment of MDD (e.g. SSRI, SNRI, NDRIs, TCA, MAOI).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Vumerity

Products Affected

- VUMERITY

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other disease modifying agents such as interferons, Copaxone, Tysabri, Aubagio, Gilenya
Required Medical Information	Documentation of relapsing form of multiple sclerosis (e.g. relapsing-remitting, clinically isolated syndrome, or active secondary progressive disease) -AND- Therapeutic failure or intolerance to generic dimethyl fumarate
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Wakix

Products Affected

- WAKIX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of narcolepsy -AND- Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) - AND- Documentation of the following (1, 2, or 3): 1) Hypocretin-1 deficiency defined by (A or B), A) Cerebrospinal fluid hypocretin-1 less than 110 pg/mL. B) Cerebrospinal fluid hypocretin-1 less than 1/3 of the normal value based on laboratory reference range -OR- 2) Multiple sleep latency test (MSLT) documenting MSL less than 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than 8 minutes and 1 SOREMP and Polysomnography substantiating 1 SOREMP. If the member has a diagnosis of cataplexy provision of baseline number of cataplexy episodes is required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	If no diagnosis of cataplexy, trial and failure, intolerance, or contraindication to generic modafinil and a generic CNS stimulant indicated for use in narcolepsy (e.g. methylphenidate, amphetamine salts) is required. For reauthorization, provider attestation of improvement in symptoms of narcolepsy or improvement in symptoms of cataplexy (if applicable).
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Welireg

Products Affected

- WELIREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For von Hippel Lindau (VHL) syndrome, one of the following diagnoses not requiring immediate surgery (1, 2, or 3): 1) Renal cell carcinoma (RCC) 2) CNS hemangioblastoma 3) Pancreatic neuroendocrine tumor. For advanced RCC, prior treatment with a vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI) -AND- a programmed death receptor-1 (PD-1) or a programmed death-ligand (PD-L1) inhibitor.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xalkori

Products Affected

- **XALKORI ORAL CAPSULE**
- **XALKORI ORAL PELLETT 150 MG, 20 MG, 50 MG**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For metastatic non-small cell lung cancer (NSCLC), disease is ALK-positive or ROS1-positive. For relapsed or refractory anaplastic large cell lymphoma (ALCL), disease is ALK-positive. For unresectable, recurrent, or refractory inflammatory myofibroblastic tumor (IMT), disease is ALK-positive.
Age Restrictions	Deny if less than 18 years of age for NSCLC. Deny if less than 1 year of age or greater than 21 years of age for ALCL.
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For crizotinib oral pellets and NSCLC, inability to swallow capsules is required. For crizotinib oral pellets and ALCL / IMT, inability to swallow oral capsules -OR- body surface area less than 1.34 m ² is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xcopri

Products Affected

- **XCOPRI**
- **XCOPRI MAINTENANCE PACK**
- **XCOPRI TITRATION PACK**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of partial-onset seizures -AND- Therapeutic failure, intolerance or contraindication to 1 other anti-epileptic drug (e.g. carbamazepine, levetiracetam)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xdemvy

Products Affected

- XDEMVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis confirmed by identification of Demodex infection via microscopic examination of pulled eyelashes -OR- identification of collarettes via slit-lamp evaluation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xeljanz

Products Affected

- XELJANZ ORAL TABLET
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For moderate to severely active rheumatoid arthritis and an inadequate response or intolerance to methotrexate. Xeljanz immediate release for juvenile idiopathic arthritis, inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) -OR- requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage. For ankylosing spondylitis, inadequate response or intolerance to at least one nonsteroidal anti-inflammatory drug (NSAID).
Age Restrictions	Deny if less than 18 years of age for rheumatoid arthritis, psoriatic arthritis, ulcerative colitis, ankylosing spondylitis. For Xeljanz regular release tablet, deny if less than 2 years of age for juvenile idiopathic arthritis
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	The member has experienced inadequate response or intolerance to at least 1 tumor necrosis factor (TNF) blocker. Doses greater than 10 mg per day for Xeljanz and 11 mg per day for Xeljanz XR will not be approved for rheumatoid arthritis and psoriatic arthritis. Doses greater than 20mg per day for Xeljanz and 22 mg per day for Xeljanz XR will not be approved for ulcerative colitis.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xeljanz Solution

Products Affected

- XELJANZ ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of juvenile idiopathic arthritis -AND- Inadequate response or intolerance to at least one DMARD (e.g., methotrexate, leflunomide) or requires initial biologic therapy due to involvement of high-risk joints, high disease activity or at high risk of disabling joint damage.
Age Restrictions	Deny if less than 2 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	The member has experienced therapeutic failure or intolerance to at least 1 tumor necrosis factor (TNF) blocker.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xenazine

Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- attestation that the beneficiary is not actively suicidal
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	In patients with comorbid depression, attestation of adequate treatment for depression is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xermelo

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of carcinoid syndrome diarrhea AND used in combination with a somatostatin analog AND trial and failure of somatostatin analog monotherapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	3 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of reduction in average number of daily bowel movements -AND- the member will continue to use in combination with a somatostatin analog.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xgeva

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For hypercalcemia of malignancy, refractory to bisphosphonates. For giant cell tumor of bone, unresectable or surgical resection is likely to result in severe morbidity -AND- one of the following (1. or 2.)- 1.) the member is 18 years old or older -OR- 2.) the member is a skeletally mature adolescent (e.g. has at least one mature long bone)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xifaxan

Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of 1 or 2. 1) Diagnosis of hepatic encephalopathy AND trial/failure, intolerance, or contraindication to lactulose. 2) Diagnosis of Irritable Bowel Syndrome with Diarrhea (IBS-D) AND trial/failure, intolerance to one of the following medications for IBS-D or documentation of contraindication to all: antidiarrheal (e.g., loperamide), antispasmodic (e.g., dicyclomine, hyoscyamine), tricyclic antidepressant (e.g., amitriptyline, nortriptyline).
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	Hepatic encephalopathy: 1 year. IBS-D: 14 days.
Other Criteria	No more than three courses of rifaximin for the treatment of IBS-D will be approved per lifetime.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xolair

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic idiopathic urticaria with trial/failure or intolerance of a second-generation non-sedating H1 antihistamine at the maximum recommended doses (e.g., cetirizine, fexofenadine, loratadine, desloratadine, levocetirizine) -OR- Documentation of moderate to severe persistent asthma in patients with a positive skin test or in vitro reactivity to a perennial aeroallergen -AND- Baseline IgE titer greater than or equal to 30 IU/mL -AND- symptoms that are inadequately controlled despite a 3 month trial of both 1. and 2. 1) medium-dose inhaled corticosteroid or systemic steroid 2) a long-acting beta-agonist or leukotriene antagonist - AND- patient is currently on a long-acting beta2-agonist, leukotriene modifier, or theophylline -OR- Documentation of chronic rhinosinusitis with nasal polyps -AND- will use concomitantly with nasal corticosteroid maintenance treatment -OR- Documentation of IgE mediated food allergy confirmed by skin prick test or food-specific antibodies -AND- previous allergic reaction to food -AND- using for the reduction of allergic reactions (type 1), including anaphylaxis -AND- used in conjunction with food allergen avoidance -AND- member has a documented prescription for epinephrine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	For reauthorization, attestation of decreased rescue medication or oral corticosteroid use, decreased frequency of asthma exacerbations, increased pulmonary function from baseline (e.g. FEV1), or reduction in reported asthma related symptoms in treatment of asthma -OR- improved symptoms in treatment of CIU -OR- reduction in nasal polyp score or nasal congestion/obstruction severity score in treatment of nasal polyps -OR- member requires continuation of therapy and will continue food allergen avoidance in IgE-mediated food allergy
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xolremdi

Products Affected

- **XOLREMDI**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of WHIM syndrome (warts, hypogammaglobulinemia, infections, myelokathexis).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For reauthorization, attestation of reduction in incidence of infections is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xospata

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- FLT3 mutations, if applicable to diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xpovio

Products Affected

- **XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK)**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of use in combination with dexamethasone for relapse or refractory multiple myeloma with failure, intolerance or contraindication to 5 therapies (e.g. bortezomib, carfilzomib, lenalidomide, pomalidomide and daratumumab) -OR- Documentation of use in combination with both bortezomib and dexamethasone for relapse or refractory multiple myeloma after receiving 1 prior multiple myeloma therapy -OR- Documentation of relapsing or refractory diffuse large B-cell lymphoma with failure, intolerance or contraindication to at least 2 lines of systemic therapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xtandi

Products Affected

- XTANDI ORAL CAPSULE
- XTANDI ORAL TABLET 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- one of the following (1 or 2): 1) Concomitant GnRH analog, 2) The member has had a bilateral orchiectomy, if applicable to diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xuriden

Products Affected

- XURIDEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of hereditary orotic aciduria
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xyrem

Products Affected

- *sodium oxybate*
- **XYREM**

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>Diagnosis of narcolepsy -AND- Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) - AND- Documentation of the following (1, 2, or 3): 1) Hypocretin-1 deficiency defined by (A or B), A) Cerebrospinal fluid hypocretin-1 less than 110 pg/mL. B) Cerebrospinal fluid hypocretin-1 less than 1/3 of the normal value based on laboratory reference range -OR- 2) Multiple sleep latency test (MSLT) documenting MSL less than 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than 8 minutes and 1 SOREMP and Polysomnography substantiating 1 SOREMP. If the member has a diagnosis of cataplexy provision of baseline number of cataplexy episodes is required.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	<p>If no diagnosis of cataplexy- trial and failure, intolerance, or contraindication to generic modafinil AND a generic CNS stimulant indicated for use in narcolepsy (e.g. methylphenidate, amphetamine salts) is required. For reauthorization, attestation supporting improvement in symptoms of narcolepsy and cataplexy (if applicable) is required.</p>
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Xywav

Products Affected

- XYWAV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	<p>Diagnosis of narcolepsy -AND- Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) - AND- Documentation of the following (1, 2, or 3): 1) Hypocretin-1 deficiency defined by (A or B), A) Cerebrospinal fluid hypocretin-1 less than 110 pg/mL. B) Cerebrospinal fluid hypocretin-1 less than 1/3 of the normal value based on laboratory reference range -OR- 2) Multiple sleep latency test (MSLT) documenting MSL less than 8 minutes and 2 sleep-onset rapid eye movement periods (SOREMP) -OR- 3) MSLT documenting MSL less than 8 minutes and 1 SOREMP and Polysomnography substantiating 1 SOREMP -AND- Sensitivity to sodium intake due to heart failure, hypertension or impaired renal function. If the member has a diagnosis of cataplexy, provision of baseline number of cataplexy episodes is required. -OR- (II) Diagnosis of idiopathic hypersomnia - AND- Documentation of baseline data of excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS) or Maintenance of Wakefulness Test (MWT) -AND- documentation the member does not have cataplexy -AND- documentation of less than 2 SOREMPs -AND- documentation of the following (1, 2, or 3): 1) MSLT documenting MSL less than or equal to 8 minutes -OR- 2) polysomnography demonstrating total sleep time greater than or equal to 660 minutes per 24 hours -OR- 3) wrist actigraphy demonstrating total sleep time greater than or equal to 660 minutes per 24 hours.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	If diagnosis of narcolepsy without cataplexy- trial and failure, intolerance, or contraindication to generic modafinil AND a generic CNS stimulant indicated for use in narcolepsy (e.g. methylphenidate, amphetamine salts) is required. For reauthorization, attestation supporting improvement in symptoms of narcolepsy, idiopathic hypersomnia and cataplexy (if applicable) is required.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Yonsa

Products Affected

- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- all of the following: 1) Alternatives tried/failed 2) Concomitant therapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zavesca

Products Affected

- *miglustat*
- YARGESA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of mild to moderate type 1 Gaucher disease confirmed by the following (A. or B.) A. (1, 2, 3, 4, or, 5): 1)Hepatomegaly. 2)Splenomegaly. 3)Bone disease (i.e. osteonecrosis, osteopenia, secondary pathologic fractures, bone infarct). 4)Bone marrow complications as defined by anemia with hemoglobin less than or equal to 11.5 g/dL for females or 12.5 g/dL for males or thrombocytopenia with platelet count less than or equal to 120,000/mm ³ -OR- 5)Symptomatic disease (e.g. bone pain, exertional limitation, cachexia). -OR- B. Attestation of deficiency in glucocerebrosidase activity in peripheral leukocytes or genetic testing confirms mutant alleles.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Attestation enzyme replacement therapy (e.g. Cerezyme, Elelyso, or VPRIV) is not a therapeutic option
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zavzpret

Products Affected

- ZAVZPRET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of acute migraine headaches with or without aura -AND- Therapeutic failure, contraindication or intolerance to one generic triptan -AND- Inability to swallow capsules/tablets
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months initial authorization, 12 months reauthorization
Other Criteria	For reauthorization, attestation of reduction in migraine symptoms.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zejula

Products Affected

- ZEJULA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis. For advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer, member is in complete or partial response to first-line platinum-based therapy. For recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer, all of the following (1-2): 1) disease harbors a deleterious or suspected deleterious germline BRCA mutation 2) member is in a complete or partial response to platinum-based chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zelboraf

Products Affected

- TAFINLAR ORAL CAPSULE
- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	Wild-type BRAF melanoma
Required Medical Information	Documentation of diagnosis -AND- both of the following. 1) BRAF mutations, if applicable to diagnosis. 2) Alternatives tried/failed and concomitant therapy, if applicable to diagnosis (e.g. diagnosis of V600K metastatic melanoma and drug regimen of Zelboraf and Cotellic)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zepatier

Products Affected

- ZEPATIER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guidance - AND- the member has a contraindication to or is otherwise not a candidate for all regimens recommended by the AASLD/IDSA guidelines containing the following agents: ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, glecaprevir/pibrentasvir.
Age Restrictions	Deny if less than 12 years of age
Prescriber Restrictions	
Coverage Duration	Criteria/duration applied consistent with current AASLD-IDSA guidance
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zeposia

Products Affected

- ZEPOSIA
- ZEPOSIA STARTER KIT (28-DAY)
- ZEPOSIA STARTER PACK (7-DAY)

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Zeposia and other disease modifying agents such as interferons, Copaxone, Tysabri.
Required Medical Information	Documentation of diagnosis. For moderate to severe active ulcerative colitis, inadequate response or intolerance to one systemic therapy (e.g. methotrexate, cyclosporine).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Ulcerative Colitis: 12 months, Multiple Sclerosis: 24 months
Other Criteria	For moderate to severe active ulcerative colitis, patients must have therapeutic failure or intolerance to 2 of the following preferred products Humira, Xeljanz/Xeljanz XR and Stelara SC.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zokinvy

Products Affected

- ZOKINVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Hutchinson-Gilford Progeria Syndrome with mutation of the LMNA gene and BSA of 0.39 square meters or above -OR- Documentation of processing-deficient Progeroid Laminopathies with BSA of 0.39 square meters or above -AND- one of the following (1 or 2): 1) Heterozygous LMNA mutation and progerin-like protein accumulation 2.) Homozygous ZMPSTE24 mutations or compound heterozygous ZMPSTE23 mutations
Age Restrictions	Deny if less than 12 months of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zolinza

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of cutaneous manifestations in patients with cutaneous T-cell lymphoma (CTCL) who have progressive, persistent, or recurrent disease on or following 2 systemic therapies. Systemic therapies include bexarotene, interferon alpha, extracorporeal photochemotherapy, PUVA, single agent or combination chemotherapies (e.g. cyclophosphamide, vinblastine, romidepsin)
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zonisade

Products Affected

- ZONISADE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of partial-onset seizures -AND- Documentation of adjunctive therapy -AND- Inability to swallow capsules -AND- Therapeutic failure/intolerance to 2 or contraindication to all of the following (1-3): 1) generic carbamazepine suspension/chewable tablet/extended-release capsule, 2) generic lacosamide solution, 3) generic oxcarbazepine suspension.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ztalmy

Products Affected

- ZTALMY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of seizures associated with CDKL5 deficiency confirmed by genetic testing -AND- therapeutic failure or intolerance to 2 previous antiepileptic therapies
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zurzuvaе

Products Affected

- ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis of moderate to severe postpartum depression -AND- less than or equal to 12 months postpartum.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zydelig

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	First line treatment. Combination use with benadmustine and/or rituximab for the treatment of FL.
Required Medical Information	Documentation of diagnosis -AND- all of the following, if applicable to diagnosis: 1) Alternatives tried/failed 2) Concomitant therapy 3) Candidacy for use of rituximab alone
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zykadia

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- ALK mutations, as detected by an FDA approved test.
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Zytiga

Products Affected

- *abiraterone oral tablet 250 mg, 500 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis -AND- concomitant therapy
Age Restrictions	Deny if less than 18 years of age
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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ZILBRYSQ SUBCUTANEOUS SYRINGE 16.6 MG/0.416 ML, 23 MG/0.574 ML, 32.4 MG/0.81 ML	196
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ZOLINZA	398
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Brand ADHD

Products Affected

- *lisdexamfetamine 10 mg capsule*
- *lisdexamfetamine 20 mg capsule*
- *lisdexamfetamine 30 mg capsule*
- *lisdexamfetamine 40 mg capsule*
- *lisdexamfetamine 50 mg capsule*
- *lisdexamfetamine 60 mg capsule*
- *lisdexamfetamine 70 mg capsule*
- **QUILLIVANT XR 5 MG/ML (25 MG/5 ML) ORAL SUSPENSION, EXTEND RELEASE 24HR**

Details

Criteria	Require a 1 month trial of 2 of the following generic ADHD medications (Step 1 drug) when being utilized for the same medically accepted indication: methylphenidate, atomoxetine, dextroamphetamine/amphetamine or dexmethylphenidate in the last 180 days
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Celecoxib

Products Affected

- *celecoxib 100 mg capsule*
- *celecoxib 200 mg capsule*
- *celecoxib 400 mg capsule*
- *celecoxib 50 mg capsule*

Details

Criteria	Require a 1 month trial of 2 formulary generic NSAIDs (Step 1 drug) in the last 180 days
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GnRH Agonists

Products Affected

- *leuprolide 22.5 mg (3 month) intramuscular suspension*
- **LUPRON DEPOT 11.25 MG (3 MONTH) INTRAMUSCULAR SYRINGE KIT**
- **LUPRON DEPOT 22.5 MG (3 MONTH) INTRAMUSCULAR SYRINGE KIT**
- **LUPRON DEPOT 3.75 MG INTRAMUSCULAR SYRINGE KIT**
- **LUPRON DEPOT 30 MG (4 MONTH) INTRAMUSCULAR SYRINGE KIT**
- **LUPRON DEPOT 45 MG (6 MONTH) INTRAMUSCULAR SYRINGE KIT**
- **LUPRON DEPOT 7.5 MG INTRAMUSCULAR SYRINGE KIT**
- **TRELSTAR 11.25 MG IM SUSPENSION**
- **TRELSTAR 22.5 MG IM SUSPENSION**
- **TRELSTAR 3.75 MG IM SUSPENSION**

Details

Criteria	Require a trial of Eligard (Step 1 drug) in the last 180 days when being utilized for the same medically accepted indication
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Herpetic Keratitis

Products Affected

- ZIRGAN 0.15 % EYE GEL

Details

Criteria	Require a 1 month trial of generic trifluridine eye drops (Step 1 drug) in the last 90 days
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Riomet

Products Affected

- *metformin 500 mg/5 ml oral solution*

Details

Criteria	Require a 1 month trial of generic metformin IR tablets in the last 90 days -OR- documentation supporting the inability to swallow or difficulty swallowing tablets containing metformin
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Rytary

Products Affected

- **RYTARY 23.75 MG-95 MG
CAPSULE,EXTENDED RELEASE**
- **RYTARY 36.25 MG-145 MG
CAPSULE,EXTENDED RELEASE**
- **RYTARY 48.75 MG-195 MG
CAPSULE,EXTENDED RELEASE**
- **RYTARY 61.25 MG-245 MG
CAPSULE,EXTENDED RELEASE**

Details

Criteria	Require a trial of generic carbidopa/levodopa product (Step 1 drug) in the last 90 days
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Topical Antifungals

Products Affected

- *naftifine 1 % topical cream*
- *naftifine 2 % topical cream*
- *naftifine 2 % topical gel*
- **OXISTAT 1 % LOTION**

Details

Criteria	Require a 1 month trial of generic econazole cream and one of the following: generic ketoconazole cream or ketoconazole shampoo (Step 1 drugs),when being utilized for the same medically accepted indication, in the last 180 days
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Topical Psoriasis

Products Affected

- *calcipotriene-betamethasone 0.005 %-0.064 % topical suspension*
- *calcipotriene-betamethasone 0.005 %-0.064 % topical ointment*
- *calcitriol 3 mcg/gram topical ointment*

Details

Criteria	Require a 1 month trial of generic calcipotriene cream, ointment or solution (Step 1 drug) in the last 90 days when utilized for the same medically accepted indication
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Index of Drugs

calcipotriene-betamethasone 0.005 %-0.064 % topical ointment 8

calcipotriene-betamethasone 0.005 %-0.064 % topical suspension 8

calcitriol 3 mcg/gram topical ointment 8

celecoxib 100 mg capsule 2

celecoxib 200 mg capsule 2

celecoxib 400 mg capsule 2

celecoxib 50 mg capsule 2

leuprolide 22.5 mg (3 month) intramuscular suspension 3

lisdexamfetamine 10 mg capsule 1

lisdexamfetamine 20 mg capsule 1

lisdexamfetamine 30 mg capsule 1

lisdexamfetamine 40 mg capsule 1

lisdexamfetamine 50 mg capsule 1

lisdexamfetamine 60 mg capsule 1

lisdexamfetamine 70 mg capsule 1

LUPRON DEPOT 11.25 MG (3 MONTH) INTRAMUSCULAR SYRINGE KIT 3

LUPRON DEPOT 22.5 MG (3 MONTH) INTRAMUSCULAR SYRINGE KIT 3

LUPRON DEPOT 3.75 MG INTRAMUSCULAR SYRINGE KIT 3

LUPRON DEPOT 30 MG (4 MONTH) INTRAMUSCULAR SYRINGE KIT 3

LUPRON DEPOT 45 MG (6 MONTH) INTRAMUSCULAR SYRINGE KIT 3

LUPRON DEPOT 7.5 MG INTRAMUSCULAR SYRINGE KIT 3

metformin 500 mg/5 ml oral solution 5

naftifine 1 % topical cream 7

naftifine 2 % topical cream 7

naftifine 2 % topical gel 7

OXISTAT 1 % LOTION 7

QUILLIVANT XR 5 MG/ML (25 MG/5 ML) ORAL SUSPENSION,EXTENDED RELEASE 24HR 1

RYTARY 23.75 MG-95 MG CAPSULE,EXTENDED RELEASE 6

RYTARY 36.25 MG-145 MG CAPSULE,EXTENDED RELEASE 6

RYTARY 48.75 MG-195 MG CAPSULE,EXTENDED RELEASE 6

RYTARY 61.25 MG-245 MG CAPSULE,EXTENDED RELEASE 6

TRELSTAR 11.25 MG IM SUSPENSION 3

TRELSTAR 22.5 MG IM SUSPENSION.. 3

TRELSTAR 3.75 MG IM SUSPENSION.. 3

ZIRGAN 0.15 % EYE GEL 4